A history of the Nuffield Provincial Hospitals Trust

1940–1990

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Secretary of the Nuffield Provincial Hospitals Trust 1955–86

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Foreword

by SIR EDGAR WILLIAMS

Although later we were quite often in the same room, the only time I ever remember having a prolonged conversation with Lord Nuffield was when we first met: in the summer of 1953. He and his wife arrived an hour earlier than invited for the Rhodes Reunion Dinner at the end of our first year in Rhodes House so Gillian and I had to keep them in play. Lady Nuffield was painfully shy and her husband no man for small talk: looking back, it was much like Jane Carlyle's description of a friendship in which all the reciprocity was one side.

It must have been ten years later that we were invited, as one more instance of his purposeful hospitality, by Dr J O F Davies, the Medical Officer of Health of the Oxford Regional Hospital Board, to dine with Alison and himself at their farm in Stadhampton, Gordon McLachlan amongst the other guests. By then I was involved with at least one of the other Nuffield benefactions, for I had succeeded Dr A Q Wells as a Trustee of the Oxford and District Hospitals Improvement and Development Fund, on which I am still enjoyably serving these thirty-five years later. Too, I was already a member, alongside Carl Kingerlee, the former racing driver who was Lord Nuffield's personal secretary, of the Oxford Regional Hospital Board under the rigorous Chairmanship of Sir George Schuster, which is how J O F Davies and I had come to know one another.

Not long afterwards I got a letter from the Hon. Sir Geoffrey Gibbs (who was a fellow Curator of the Oxford University Chest) evidently drafted by Gordon McLachlan, asking me to become a Governing Trustee of the Nuffield Provincial Hospitals Trust. On 24th January 1963 there followed a coronet-headed note from Cowley, drafted presumably by Carl Kingerlee:

'I believe', Lord Nuffield said, 'the purposes and activities of the Trust have already been described to you, so I feel there is no need for me to go into further details, except to express my belief, which I hope you will share, that the Trust can continue to play its part as a body independent of the statutory authorities and thus make an important contribution to the development and improvement of the health services in this country.'

Having satisfied myself some time before, or so Gordon McLachlan has sometimes reminded me, that 'the Intelligence

set-up' was satisfactory, I accepted: or obviously I wouldn't be writing this now. Sir David Lindsay Keir, the Master of Balliol, where I was then still a Fellow (whom I was to succeed not only as a Governing Trustee but also on the Board of the United Oxford Hospitals) urged me to sustain the especial interest in the administration of the NHS which had been one among his abiding pre-occupations throughout his own time on the Trust, of which he had been one of the founding fathers. This bias I shared and so, as all the world knows, did the Secretary. Those were the days before all appointments in the NHS came from party patronage, so that when at the end of 1965 I resigned from the U O H and the Regional Board, to avoid any clash of interests on my succeeding Geoffrey Gibbs as Chairman of the Trust early in 1966, the Labour Secretary of State appointed my wife, Gill to the vacancy on the U O H. She has brought to the N H S a far clearer head and a much deeper dedication than I could begin to contribute and is still, five grandchildren later, soldiering on for it today.

Before taking over from Geoffrey Gibbs I had already begun, as a Governing Trustee, nigh upon thirty years of strenuous and untrammelled argument which has continued unbroken ever since with the writer of this history. We had in common much optimism, abominable handwriting, the fiercest of prejudices, inflated egos, shortish fuses, a love of words (especially our own), admirable G Ps and markedly unselfish wives.

Of one's original colleagues on the Trust, from which I formally retired this year, Dr John Fry alone remains, the doyen of G Ps, who has perforce himself had to retire from his N H S general practice at Beckenham this year (but, happily, not as a Governing Trustee of the Trust): Geoffrey Gibbs himself, Henry the Lord Cohen of Birkenhead (who first befriended me in the University Club in 1936 when he was the youngest clinical professor in the United Kingdom and I was the youngest Assistant Lecturer in Modern History in the University of Liverpool) and Ursula the Viscountess Ridley (who wasn't 'Ned' Lutyens's daughter for nothing) have all died: Sir George Hayter Hames, whom I first encountered when we were staying at Craiganour on Loch Rannoch, died in 1968, the year after Sir Evan Ag Norton, known to his Balliol contemporaries in the 'twenties as 'Gussie Norton', the astute solicitor who was Chairman of the United Birmingham Hospitals. Surviving us all is Mr Leslie Farrer-Brown, the originating Director of the

Nuffield Foundation who had been Secretary to the creative Goodenough Committee on Medical Schools (1942–4) and who retired from the Nuffield Provincial Hospitals Trust in 1967, not long after I became its third Chairman. I doubt if he had ever reconciled himself to the wresting of the Trust from beneath the Foundation's umbrella and my arrival as a new broom no doubt underlined the severance (Geoffrey Gibbs, like 'Will' Goodenough before him, had been Chairman of both). His departure was undoubtedly my fault. Wartime experiences followed by a year in the U N and teaching in 'Sandy' Lindsay's Balliol, itself succeeded by Sir Edward Peacock's leadership of the Rhodes Trust have all gone to convince me with the persistent belief in the importance of decisiveness. (I am not of course pretending here that they have made me decisive myself.) And Sir Douglas Veale, the Registrar at Oxford (and in whose old house I now write this) who steered most of the Nuffield benefactions from his coign of the University, shared this prejudice. He had the highest admiration for 'Will' Goodenough of Barclays Bank, the first Chairman of the Nuffield Provincial Hospitals Trust. To my great regret I never met him. I wish I had. I know about him from Douglas Veale and from George Hayter Hames who had come up to Christ Church in 1919 on 'demob leave' (as we learned to call it in a later dispensation) to begin a firm friendship with 'Will' Goodenough who arrived by way of Wellington and the Coldstream, George himself a Wykehamist from the Life Guards. They were both countrymen, Sir George eventually becoming Chairman of the Devon County Council from Chagford, Sir William Goodenough, of the Oxford County Council from Filkins where he died, too young, 23 May, 1951.

Decision, without dawdling, yet without bruising, was of 'Will' Goodenough's nature, it is my guess. Geoffrey Gibbs, his successor, a master of how to take a meeting equably to finish exactly on salivation time, had a different approach. He much preferred, I think, to dawdle to avoid any bruising. He was a very nice man and for this reason all the more difficult to succeed. He never lost a friend of that I am sure and he had them in plenty; I much enjoyed being one.

When one man—and that man a Scot—holds the executive office of a charity virtually from its inception it is obvious that his personal mark will be laid upon it, however striking the personalities of his Trustees or his Chairmen. Gordon McLachlan was Secretary of the Nuffield Provincial Hospitals Trust

for thirty years (1956–86). His background is Edinburgh—he was born in Leith in 1918—and his formative training lay in the financial side of Scottish Local Government. He was articled to the City Chamberlain of the Edinburgh Corporation and grew up with the abiding stamp of that administrative methodology. After war service as a gunnery officer in the Royal Navy, during which time he played rugby football for the United Services, he entered the National Health Service early in its history. From 1948 to 1953 he was Deputy Treasurer of the North West Metropolitan Regional Board in the heyday of Dr J O F Davies as Deputy R M O. Thence he passed as Accountant to the Nuffield Foundation.

A Q Wells, at the Sir William Dunn School of Pathology, the first Chairman of the Oxford Regional Board, who had the Founder's confidence, was determined—and so was Sir Ernest Rock Carling—that the Provincial Hospitals Trust should get out from under the Nuffield Foundation's embrace into an effectively separate entity and it was not long before the youthful Trust, with Gordon McLachlan as its Secretary, moved from Nuffield Lodge to 3 Prince Albert Road, a house belonging to the Crown Commissioners, when the Gulbenkian Foundation vacated it in 1962.

To his unique task McLachlan brought financial probity, imaginative dynamism, and a deeply emotional, nay, a Covenanter's, belief in the National Health Service.

Owing to the nature of the benefaction, only the income of the Nuffield Provincial Hospitals Trust was for regular dispersal, the capital under Lord Nuffield's wary eye having separate (Ordinary) Trustees, of whom he himself was one, lest his charities rocked the market. Clearly, a benefaction based on a single industry needed especially shrewd piloting and the Scots accountant made early provision from income for a reserve, the accumulation of which over the years might allow for diversification of the initially one-track portfolio: husbandry which enabled the Trust to continue its benevolence once the bottom fell out of the British automobile industry.

A second financial factor affecting the Trust's development lay in the evolution of the National Health Service itself. In its early days the Trust made grants as seedcorn for experiments in the Service in the provinces and set about showing whether a particular development was (or was not) worth its investment. Once however a need had been effectively proved, the Trust had

a decent expectation, the risk having been privately taken, that the burden of recurrent maintenance would begin to fall on the national purse, so that the Trust itself might then turn to other imaginative ploys of its own. It was not long before the exigencies of a persistently underfunded and increasingly expensive Service prevented the smooth passage from benefaction to recurrent subsistence and the Trust had to adapt its interpretation of its brief. Herein lay one of McLachlan's especial contributions.

Grants had come to be tested by way of recipients justifying them at a seminar—with due hospitality—of their peers. Rather than have the results of these assays remain under a bushel, Gordon McLachlan, who had already revealed his journalistic flair as a member, alongside The Hon. David Astor, of the Editorial Board of the *Nineteenth Century*, set about making available the findings of these seminars. The Trust soon became a publishing house and thus began the link with Mr Bernard Crossland who brought his efficient and sensitive craftsmanship to our service and who is printing this very book, his one hundred and twenty-seventh, for the Trust. Particular studies seeking to make health care delivery in the Provinces more effective were published alongside or after the findings of the seminars. Once the lease of No. 4 Prince Albert Road was acquired from the Commissioners, the Trust's headquarters were expanded by a seminar room linking the two buildings and bedrooms used to house the temporary recipients of the Trust's ready hospitality. Overseas visitors were welcomed as more grist and Gordon McLachlan's links with American health care delivery and especially with the American Hospitals Association, were kept in good repair. Visitors of international calibre such as Professor Walter McNerney and Professor Alain Enthoven were often to be encountered at Prince Albert Road. U K contacts were of course by no means neglected, and although not every busy mandarin or his political master might welcome their decisions or their implementation being regularly, indeed pungently, held up for close examination, nevertheless it became wry Whitehall doctrine that 'a stone in the shoe' was a character-building experience and a needful part of the price of a democratic jousting when so much public money was involved in the administration of a national Service. Moreover, the pages of the Trust publications remained open to the Elephant and Castle as well as the saturated electorate in the days well before

White and other coloured Papers deluged quite so readily from the Stationery Office at public expense.

So, with publicity which the Secretary enjoyed, sharp scrutiny which stemmed from his initial apprenticeship, imaginative enthusiasm marched hand in hand to maintain the impetus of reform throughout McLachlan's tenure.

The Trust was economically run, as his background insisted. Speed to recognise an opening was the hallmark of the former fly-half and vigour joined optimism to underpin a contributive offering to the public. Clearly, he cherished his work as Secretary and it is most remarkable that a man with no formal clinical qualifications should singlehandedly establish a trusted position as mentor (some thought the scourge) of the Health Establishment.

Much of his retirement has been devoted to an analysis of the Trust's first fifty years, of which he alone knows the inside story, a task he was invited to undertake when he was succeeded by Dr Michael Ashley-Miller when he retired in 1986 confident, as I was, and we both remain, that our legacy was utterly and entirely safe in the custody of his successor, just as it remained two years later, when Sir Maurice Shock became the Trust's fourth Chairman.

There follows Gordon McLachlan's personal account and I would not seek to lay a gloss upon it. I have been suffered to read it at each and every stage and may now cheerfully retire from the editorial committee on which I was instructed to remain until this task was accomplished. Sir Derek Mitchell, yet another Christ Church man, who is taking over this duty will bring, in the best tradition of the Public Service of which he is so notable an exemplar, a far more disciplined mind and a far tighter command of English gramatical usage than I have ever conjured up. A slight Dark Blue-rinse and the occasional semi-colonic irrigation have been about the extent of my alchemy. He will be joining on the editorial committee not only Dr Michael Ashley-Miller himself but also Professor John Ledingham, the senior Medical Fellow of New College and May Reader in the University of Oxford who but a year ago brought me back to life when I was gasping in the John Radcliffe Hospital here. I am deeply grateful to him and his clinical skill and smiling solicitude; nor must he be blamed for the unconscionable length of this preface.

So far there has been bare mention of those other Trustees who have been one's enjoyable companions on the Trust. Lord

Younger at Leckie and Sir Andrew Watt Kay in Glasgow, both widowers, have both had to disregard Dr Johnson's advice and can no longer come to London; and Professor Archibald Duncan, happily no widower, in Edinburgh, the Trust's most dependable counsellor, can no longer venture South either. Sir Hugh Norrie Robson, the Principal of Edinburgh, died prematurely in 1977. The two other of the Trust's main counsellors Sir George Pickering and Sir John Revans have also died and the loss of their verve and their ebullient contributions is an especial deprivation. There remains Sir Maurice Shock, amongst the first of my post-war 'pupils' at Balliol (and by far the ablest) from whom I learned so much then and ever since, drawing regularly as I do upon his quiet sagacity. He is now safely back in Oxford as the Rector of Lincoln College after ten years as Vice-Chancellor of Leicester, where he most successfully nursed the splendid Medical School there with Sir Robert Kilpatrick as his Dean; still serving are, the unflagging John Butterfield, a Life Peer these days who, though an Oxonian himself, has been both Regius Professor of Physic and the Master of a Cambridge College and later its Vice-Chancellor, Sir John Donne, the entirely dependable Carthusian solicitor from Sussex (and now Shropshire) who was once Chairman of the South East Thames Regional Health Authority; and 'Joe' Burnett-Stuart, (whom I first met at meetings of the Investment Committee of the University Chest) until lately the Chairman of Robert Fleming Holdings Ltd., the merchant bankers, his original black mop having frosted into a statesmanlike iron-grey, who has gently but firmly nursed our funds over these long days, so that the Trustees now have some £2.5 million each year to expend upon their righteous purposes. And finally (chronologically, that is) Sir Raymond Hoffenberg, our Rock Carling Fellow in 1986, who joined the Trustees so soon as he had completed his sapient Presidency of the Royal College of Physicians. Five clinicians, then, amongst us laity and, should any of the Trust's guests fall sick, the rush of healers is reminiscent of Twickenham.

What follows is Gordon McLachlan's account of our united history. What seems remarkable to me is the extent to which he has managed to minimise the autobiographical, a note this foreword so unashamedly fails to do, as I enter upon my eightieth year with this swansong to a body of men and women who have brought me such happiness. We have all been immensely sustained over the years by Mrs Patricia McKellar,

the Trust's devoted Publications Manager and so much else, to whom we are all most agreeably indebted. And more recently by Max Lehmann, Dr Michael Ashley-Miller's Assistant Secretary, both of them Oxonians; and, throughout, by the loyalty and willingness of the staff of 3 Prince Albert Road, especially Sheila McGregor and Michael Jones, the accountant, and at No. 4 Mr and Mrs Geoffrey Taylor. This is my last chance to record our gratitude to the friendship of their predecessors: especially, Felix Bradfield, Richard Shegog, Calum Paton, Constance Fisher, Jacqui Pearson and Elizabeth Haynes. All these, and many others, have gone to make 3 & 4 Prince Albert Road a most welcoming place; and so it is today: a pleasant half-hour's stroll (a mite longer, of course, these days) to Lord's.

94 Lonsdale Road,
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CHAPTER 1
INTRODUCTION

Introduction

THE HISTORY OF AN INSTITUTION IS CONDITIONED BY the environment in which it has operated. Thus this chronicle of the principal activities of the Trust, including the research supported over the period of review, has to be seen against some of the major contemporary questions concerning several parts of the complex infrastructure of health care services to which the Trust has reacted in seeking to fulfil its purposes.

It therefore traces the threads of the tapestry of health concerns which have affected the UK since 1939 and provides snapshots of the changing scene in health affairs, since some of the issues and problems commonplace now, were undreamt of when Lord Nuffield gave notice of its founding in December of that year. Most of the thinking then was concentrated on the need for a rationalisation of hospital services providing essentially personal services, the bases and understanding of the nature of which have developed since, almost beyond recognition. It does not however pretend to include an outline of a definitive history of the health services over that period, since inevitably the effects of the various changes in the infrastructure of services and the appreciation of the results of much research and activity in the areas of health in which the Trust operates take a considerable time to show results.

The narrative shows how the Trust developed a character and a distinct *persona* early in its life which, convenient for the telling of history, subsumes the positive roles and personal contributions of individual Trustees and staff. The several references which constitute the co-ordinates of the historical outline, however, also enable special point to be given to the fact that the Trust has always recognised that its constituency and the sinews for action are the individuals and institutions concerned with improving the provision and quality of services.

The sketch, for it claims to be no more, is drawn from the developing life of the Trust as revealed by its prime records and its publications, consisting of the periodic Reports together with the wealth of books and essays the authors of which are those individuals whose ventures have been supported. These are some of the heroes and many of the most talented players in the field of health in the United Kingdom over the past 50 years, and on whose capabilities the Trust has been proud to rely. Their actions and the writings referred to in the text and especially

those listed severally in Appendix 3 constitute a substantial part of the post-war literature of health services research and analysis, with the Trust acting as broker, impresario and publisher. Indeed, together with the Trustees and Advisers, the authors form a Who's Who of distinction in the health field since 1940.

Foundations have been likened to merchant banks. This albeit abbreviated record of the main activities of the Trust indicates where the main 'investments' have been placed; and the publications show what has resulted by way of relevant information for those who wish for a better illumination of the health scene to allow for objective assessments of the problems and so to their solutions. Whether such enlightenment has had any effects on those who determine public or private policies at both national and local levels is almost impossible to judge. The temptation to reproduce the multitude of favourable comments in the archives of the Trust on the material published and referred to in the text has however been resisted (with only one exception to make a special point), since their quality and worth can best be judged by studying them severally and in detail. It is however tempting to believe that some of the publications and contemporary comments on them may well provide the sources for future theses in the burgeoning area of health policy research.

While fiercely proud of its independence, the Trust because of the breadth of its purposes has had for a long time a special affinity to the NHS. In the years during the War when the structure of the Hospital Service was being determined, a special partnership was created with the Health Ministries which resulted in the production of the Hospital Surveys which were popularly known as the Domesday Books and on which the regionalisation of hospitals, the main feature of the 1946 Acts, was based. Subsequently because of the common nature of objectives, the text contains notes of some of the relevant contemporary problems of Health Services in the United Kingdom the *improvement* of which is an obligation which the consolidating NHS Act 1977 has specifically placed on the Secretary of State but which has always been the objective of the Trust. It hardly needs underlining that how the Trust has reacted to certain events and problems and how these have influenced its policies, are necessary ingredients in its History.

Like most histories, that of the Trust does not start with its foundation. Its genesis, as indeed that of the NHS, was

undoubtedly in the drive for greater efficiency in service provision and the thinking about the need to co-ordinate hospital services between the two World Wars as the major step towards effective, economical health services. While the Trust's geographical area of operations is the Provinces as a whole, viz. 'that part of the United Kingdom outside of the Metropolitan Police District of London', the bulk of the issues addressed are of a national, many indeed of a universal nature.

The place of conception and the determination of its character and style however, was Oxford; and the enthusiasm and drive at its birth owed much to the success pre-War, of the Oxford and District Hospital Council in co-ordinating Hospital Services. It is perhaps significant of the necessarily close bond which for effectiveness has to exist universally between learning and service, that part of the success which attracted Lord Nuffield was due to the close association the Council formed with the University during the critical period of the founding of the Clinical School.

CHAPTER 2
THE FIRST YEARS
CREATION AND DIRECTION

The First Years

CREATION AND DIRECTION

1. THE BIRTH OF A FOUNDATION

In mid November 1939 Lord Nuffield wrote informally to the Minister of Health, Colonel Walter Elliot, telling him of his intention to create a new Foundation to be called The Nuffield Provincial Hospital Trust; and the following month on the 6th of December he wrote formally that he was founding the Trust with a fund consisting of one million Ordinary Shares in Morris Motors Ltd, then worth about one million pounds and estimated to produce an annual income of about £100,000[1].

His hope was that, in course of time, a truly national hospital service might be evolved '... which would embrace all that is best of both public and voluntary effort, with the maximum of economy to the State and to the private purse'.

The broad objective of the Trust was to promote the co-ordination of hospital and ancillary services in the provinces, both voluntary and local authority, and also in general to create a provincial equivalent of the King Edward's Hospital Fund for London.

The purposes of the Trust set out in the Trust Deed which was formally signed on 25 June 1940 were:

> the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of financial provision for the creation and carrying on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination. (See Appendix 1).

2. THE ATMOSPHERE AT BIRTH

The winter of 1939 was the first of the Second World War and, on land, it was the period of the 'phoney war', so termed because little activity was taking place either as had been expected and feared in the air, or on land involving large armies. Yet there were constant reminders of a real enough war in reports about occasional air sorties and a war at sea with already not a few

1. The 1990 value of these sums would be respectively Capital c. £27m and Income c. £2.7m p.a. (see p. 327)

disasters which caused uneasiness, since these posed threats which boded ill for the lifelines necessary for our island survival.

Thus when Lord Nuffield was corresponding with the Minister of Health there was as yet little evidence of any major success to place against these dire happenings to the traditional first line of the nation's defences.

Nevertheless, these serious conditions did nothing to halt the birth of the Nuffield Provincial Hospitals Trust in an atmosphere of optimism for the rationalisation and improvement of hospital services in the future. Optimism is perhaps the key element in the establishment of all philanthropic Foundations, the very nature of which requires their Trustees to be concerned with the long view of their purposes, working in one way or another to improve the welfare of mankind. Nor was this optimism in any way shaken before the Trust Deed was formally signed in June 1940, by the traumatic contemporary events when the campaigns in Norway and France aroused anxieties about British survival in the face of overwhelming German victories on land and thus at the beginning of our lowest ebb. Indeed the Trust Deed was signed after 'Dunkirk' had become more than the name of a French Channel port.

A review of the Trust's policies and actions shows that this optimism has been a major motivating force and has not faltered at any time during the fifty years of its existence.

3. THE HOSPITAL CO-ORDINATION SCHEME

THE BACKGROUND TO LORD NUFFIELD'S GIFT.

The general background of interest in health care against which the Trust was founded, and the efforts made previously to solve the difficulties encountered and the progress achieved in the 1920's and 1930's in hospital development, has been sketched in some detail largely from the Whitehall point of view by Mr J E Pater in *The Making of the National Health Service* (1981) and by Dr Charles Webster in *Health Services since the War (Vol. 1)* (1988); but it is perhaps worthwhile to highlight the issues of health services as seen from a peripheral viewpoint, rather than from that of Central Government.

The idea of the co-ordination of hospital services was not new, but, by the beginning of the War the pressures made to translate it into action from those concerned with the key institutions, the hospitals, had borne very little fruit.

As far back as 1920 the *Report of the Consultative Committee on Medical and Allied Services* (appointed by the Ministry of Health under the Chairmanship of Lord Dawson of Penn) had advocated the amalgamation of Municipal and Voluntary Agencies as the basis of a scheme for the establishment of Health Authorities whose task it would be to administer locally all forms of medical service. Later, both the Voluntary Hospitals ('CAVE') Committee, set up by the Ministry of Health, and Regional Committees established by the British Hospitals Association, attempted to bring about closer relations between the Voluntary Hospitals in certain areas. Section 13 of the Local Government Act 1929 (later repealed and its provisions strengthened by the Public Health Act 1936), gave for the first time statutory expression to the need for co-operation between Voluntary Hospitals and Local Authorities.

The Public Health Act 1936 made it obligatory for a Local Authority, when making provision for hospital accommodation, to consult a committee or body representative of the governing bodies and the medical and surgical staffs of the Voluntary Hospitals in the area.

The year before this Act was passed the British Hospitals Association appointed a Commission presided over by Lord Sankey. This Commission recommended:

(i) the division of the country into hospital regions

(ii) the formation of voluntary hospital regional councils to correlate hospital work and needs in each region

(iii) the setting up of a voluntary hospitals central council to co-ordinate the work of the regional councils.

A Provisional Council was appointed to decide how these recommendations might be put into effect, but it was hampered by lack of funds. The Commission had confined its enquiries and recommendations to Voluntary Hospitals but it had for some time been apparent that it was not possible to ensure the full co-ordination of hospital and ancillary medical services unless the co-operation of Public Health Authorities was secured. Even within the voluntary hospital field the efforts of the Provisional Central Council met with little success, and progress towards co-operation between Voluntary Hospitals and Local Authorities, except in a relatively few areas, was still limited. Voluntary and Municipal Hospitals were competitive rather than complementary. A major factor was the growth and improvement during

the Thirties of Local Authority Hospital Services, in particular in London, Middlesex and Lancashire, which were examples to other Local Authorities of what was possible by public enterprise.

With the outbreak of war the financial position of hospitals throughout the country became increasingly precarious, and it was obvious that, unless steps were taken to accelerate the co-ordination of hospitals, there was a grave danger that the financial difficulties of the voluntary hospital system would soon be so serious as to affect local services.

An important factor in the situation outside London, which had become all too evident, was the lack of central finance due to the absence of any Central Fund for Provincial Hospitals including those in Scotland and Northern Ireland. The King Edward's Hospital Fund served as a central organisation which catered in a limited way for the special financial needs of Voluntary Hospitals in the London area. There was no comparable fund for Provincial Hospitals.

Lord Nuffield had in 1935 been persuaded to support the initiation of an experiment which had proved successful in the co-ordination of hospitals in the Oxford District; and with these considerations in mind, in November 1939, Mr W M (later Sir William) Goodenough, the local Director of Barclays Bank Oxford, a participant in the successful Oxford experiment and a close confidant, approached Lord Nuffield about the urgency of the problem in the country as a whole. His main point was that the time probably provided a unique opportunity for founding on the success achieved in Oxford and promoting the regional organisation of hospital services, both Voluntary and Local Authority, in the Provinces.

Lord Nuffield, an action man if ever there was, 'with characteristic foresight and public-spiritedness', immediately grasped the points made to him and at once approached the Minister of Health and announced his intention of creating a new charity, a Provincial Hospitals Trust, to which he proposed to donate one million shares in Morris Motors Limited. The Minister of Health was appreciative of Lord Nuffield's munificent proposal and responded with the important gesture that the proposal to promote the co-ordination of the hospital services in the provinces had his entire approval. He urged Public Health Authorities to co-operate with Voluntary Hospitals in the furtherance of the scheme.

4. THE OXFORD CONNECTION

At the outset, the Oxford connection in the conception of the Trust and its environment, is perhaps crucial to an understanding of the origin of the Trust's purposes and its subsequent policies. Not only was Lord Nuffield closely associated with Oxford, but so also were the first officers of the Trust, the Chairman, Mr (later Sir) William Goodenough and the Secretary, Mr William Hyde, together with the Regius Professor of Medicine, Sir Farquhar Buzzard, firmly rooted in Oxford too. The pride in the inspiration Oxford gave to the Trust's foundation is reflected in the original Trust Deed providing specifically that the Headquarters of the Trust were to be in Oxford.

It is evident, however, that this inspiration grew out of the fact that not only had Lord Nuffield, over the years, become fascinated by the notion of improving health arrangements, but he had scored a marked success in his support through his benefactions which contributed greatly to the founding of the Oxford Clinical School. Oxford too, had been the site for two successful ventures in the medical care field in which he had been involved which contributed greatly to the hospital cover in the area and of which he was proud. These were the setting up and operation of the Oxford and District Council for Hospitals, as well as the the Oxford Provident Association which had been started by Alderman William Hyde in the Twenties and Thirties to promote financial support for hospitals. Indeed, the success of the former venture was indeed the origin of the main purpose of the Trust. Thus, from the beginning, not least because it had the resources previously lacking to those interested in better co-ordination, the Trust became the leader in practical steps to make concrete the notion of the regionalisation of Hospitals which eventually was a fundamental feature of the NHS Act 1946.

5. THE PANTHEON OF THE TRUST

Four remarkable Oxford men, in at the birth of the Trust, in different ways exercised great influence in the early days, in the approach to fulfilling the purposes set out in the Trust Deed and the development of a distinct *persona*. The most notable features were the establishment of an independent attitude and stance, and a spirit of enterprise.

Prime among these individuals was of course the Founder, Lord Nuffield. The benefactions of Lord Nuffield altogether add

up to an impressive list and one or two are specially relevant in the history of the Trust. Before the advent of the Trust in 1939, Lord Nuffield had helped considerably the development of the Oxford and District Hospital Council which had blazed the trail of co-operation in its successful attempts to co-ordinate hospital services of all kinds, public as well as private, in the Oxford District. The major benefaction to the University for medical purposes was a major step forward being a matter of universal medical as well as local interest in the stimulation it gave to the development of the Clinical School in Oxford.

Mr (later Sir) William Goodenough, the Local Director of Barclays Bank in Oxford had been closely concerned for the previous 15 years in giving advice to Lord Nuffield, as a direct result of Morris Motors banking with Barclays. He became the Chairman of virtually all of the Nuffield benefactions, of which the major were the setting up of the Nuffield Institute of Medical Research, the Dominion Scholarship Fund, the Medical School Benefaction, Nuffield College, the Nuffield Forces for the Crown, the Nuffield Trust for the Advancement of Medicine and ultimately the Provincial Hospitals Trust.

Sir Farquhar Buzzard, Regius Professor of Medicine at Oxford from 1927 to 1943, was a considerable figure in Oxford life and in the development of Oxford medicine. Buzzard had been closely connected with Lord Nuffield in his medical benefactions for the development of the University Clinical School. By the time he retired it was generally accepted that Oxford had moved to the forefront of British Medicine because of his leadership. It was he who first presented the needs of Oxford Medical Studies and the possibilities of their development in such a way as to capture the imagination of Lord Nuffield which eventuated in Lord Nuffield's benefaction in two main stages: the foundation of the Nuffield Institute of Medical Research in 1929, and in 1936 in the promotion of the Nuffield scheme for the Advancement of Medicine. What was less apparent to the general public in these foundations, was that there were no little local difficulties with the existing Medical School and that the successful working of all depended upon the linking up and close co-operation between three groups of institutions, the Oxford and District Joint Hospitals Board, the Nuffield Clinical Departments of the University and the University Pre-Clinical Departments of Physiology, Anatomy, Pathology, Biochemistry and Pharmacology. It was held that it

was 'mainly due to Buzzard's efforts that this successful co-operation had been achieved, possessing as he did in abundance those qualities of tact, patience, a receptiveness to criticism, power of conciliation, combined with quiet determination which are necessary to statesmen and to all pioneers of noble schemes'. It is also notable, and relevant to all the Trust's early interests that Buzzard in association with Alderman William Hyde was behind the development of the Oxford Provident Association Scheme, which in time was extended to Members of the University. This had the twin advantage of not only helping the individuals concerned, but importantly helping the finances of the Oxford Hospitals as well. This was also the forerunner and the base to what became the British United Provident Association (BUPA), the first General Manager of which, E F Webb, had been employed by Hyde.

Alderman Hyde was another unusual character who was closely rooted in Oxford life, both as a public figure and private individual. He had become a Member of the Oxfordshire County Council soon after the 1914–18 War and from 1931 he was an Alderman particularly interested in Public Assistance and in Regional Planning. Hyde who became the first Secretary of the Trust, was also an adviser to Lord Nuffield in his charitable activities and had taken a leading part in the organisation of hospital services in Oxford and its surrounding District. When he died, it was commented that

> his unrivalled knowledge of Medical Services and everything appertaining to them was the foundation upon which the Nuffield Provincial Hospitals Trust and Associated Services were erected. Lord Nuffield's boundless generosity provided the materials but Hyde was the chief architect of the structure of the Trust, which will stand for all time.

His interests in hospitals had been predated by his interest in Friendly Societies bringing them into alignment with National Health Insurance.

6. THE TRUST DEED

No time was lost after Lord Nuffield's announcement to draw up the details of the Trust Deed.

Initially the work of developing the purposes of the Trust was taken on by Goodenough, Buzzard and Hyde with L F Herbert, Lord Nuffield's lawyer, as legal adviser. While the

letter sent to Colonel Walter Elliot, the Minister of Health in 1939, announcing the formation of the Trust on 6th December 1939, was in general terms, the details of the Trust Deed had to be worked out between then and the signing of the Trust Deed on the 25th June 1940.

At first there seemed to have been some intention of including in the Trust Deed details about the way in which Councils, envisaged as responsible for co-ordinating services in particular areas, should be set up, but this idea was dropped as being unnecessary, and eventually only the minimum of such details were incorporated. This avoidance of conditions which might lead to bureaucratic difficulties became a mark of Trust policy.

Thus, at first there was some question whether it should contain anything concerning the constitution of the Central Council for Hospitals mentioned in Lord Nuffield's letter to the Minister, to ensure widespread support for the main purpose of the Trust - the co-ordination of hospital and ancillary medical services in the Provinces.

Letters from L F Herbert, the Legal Adviser and Senior Partner in Andrew Walsh and Co., Oxford, to the Chairman dated 18th December 1939, and to Hyde on 25th December give some idea of not only the contemporary style but how the immediate problems were seen, refined and disposed of. They are also indicative of the thought which had already been given to the setting up of a foundation, primarily concerned with improvement in services.

Letter from L F Herbert to W M Goodenough dated 18th December 1939

Dear Mr Goodenough,

Ref: L.F.H.

Lord Nuffield Trust for the Provincial Hospitals

I have given some thought to this matter over the week-end, and there are one or two points upon which I should be glad of your advice before I actually proceed to get out a draft of the Trust Deed.

The position with regard to the Ordinary Trustees and the Governing Trustees is, I think, quite clear, but several questions occur to me in reference to the lower orders of the hierarchy. First, as to the *Central Council:*

1. By whom do you think the members of this Council ought to be nominated? - the body which naturally occurs to me is that of the Governing Trustees.

2. How are vacancies to the Council to be filled - by the Governing Trustees, or the remaining members of the Council, or by the Regional Councils?

3. On what principles are nominations to the Council to be made? From the memorandum with which Mr Hyde has furnished me, it is clear that the nominees should represent regional interest, but are they to be members of the Regional Boards, or are they to be merely representative of the regions without necessarily being members of the Boards? I take it that, in any event, the first members of the Central Council cannot be members of the Regional Boards, because the Central Council will come into being before the Regional Boards.

4. What term of office will the members of the Central council enjoy? - will they remain members at the pleasure of the Governing Trustees, or for the period during which they are members of the respective Regional Boards, or during which the Governing Trustees deem them representative of regional interest?

With regard to the *Regional Boards*:

Whereas the constitution, duties and powers of the Ordinary Trustees, the Governing Trustees and the Central Council can be stated with some precision in the Deed, I take it that the provisions with regard to the inauguration of the Regional Boards will have to be framed in more general terms, and I suggest for your consideration that the Deed provides:

(a) For the drafting of a scheme dividing the provinces into regions and inaugurating Regional Boards. Am I right in assuming that the drafting of this scheme will be one of the duties of the Central Council when constituted?

(b) For the Regional Boards so constituted to have the functions set out in the Deed. These functions will be similar, I take it, to those mentioned in the constitution of the Oxford & District Joint Hospitals Board.

(c) For the Regional Boards so constituted to comprise representatives of the voluntary hospitals, local authorities, honorary medical staffs, and hospital contributory and provident schemes, along with co-opted members possessing special experience in hospital and public health administration.

(d) For each region to include a 'key hospital'. I think that I have a pretty good idea what is meant by a 'key hospital' but I should be glad to have a note of the main points which the initiators of the scheme have in mind in this connection.

(e) For each region to include a hospital having a medical school, or else to be attached to some other region which has a medical school.

Do you think these provisions too detailed? or are they not detailed enough, in that some fundamental feature of the system is omitted? Again, the regionalisation scheme may be more advanced than I apprehend it is, and it may be desired to give details of the regions and more exact particulars of the constitution and functions of the Boards.

I observe that the memorandum which Mr Hyde handed me contains no mention of Divisional Councils, whereas in another memorandum dealing with the policy in connection with hospitals generally, the inauguration of Divisional Councils is apparently part of the regionalisation scheme. In fact, is it intended to have Divisional Councils, and if so, do you think it necessary to mention them in the Deed? Assuming that you think it is in fact necessary, rather similar questions arise in relation to their constitution to those mentioned above in regard to the Central Council.

The proposal to form an Advisory Committee should, I take it, definitely be mentioned in the Deed, and if you agree, I should be glad of particulars as to the proposed constitution of the Committee, similar to those for which I have asked in connection with Central Council.

There are two other small points. The first is the name of the Trust, and here I would suggest, 'The Lord Nuffield Trust for the Provincial Hospitals' rather than 'The Lord Nuffield Provincial Hospitals Trust' - which I find rather a tongue-twister; and the second is the formulation in as few words as possible of the primary objects of the Trust, and here I suggest the following:

'To co-ordinate public and voluntary hospital and ancillary medical services by means of a scheme or regionalisation throughout the provinces.'

I shall be most grateful to you for your help over all these questions. I am sending a copy of this letter to Mr Hyde.

Herbert's ideas were however not welcomed by Goodenough as Herbert's letter to Hyde dated 29th December shows.

Letter from L F Herbert to W Hyde dated
29th December 1939

Dear Mr Hyde

Ref: L.F.H.
Lord Nuffield Trust for the Provincial Hospitals

I had the pleasure of seeing Mr Goodenough last Saturday, when we discussed the subject-matter of my letter to him of the 18th December. In the result Mr Goodenough expressed the opinion that it was not necessary to deal with the constitution and function of the Central Council, the Regional Boards, the Divisional Councils and the Advisory Committee in the Deed itself, and he suggested that the

Governing Trustees should be given power in the widest terms to create the necessary organisation, and to delegate to the constituents of that organisation the Trustees' powers and duties. Mr Goodenough also suggested that, having arrived at a formula, I should get into touch with you and invite your views on it as a matter preliminary to the consideration of the draft Trust Deed as a whole. During the holiday I have turned the matter over in my mind, and I put forward the following:

The Governing Trustees shall inaugurate and carry into effect a scheme for the co-ordination on a regional basis of hospital and ancillary services throughout the provinces, and for that purpose shall do all such acts and things as shall in the Governing Trustees' absolute discretion be necessary, and in particular but without prejudice to the generality of the foregoing the Governing Trustees shall have power:

1. To create or appoint such Regional, Divisional and Central or other Boards or Committees and such officers to administer the said scheme and such advisory or other bodies and officers to assist in such administration as the Governing Trustees shall in their absolute discretion think fit, with power to the Governing Trustees to make rules for their own guidance and for regulating the constitution, function and procedure of any Board, Committee or other body so created or appointed by them and the duties and powers of any officer so appointed by them, and

2. To delegate to any such Board, Committee or other body or to any such officer all or any of the powers and duties reposed in the Governing Trustees under the provisions of this Deed.

Will you be so good as to let me have your views upon this draft clause.

By the time the Trust Deed was signed it had been decided that fundamental to the work of the Trust, a Medical Advisory Council, chaired by Sir Farquhar Buzzard, should be set up consisting of a number of the most distinguished medical people in the country. The objectives of the Medical Advisory Council were keyed to the purposes of the Trust and eventually contributed to the policies which were developed into the programmes of work to fulfil the purposes of the Trust.

7. TRUSTEES

Ordinary Trustees

The Trust constitution was arranged so that there were two bodies of Trustees the 'Ordinary Trustees' who hold the

investments and the 'Governing Trustees' who are responsible for carrying out the purposes of the Trust. It was maintained that this separation of function was designed to relieve the Governing Trustees of detailed financial responsibility, so enabling them to concentrate on grant-making to achieve the purposes laid down. It of course also had the advantage to the Founder, that it enabled Lord Nuffield to control the share holding since the first Ordinary Trustees consisted of Lord Nuffield himself, his former Secretary Wilfred Hobbs FCA, who was also Secretary of Morris Motors, and Barclays Bank Trustee Department.

Governing Trustees

Nor were Goodenough and Hyde slow about the appointment of the first Governing Trustees who were recruited to fulfil the purposes, as is indicated by the draft letter drawn up some three weeks after the announcement of the founding of the Trust which in its essential procedures was approved by the Founder.

Draft letter from Lord Nuffield to the proposed Governing Trustees dated 1st January 1940

Dear . . . . . .

You will perhaps have seen from the press that I have recently been able to establish a Trust Fund for the benefit of hospital services in the Provinces. This arrangement has been made after consultation with the Minister of Health. It has already been welcomed by the Labour Party who have asked that Labour interests should be represented on the Trust.

I enclose a copy of the leading article and of the new paragraph which appeared in *The Times* when my proposal was announced. These, I think, give a clear idea of the intended scope of the Trust.

The Trustees will be twelve in number and will be appointed for a period of . . . . . years, being eligible for reappointment at the end of that time. I shall myself nominate the Trustees on the first appointments being made after consultation with the Minister of Health. In the case of subsequent appointments, the Trustees will themselves make the nominations, after consultation with the Minister, whose views, however, will not be binding on them.

I am now writing to ask you if you will allow me to nominate you as a Trustee, and to tell you how grateful I shall be if you will undertake this office. I feel that the work of the Trustees will be of great importance and am naturally anxious to enlist the services of people whose names will command general acceptance in the various

localities where they are well known. At the same time, I can assure you that the Trust will be provided with an adequate secretariat and that the Trustees will be able to count on the services of a central council composed largely of experts in hospital work, which will be under their direction. I can, therefore, safely tell you that the Trustees' duties will not be unduly onerous. It is intended that the office shall be at Oxford, but for convenience of the Trustees meetings will be held in London.

I venture to hope that you will be kind enough to accept my suggestion.

The first Governing Trustees, twelve in all, were drawn from a wide spectrum of influential people covering most regions in the country who not only had some association with hospital and academic medicine but also with politics, local government and business. Thus, Lord Woolton was a successful businessman with influence in public affairs. Mr Thomas Johnston, MP and Sir William Jenkins, MP were not only politicians but had broad social interests. Both Woolton and Johnston became members of Churchill's War Administration. The others included Mr Francis Bland, Chairman of Suffolk County Council, Colonel E H W Bolitho, a leading public figure in Cornwall, Mr E G Rowlinson, Lord Major of Sheffield, Sir Charles Herbert Smith FCA, a prominent Accountant from the Midlands, Miss K J Stephenson, a lady prominent in public affairs in Wiltshire, Sir Farquhar Buzzard, Regius Professor of Medicine of Oxford University, Lord Eustace Percy, a former Minister of Education and then Vice Chancellor of the University of Durham, and Mr (later Sir) Noel Mobbs, a noted industralist and the founder of Slough Industrial Estates.

This was a notably influential group representative of all the interests concerned with health matters, Hospitals, Universities, business and politics at both National and Local levels which were recognised as important in how health services should be developing.

8. THE INITIAL MEETING

The first meeting of the Governing Trustees actually took place before the Trust Deed was signed, on the 6th March 1940 in the presence of Lord Nuffield, when the Chairman set the scene with the following statement which set out a plan of action!

'Before we go on to deal with our administration arrangements, I think it may perhaps be useful to review, very briefly, the objects of the

Trust, which were fully set out by Lord Nuffield in his letter to the Minister of Health when his Gift was announced in the Press.

The object of the Trust, as stated in this letter, is to procure that the Voluntary Hospitals should become an integral part of the properly co-ordinated National Service. To achieve this it is not only necessary that the Voluntary Hospital effort shall be co-ordinated through the establishment of Regional Boards, but that these Boards - and through them a Central Provincial Council – shall also be representative of other interests, including the Public Health Authorities - whose co-operation we should seek – the Medical Profession, Medical Teaching and Medical Research. It should be our aim so to organise the Voluntary Hospital System that the Public Health Authorities will be induced to make the fullest use of the Voluntary Hospitals, and that as their confidence in these Hospitals is established the Health Authorities should be willing, where necessary in the public interest, to make contributions to the Hospital Boards, as they are entitled to do under the Local Government Act 1929 and the Public Health Act 1936. It is necessary that the authority of our Central Council, which is yet to be established working under the Trustees, shall be recognised as the co-ordinating body between the various Regions, and that our Trust Fund shall grow so that we may make substantial contributions to the finances of the Regional Boards. In making these contributions we should take into account every local factor, including the encouragement of Medical Teaching and of Medical Research and the development of those services which are ancillary to the Hospital Services. The field which we have to cover is a very wide one indeed, and I have no doubt that anything like a full achievement of our aim will take much time and a great deal of work. Indeed, if we found the field quite untouched it might be difficult to know where and how to make a beginning.

Fortunately, however, this is not the case. Our first object must, I think, be to procure the establishment of Regional Boards, which, no doubt, will vary somewhat in character and composition according to local circumstances in different parts of the country. Probably, in the early stages, these Boards will not be so comprehensive in character as we should wish for, but they must be allowed to grow and develop with proper direction and encouragement. We have already at Oxford very satisfactory Regional arrangements supported by a separate Endowment from Lord Nuffield. Mr Hyde, who has been very closely concerned with the work, can tell you that there is a desire expressed in various localities to proceed on similar lines, and that in some centres arrangements for doing so are actually in hand. There is, in fact, a great deal of material available on which we can build.

I have been able, during the past few weeks, to do a little preparatory work on various people who are likely to be specially

useful to us. I should tell you, in the first place, that we have had several discussions with the Minister of Health and with the Secretary of State for Scotland. The Ministry's attitude is a thoroughly helpful one and I have undertaken that we shall keep in close touch with them as our work progresses. I have also been able to talk to Mr Attlee and have been assured of the friendly interest of himself and, I hope, of his political colleagues. I have arranged with Sir Harold Wernher that we shall have discussions with the King Edward's Hospital Fund for London, which he represents, about our mutual relations, and with Sir Bernard Docker, the Chairman of the British Hospitals Association, whose organisation will be at our service. There are one or two others whom I can mention as we come to their business later in the Agenda. You will have received already, with your papers, particulars of such progress as has been made in various parts of the country'.

One of the first important decisions of the Governing Trustees was to set up a Medical Advisory Committee to which were appointed some of the most distinguished practising clinicians together with the Secretary of the MRC (Sir Edward Mellanby) and the Dean of the London School of Hygiene Dr (later Sir) Wilson Jameson, soon to be appointed Chief Medical Officer of the Ministry of Health. The latter, who when Dean of the School of Hygiene had earlier assembled a powerful group of leading doctors to consider the future of health affairs, was prominent with Buzzard in establishing the spirit of enquiry which became a hallmark of the Trust. The Medical Advisory Committee provided a real stimulus and were the initiators of the research and intelligence policy which has been developed over the years and became the main feature of Trust policies.

9. THE ESTABLISHMENT OF A POLICY OF ENQUIRY

The first year of the Trust's existence was the time for laying the foundation of a structure for the co-ordination of hospital and ancillary services which was the main purpose of the trust. By mid–1941 a great deal had been accomplished in the setting up of the Regionalisation Council and Subsidiary Committees.

An account of the progress made, and the policy hammered out as appropriate to the time is indicated in the copy of a memorandum from Sir William Goodenough to Lord Wigram, dated 18th June 1941, when inviting him to be a Trustee, which perhaps at the same time gives a report of the major actions taken during the first effective year of the Trust's life.

The Nuffield Provincial Hospitals Trust

The Nuffield Provincial Hospitals Trust was founded in December, 1939, with the object of promoting a policy of Regionalisation of Hospital Services in the Provinces in England, in Scotland and in Northern Ireland, in which the Voluntary Hospitals and the Public Health Authorities would be interested in common.

By the term 'Regionalisation' is implied the proper co-ordination of Hospital Services round appropriate centres in a way which will ensure the best treatment for the community, together with the greatest measure of efficiency and of economy both of public and of voluntary funds.

This policy, as affecting Voluntary Hospitals only, was advocated by the Sankey Commission, which was set up by the British Hospitals' Association and which made its Report in 1937. It is widely recognised, however, that Regionalisation should be on a more comprehensive basis than that which was recommended by the Commission, and that both the Public Health Authorities and the Voluntary Bodies should be included in its scope. This extended policy has recently been endorsed by Lord Sankey himself. It aims at an efficient national service and provides the means for reconciling the interests and loyalties which attach themselves to the work of the Public Authorities and of the Hospitals respectively.

It is laid down that the Trustees should work in close contact with the Ministry of Health. At the time of the foundation of the Trust warm approval and encouragement were obtained from Mr Walter Elliot, who was then Minister; this approval has been re-affirmed from time to time by his successors during the past eighteen months.

The income of the Trust Fund is at present derived from Lord Nuffield's Donation of One Million Morris Motors Limited Ordinary Share Units. This Donation is treated as the Capital of the Fund, and the income has, until now, been approximately £100,000 per annum. Morris Motors Limited have paid a high rate of dividend for a number of years past. The Company's position is a very strong one.

During the first year of the Trust's activities the expenditure has been small, as nothing has been required of a substantial sort beyond the cost of central administration; a considerable sum of money out of the income has thus been already set aside toward any large demands which may be made on the Trust after the War is over. It should be possible to add to this sum to a certain extent from year to year during the continuance of the War, but as the Trust's organisation is now developing very rapidly it is becoming necessary to make Grants-in-aid to Regional Councils which are being established throughout the country for the benefit of the Hospital Services in their respective areas.

Meanwhile, the trustees are in course of establishing a working

arrangement with the League of Mercy, which will have the effect of the League's income from appeals throughout the Provinces being paid out in agreement with the Trust, and in a way which will be in accord with the policy which the Trust has in view. The League's income has been as high as £25,000 to £30,000 a year in good time, but, at the moment, it is naturally at a considerably lower figure.

It is hoped that in course of time the Capital of the Trust will not be confined to Lord Nuffield's original Donation. It is obviously inexpedient to ask for further funds under present conditions, but there is every reason to suppose that appeals connected with any really major development should be successful when the proper moment arrives.

There are other important developments in view in connection with the Trust. Firstly, it is hoped to proceed with a scheme which has been worked out by Mr A Noel Mobbs for raising Loan Capital for the purpose of financing the development of Pay-Bed accommodation at Voluntary Hospitals, and of other units which can be established on a paying basis. This scheme has recently been approved by the Trust's Legal Advisers and it should be possible to proceed with it very shortly. It should meet urgent need when the war is over. Secondly, the trustees have just received a generous promise from Lord Nuffield of a Guarantee of £150,000 for establishing a Central Reserve Fund for Provident Associations throughout the country, which have, as their object, the provision of benefits to meet the cost of hospital and medical treatment of people of middle incomes. It is believed that this development will have an important future and that it will be of great assistance, not only to members of Provident Associations but, also, to hospitals and to the medical profession in such conditions as are likely to exist after the War.

The administrative costs of running the Trust are of the order of £10,000 to £15,000 per annum, and although there may be some increase in the future as activities develop it is not anticipated that this figure will be greatly exceeded; the bulk of the income will be available for making grants to the Trust's Divisional and Regional Councils for the benefit of Hospital Services in their respective areas.

The organisation which the trustees have in mind is briefly as follows. The smallest unit is that of the Division, consisting of a geographical area which attaches itself conveniently to a key hospital. These Divisional Areas are arranged for on a purely service basis. The larger local unit is that of the Region, which is a grouping of Divisions which may have matters of mutual concern to discuss and decide upon from time to time. Officers of the Ministry of Health would be associated for purposes of liaison with the Regional Councils.

At the centre, under the trustees, there is the Central Regionalisation Council of the Trust, on which all the Regions, and - through them - the Divisions are represented. There is also representation on

the Central Council of special interests such as the Medical and Nursing Professions, Contributory Scheme organisations, the central organisations of Public Health Authorities, the British Hospitals' Association and others. The Central Council considers all matters that are remitted from the Regions and advises the Trustees on the general policy to be pursued and on the allocation of grants.

There is a Medical Advisory Council of the Trust, which is to advise the trustees on the purely medical aspects of their work. This is a very strong body under the Chairmanship of Sir Farquhar Buzzard, who is himself a trustee. The Medical Advisory Council has already done admirable work and is beginning to put forward important suggestions in regard to future policy.

There have naturally been local problems to be dealt with in the course of developing the work of the Trust throughout the country, but there has been a very general measure of agreement and of support for the policy of the Trust. It is expected that by the end of the present year the principle of Regionalisation will be well accepted throughout the whole of Great Britain, Scotland and Northern Ireland, and, in a number of cases, Regional and Divisional Councils are already doing extremely useful work. In addition, the trustees have established the happiest relations with the King Edward's Hospital Fund for London and with the British Hospitals' Association. There is in being a Standing Joint Committee which is representative of these three Bodies, and on which it is hoped that the Public Health Authorities will also be represented in course of time.

It is, therefore, possible to regard the Trust as being properly established and to look forward to its having a very leading part to play in the future. The whole of its work is based on the voluntary co-operation of all parties concerned, and this point of view has been widely understood and appreciated.

A further letter written to Lord Wigram the following day is significant to indicate that the Trustees intended to take a 'more active policy in regard to hospital arrangements' than had been traditional hitherto.

Copy of letter to Lord Wigram from Sir William Goodenough dated 19th June 1941.

I had written to you about the Nuffield Provincial Hospitals Trust before receiving your letter this morning. May I add one further word. I think it is perfectly true to say that the Trust is intended to occupy a similar position in hospital matters in the Provinces as the King's Fund does in London. You will appreciate, however, from the memorandum which I have sent you, that the Trust has developed a much more active policy in regard to hospital arrangements than has been initiated

by the King's Fund hitherto. To say that is not to criticise the King's Fund, because I feel that until now the moment has not been opportune for such a policy. As I have explained, however, we are in very close touch with the King's Fund and I have no doubt that they will have to take a somewhat similar line to that which the Trust is pursuing. I cannot, of course, speak for them but this is a matter which I know they have under close consideration.

These letters together serve both as a progress report to mid-1941 and an introduction to a period of great activity in pursuit of the Trust's purposes, as well as an indication of the means being adopted to achieve them.

CHAPTER 3
FINDING THE BEARINGS
THE EARLY DAYS 1939 – 1948

Finding the Bearings

THE EARLY DAYS 1939 - 1948

This chapter gives a brief account of the Trust's activities up to the introduction of the National Health Service on 5th July 1948. It is principally concerned with the Trust's successful attempts to help towards the co-ordination on a Regional and Divisional basis of the Hospital and Ancillary Services of the United Kingdom, both Voluntary and Local Authority outside London. It indicates the Trust's part in the hospital surveys which preceded and formed the factual baseline for planning by the Regional Hospital Boards set up under the National Health Service Act. It also refers to the grants for the other pioneering activities which the Trust made within the pre-NHS system (for there was a system of sorts) of Voluntary and Local Authority Health and Hospital Services.

The keynote and purpose of all those activities of the Trust were repeatedly stressed as the improvement of the health care available to the patient. It was confirmed at the outset of the NHS arrangements which came into effect on 5th July 1948 that this objective remained the unchanged and continuing purpose of the Trust. The purposes are indeed the connecting link between those earlier contributions and the new directions which the Trust had decided to pursue by way of special studies, not only to highlight important gaps in the system but to give a better understanding of what is involved in improving the complex infrastructure of health services.

In the absence of suitable units in Universities, two important studies which proved in time to be seminal, the job-analysis of Nursing Services and the Investigation into the 'Function and Design of Hospitals', were carried out by in-house units administered by the Trust for both of which expert advisory committees were appointed.

1. THE TRUST AND ITS CONSTITUTION

(i) The purposes

The purposes of the Trust set out in the Trust Deed which was formally signed on 25th June 1940 were:

the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of financial provision for the creation and carrying on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination.

(ii) The means and the charge

The founding Trustees had a clear concept of what was involved.

The charge to them was two-fold:

(a) They were to encourage the organisation of Regional and Divisional Hospital Councils and, where necessary, to assist in the formation of these Councils by making contributions towards the cost of organisation during the initial period.

(b) They were also authorised to make grants and donations to hospitals through approved Regional and Divisional Hospital Councils. They would not, ordinarily, make grants or donations to individual hospitals otherwise than through these Regional and Divisional Councils.

(iii) The Scheme

A great deal of preliminary consideration had taken place in the early part of 1940 and at the outset it was envisaged that the Hospitals' Regionalisation Scheme would involve:

(a) The organisation of some 50 to 70 Divisional Hospital Councils each based on the service requirements of the areas concerned. All divisional areas would include a 'key' hospital and, where the divisional area did not itself possess a hospital having a Medical School, it would be attached to a Region in which a Medical School was located.

(b) The creation of 15 to 16 Regional Councils each of which would include representatives of a number of divisional areas.

(c) The formation of a Central Hospitals' Board to be undertaken when the regional and divisional grouping had been completed.

(iv) The Medical Advisory Committee

The key position was recognised to be held by the medical profession and at their initial meeting in March 1940 the Trustees decided to constitute a Medical Advisory Council to advise them and the Provincial Hospitals' Regionalisation Committee of the Trust on the medical policy and problems of their work. The Chairman and Vice-Chairman of the Council would be ex officio members of the Provincial Hospitals' Regionalisation Committee and the Chairman might appoint one additional member of his Council to attend meetings of the

Provincial Hospitals' Regionalisation Committee at which matters requiring special medical knowledge were to be discussed.

The functions of the Medical Advisory Council of the Trust included:

(a) Receiving and reporting on questions referred to the Council by the Trustees or by the Provincial Hospitals' Regionalisation Committee.

(b) Arranging for members of the council to inspect personally the conditions obtaining in a Region or Division at the discretion of the Chairman or at the request of the Trustees or the Provincial Hospitals' Regionalisation Committee and to report thereon to the appropriate body.

(c) Communicating directly to the Trustees any expression of opinion formed by the Council on matters of medical policy and interest in so far as they concern the actions and purposes of the Trust.

An important part of the Hospitals' Regionalisation Scheme was the decision to form Regional Medical Advisory Committees. One of these Committees was immediately appointed in the Berks, Bucks and Oxon Region, the successor to the successful Oxford Joint Board founded in 1935, which was the inspiration of the Trust. This was the model for similar Committees in process of formation in other Regions. One of the matters which required the immediate consideration of the central Medical Advisory Council was that of ensuring contact between the Council and the Regional Medical Advisory Committees.

(v) The immediacy of action

No time was lost in getting the Trust under way since it was evident the war conditions made it more than ever necessary that hospital services should be re-organised on the basis of co-operation between the State, Local Authorities and Voluntary Hospitals.

From the beginning it appeared essential that hospitals should be dealt with as groups rather than as isolated units. This position was being recognised in the Government's 'Emergency Hospitals' Scheme drawn up in the expectation of casualties following air raids. The disorganisation of administrative and

service arrangements of individual hospitals, inevitable in war time, and the effect of war conditions upon hospital contributory schemes and other sources of voluntary financial support, combined to strengthen the case for the early adoption of a system of co-ordination which suggested the grouping of hospital services on a regional basis.

It had long been recognised that public funds would be necessary for the early development of a hospital system, but equally that any scheme involving the abolition of the Voluntary Hospitals' system and the substitution of State Hospitals would require an immense expenditure of public funds. The regionalisation scheme - a kind of confederacy of both public and voluntary hospitals - was the particular solution supported by the Trust which had the resources to initiate and support experimental schemes, providing what was regarded as a practicable alternative to the nationalisation of hospital and ancillary medical services.

THE TRUST'S PLAN FOR REGIONAL CO-ORDINATION

1. Demarcation into regions and creation of regional and divisional councils

The Trust set out to establish Regional and Area Advisory machinery which it hoped would bring together in a full partnership, yet without prejudice to the individuality of each, the various hospitals within a given area. The areas suggested for the Regions corresponded roughly to the Regions subsequently established under the National Health Service Act, and were, in turn, subdivided into Hospital Divisions.

The scheme was fully described in a memorandum on the co-ordination of hospital services, published in 1941 which was the first publication of the Trust.

Features were incorporated which were fresh and new at the time. Thus the basis of the plan was the demarcation of the country into a series of hospital Regions, each having as the focus of the Hospital and Health Services a University Medical School and a 'key' hospital. The Regions were divided into Hospital Divisions, each with a main hospital at the core to which the smaller hospitals and clinics of the Division were linked. In turn the main Divisional Hospitals were linked to the Regional 'key' Hospital. Ambitious and pioneering in spirit it is not to exaggerate that the plan was claimed to have helped to

form opinion in the UK which was the basis of support for the NHS Act 1946, and to have exerted an influence on hospital planning as far afield as the United States.

The original plan of the Trust to establish a series of regional and divisional advisory councils covering the country was not actually carried through. The Government, following its announcement of post-war hospital policy in 1941, and after consultation with the local authorities, asked the Trust to suspend further action to avoid administrative and other difficulties. Since the Trust's only concern was to improve the arrangements for the nations's health and hospital services it felt bound to respond to this request[1].

The Trust scheme had by 1941 provided for four regional and eleven divisional councils in *England and Wales.*

In *Scotland* an advisory committee on the regionalisation of hospital services and a medical advisory committee had been established as early as 1940. Indeed one of the Founding Trustees, Mr Thomas Johnston, the then Civil Defence Commissioner and subsequently Secretary of State for Scotland, had held a meeting as early as March 1940 and had reported to the Trustees in June at almost the bleakest time of the War, that there had been agreement to a regionalisation scheme based on the five Scottish Regions, which eventually were those determined in the Act of 1946.

A regional hospitals Council for *Northern Ireland* was formed in 1942.

Sometimes there was a region without a division, elsewhere a division without a parent region, mainly because from the administrative point of view it was easier to begin in one place on divisional lines, in another to start at the top. Where the setting up of a new Council would have meant an unnecessary duplication of administrative machinery the Trust used in its own plan - side by side with the new councils it had formed, existing hospital councils such as the Manchester, Salford, and Stretford Joint Hospitals Advisory Board, which had been

1. The suggestion, made in Webster's History, that the Government by this request (see section 2 below) ensured that all efforts of the Trust were diverted to the important Surveys in which they took the leading role, is somewhat wide of the mark. Only one side of its proposed activities in the Provinces, the proselytising for regionalisation particularly on the part of Buzzard and Hyde in a series of meetings covering the country, came to a partial halt. By this time the Trust was already exploring the main issues involved in the infrastructure of this most complex of comprehensive services.

influenced by the success of the Oxford Trust Health Board (Platt, Sir Harry 1963). The tasks set out for the Regional and Divisional councils were varied, yet at the same time they all led to the same end; 'to achieve in every possible way the aim of raising the standard of service to the patient throughout the region.'

2. THE EFFECT

It was constantly stressed that the search for co-ordination was never pursued in the interests of administrative convenience, but always as a means of ensuring that the patient might find in his own area a good and indeed a complete service. Indeed it was to this end that the policies of the Trust were directed.

By the time the National Health Service became a fact the Trust's regionalisation scheme had reached the stage where about half the country possessed active advisory hospital councils of one kind or another. Some of these remained in existence even after the Appointed Day, others closed down on the introduction of the new Statutory scheme.

Although, by force of circumstance, the Trust had not been able to complete its experiment, it was claimed with some justice it provided a practical demonstration over a number of widely different areas and for a period long enough to be valuable, of the way in which a Joint Advisory Council could help to co-ordinate and improve the hospital and ancillary services of an area.

Again, by its extensive surveys - with their discovery of deficiencies and their plans, often of a long-term nature, to remedy them, the Trust was able to present the new statutory bodies with a solid background of facts against which to build. But perhaps the greatest contribution which the Trust made was in educating people to think in terms of a complete hospital service for an area where formerly they had thought only in terms of individual hospitals working largely in isolation.

The Trust promoted the co-operation with the objective of defining area needs, of men and women, doctors, and laymen, with an intimate knowledge of voluntary hospitals, local authority experts engaged on municipal hospital problems and public health work. Not only did those familiar with one type of hospital begin to understand the others' difficulties but, more important still, they prepared themselves to take part in a comprehensive and co-ordinated service.

Indeed, for many, being a member of the Trust's advisory councils became a passport to membership of the first administrations constituting the National Health Service.

3. THE SURVEYS OF HOSPITAL SERVICES

(a) Britain at War

From the start of its activities it had been clear to the Trust that it would not be sufficient in itself, merely to set up regional and divisional councils and to rely upon a better, or even a very good, understanding between local authority and voluntary hospital representatives to bring about a better co-ordination of the various parts of the hospital service. For one thing, even the most friendly rivalry and competition was not what was wanted. But, more important, nobody knew whether, if the various parts of the service were dovetailed together, completeness would be achieved. It seemed fairly certain there would be some gaps in the jigsaw; the first need was to discover their nature and their whereabouts. A survey of hospital services in a given area was the obvious answer and, at the suggestion of the Trust, the regional and divisional hospital councils had provided in their constitution for the making of such surveys.

The Trust had already made three surveys of hospital services - in Cornwall, in Devon, and in Bristol, when, in 1941, the Government announced its intention of instituting a series of surveys, starting with London and the surrounding area, to provide the information needed as a basis for future plans. The Trust thereupon offered to undertake the organisation and financing of the provincial surveys - an offer which was welcomed by the then Minister of Health, the Rt. Hon. Ernest Brown. It was agreed that the surveys made by the Trust and those made by the Ministry should proceed according to the same plan and all the survey teams were given the same terms of reference:

> to survey the Hospitals (other than mental hospitals and mental deficiency institutions) in the Counties of ... and having regard to the information thus obtained, and to the general principles of postwar policy laid down by the Minister of Health in the House of Commons on 9th October 1941, to advise the Minister what modifications or developments of the existing hospital facilities would be necessary or desirable to give effect to that policy.

The areas to be surveyed were decided in consultation with the Ministry of Health and the Trust undertook the planning of

the seven surveys referred to in the Appendix. The cost to the Trust was £8,257!

The ten teams - three appointed by the Ministry and seven by the Trust - naturally found good things here and deficiencies there in the varying conditions of widely different areas. Yet there was a unanimity as monotonous in detail as it was startling in cumulative effect in the final conclusions of the reports that the three main defects of the hospital service some of which, although the worst defects have been corrected in the 40 years of the NHS, have echoes in today's problems. These were:

(i) inadequate accommodation due to shortage of beds

(ii) shortage and maldistribution of consultant and specialist services. Because of necessity they were concentrated in the places in which it was possible to build up an adequate private practice

(iii) Faults in co-ordination because of faults in bureaucratic priorities

The reports of the surveys were printed and published as Blue Books by H M Stationery Office. Their undeniable value, in that whatever future hospital policy might be decided upon, was that they provided the first and only national statement of existing conditions. This prompted the Trust to publish a summary of the conclusions reached by all ten teams of surveyors of the existing services. The chief fault, it was agreed lay in the lack of an overall system in which cover for the population might be judged. This pamphlet published as *The Hospital Survey* (1946) succeeded in its intention to pin-point, among the detail of each substantial Blue Book, the criticisms and suggestions that were of national application and, in so doing, 'to demonstrate how wide is their agreement'.

(b) Scotland

The Scottish Medical Advisory Committee of the Trust originally led by Mr Thomas Johnston were early in action. They produced three reports, the first in 1941: the second which was a comprehensive review delved into the constituent specialist services in 1943: the third picked up special issues in 1946. All, and particularly the second, provided the basis of planning Hospital Services in Scotland after 1948.

(c) Northern Ireland

The survey of the six counties of Northern Ireland was in a different category from those already mentioned. Directly sponsored and financed by the Trust, the surveyors were given the following terms of reference:

> to survey the Hospitals including mental hospitals and mental deficiency institutions in Northern Ireland and, having regard to the information thus obtained, to advise the Northern Ireland Regional Hospitals Council through the Trust what modifications or developments of existing hospital facilities would be necessary or desirable to give effect to a co-ordinated and comprehensive hospital service.

Thus it will be noted that mental hospitals and mental deficiency institutions, excluded from the English surveys, were brought within the scope of the Northern Ireland survey.

4. PLANNING OF AREA HOSPITAL SERVICES

Apart from the major regional surveys made by the Trust, many of its associated councils were encouraged to set up special committees to survey existing hospital services within their areas, and some of the resultant reports on individual problems are of more than passing local interest, since there were still echoes of their findings, even in the 1980's.

(a) England

The Medical Services Committee of the *Yorkshire Regional Hospitals Council* produced, in June 1944, a report which stands apart from previous survey reports sponsored by the Trust in that it was multi-faceted, and compiled from an unusual angle. The Medical Services Committee of this Council concluded that the approach to a new organisation of hospital services should be clinical, and at the same time decided that, since modern medicine was made up of so many specialities, it was not, as a body, qualified to pronounce on policy or to make plans without further specialist advice. It therefore set up sixteen sub-committees to consider the principal specialities:

> Each sub-committee being composed of members of the consulting staffs of municipal and voluntary hospitals, representatives of local authorities and general practitioners, with the addition of experts co-opted from outside the region to give their views on certain specific points.

The reports of the sixteen sub-committees were issued in the

one volume, and requests for copies came from many parts of the world.

The Essex Hospitals Joint Advisory Council was set up in 1945. The report of the surveyors of the hospital services of London and the surrounding area (which included Essex) had then been issued, and the Council brought together a survey sub-committee to consider the implications in Essex of the surveyors' report and to advise on the problems involved. In their discussions the sub-committee had the benefit of knowing not only the principles contained in the National Health Service Act, 1946 (including the intention to create management committees for groups of hospitals), but also the delineation of the area of the proposed North-East Metropolitan Region Hospital Board.

The report of the sub-committee, issued by the Trust in 1947, contained an up-to-date revision of the factual material relating to the geographical county of Essex which had been included in the London surveyors' report, and also suggestions for the improvement of hospital services in the area, recommendations for the future grouping of hospitals, and comments on the London surveyors' recommendations.

The Council also set up a **cancer** sub-committee to consider and make recommendations about the establishment of a comprehensive cancer scheme for Essex with a view to the submission of recommendations to the local authorities concerned. The report of the cancer sub-comittee, outlining a scheme to provide facilities for the diagnosis and treatment of cancer, was issued as an Appendix of the survey sub-committee's report.

The Surrey Hospitals Divisional Council brought out, at the end of 1945, a plan for the co-ordination and extension of existing hospital services in their area. The report gave an account of existing hospital facilites and included a plan for a structure on which a comprehensive hospital service could be built in and around the county of Surrey and the county borough of Croydon.

Under the *Berks, Bucks and Oxon Regional Hospitals Council* a number of special sub-committees were appointed to consider such questions as the provision and organisation of regional services for the acute and chronic sick and for such specialities as pathology, opthalmology, orthopeadics, maternity, cancer and psychological medicine, and the formation of a regional accident

service; their findings and recommendations were summarised and published in one volume in January 1947. Perhaps the most notable of these special committees was appointed in 1947 to conduct a survey of the child health services of the area. This report, published in 1948, was widely commented upon with approval. It was generally felt that the picture drawn of the facilities then available in the Berks, Bucks and Oxon Region and the measures suggested to improve the child health services in the region were of more than local interest and applicability.

(b) Scotland

The three reports issued by the Medical Advisory Committee of the *Scottish Advisory Committee* indicated a marked progression in thought. The first, published in 1941, was general in character, discussing problems of the hospital services and the advantages which might be derived from the correlation of medical services on a regional basis. The second report, published in 1943, dealt with hospital staffing in all its aspects; hospital planning and design. The third report, issued in 1946, outlined the Committee's view on health services for university students, the care of the chronic sick, standards of hospital services, and the hospital almoner; and because the Committee felt that the epidemiological base was important it also gave an account of the information provided by the Glasgow Bureau of Health and Sickness Records, which had been set up by the Trust in 1943.

(c) Northern Ireland

In August 1946 the *Northern Ireland Regional Hospitals Council* published its plan for the hospital services of Northern Ireland. Following the survey of hospitals in the Province already referred to, the Council set up a co-ordination committee and fourteen sub-committees. Their reports were 'made available to the people of Northern Ireland as being the best foundation for a properly co-ordinated hospitals service of the future'. The Plan was extensive; it included proposals for the development in Belfast of a 'key' hospital centre for the Province, the establishment of nine Provincial hospitals of the order of 500 beds each, the basing of the psychiatric services upon a Central Institute of Psychiatry and the Mental Hospitals, and the erection of General Practitioner Clinics. It also dealt with many other relevant matters, such as child health, tuberculosis, special and ancillary services, and staffing.

5. PROBING THE INFRASTRUCTURE

The Grant-Making Policy

The policy of the Trust in its grant-making role was established as a result of the success of the hospital surveys which were likened to the stretching of a tapestry upon a frame. An inspection showed up equally the good strong fabric, the weak, threadbare, and cobbled patches, and the holes. It was held it was never the intention of the Trust then to sit back and leave it to others to remedy defects. The Trust felt bound both to seek a better ordering of the various services then existing and also, and equally important, to try by positive means to improve specific parts of the services and to encourage new developments.

In the Trust Deed the income of the Trust was applicable -

(a) to carrying into effect and administering the Trust's co-ordination scheme for hospitals

(b) to making grants for the establishment, extension, or maintenance of voluntary hospitals and ancillary medical services throughout the provinces

(c) to advancing co-ordination by any other means the Governing Trustees thought fit.

At the start the Trust supplied its various regional and divisional councils with annual sums for administrative purposes, and also allocated a block grant yearly to each council. These block grants, which were used for miscellaneous purposes - generally as grants to individual hospitals - were discontinued in April 1945, their purpose of local support having been largely achieved.

Apart from these block and annual expenses grants, the Trust at the outset specifically devoted a part of its funds in seeking to foster a spirit of co-ordination between Municipal and Voluntary hospitals, Local Authorities, and Universities.

In developing their grant policy the Trustees decided that, as a general principle, they would support only one project in a particular field and that their aid should be direct, wherever possible, towards projects which might be described, if not as frankly experimental, at least as giving a lead. This meant there was no place for making subventions for the carrying on of existing hospital services, or to supplement the income of hospitals or to reduce deficits on maintenance accounts.

In 1945 (at the same time that the block grants were

discontinued) the Trust felt that it had reached a stage when a wider view should be taken of projects which might be supported. At about the same time the decision to make the general policy of the Trust complementary, so far as possible, with that of the Nuffield Foundation (which had been created by Lord Nuffield in 1943) began to take effect.

As a result the trustees agreed that the three following considerations should largely govern their choice of schemes for support:

(a) The scheme should aim at the application or extension of knowledge likely to lead to the promotion of social welfare and to the co-ordination of health services.

(b) It should provide the opportunity for a practical demonstration of an accepted theory, and by so doing lead the way to some development in preventative or remedial medicine able to command widespread interest and support from Government, University, Local Authority, or Voluntary Bodies.

(c) The scheme should be associated, whenever appropriate and possible, with an individual of outstanding capacity, and personality to direct and guide its development.

6. THE MOVE TOWARDS A RESEARCH POLICY

(i) An Early Venture - The Surveys

The first major effort of the Trust reflected not only the objective of co-ordination of hospitals but also the wider context of how health policies are shaped by a mixture of ideas, ideals, individual initiative, the study of history and facts.

In those days, during the War there was virtually no research activity unrelated to war aims in the centres of learning, the Universities. This is why from 1941 the Trust played the principal part in organising the studies on which the regionalisation of hospitals was based, that is the nine reports which became known as the Blue Books, which together became the Domesday Book of Hospitals on which the regionalisation of hospitals as provided for in the 1946 National Health Service Act was founded. Indeed, it is not to exaggerate to claim that the Trust in its early days working in association with the Ministry of Health had the pre-eminent influence on the way in which hospitals are now regionalised, which was perhaps the first major step in the rationalisation of our health resources.

(ii) Broadening the Base of Research

From the outset the Trustees saw the importance of good management. Thus in the pre-NHS days, from time to time, at the request of their boards of management, the Trust arranged for confidential inquiries to be made into the administration and services of a number of hospitals in different parts of the country. In each case the part the hospitals should play within a co-ordinated scheme was thought to be at least as important as the merits and demerits of the services provided by the hospital concerned. All enquiries were followed by the making of grants to improve administration.

Almost from their first meeting the Trustees took the view that because good information was not to be found, research was necessary which reflected and applied the often stated charge of the Founder, to be enterprising. This was the reason for the decision that in allocating its resources the Trustees would not make deficit grants to hospitals for the carrying out of existing services. Instead it took the opportunity of engaging itself in research about the future of hospital and ancillary services and in so doing, tried to back ideas on that subject which came from outstanding people. This was within the stated objectives in the Trust Deed and the grant-making policy which had been adopted.

Indeed the Trust from its beginning looked to the spirit behind its purposes in relation to the health world as a whole, within which the hospitals operated as key institutions, and were prepared to interpret widely the charge given them to advance their main purposes by any other means they thought fit.

Accordingly they devoted a part of the funds, occasionally directly based on in-house groups, to projects of a wider nature, in each of which the Trust sought the production of appropriate background information which would help the drive towards the co-ordination of hospital and ancillary services of whatever type, with Universities providing a special influence to innovative practice. This indeed was the practical application of the policy forecast in Sir William Goodenough's letter to Lord Wigram in June 1941.

The policy then became that a proportion of the income was allocated for grants to outside bodies for projects which were regarded as investigational or experimental and for a limited period, in the hope that where the result was sufficiently promising the studies or schemes would receive continuing

financial assistance from sources other than the Trust. For studies this policy was particularly aimed at Universities, which in those days operated on quinquennial budgets and were then prepared to take over support of promising ventures, such as successful research groups whose initial establishment was primarily due to the Trust.

As will be seen from the Supplement to this Chapter the field covered in the first years of the Trust, therefore, was diverse and the projects to which it gave support were designed to help the establishment of the idea of research and development as a basis of administrative action and ranged widely from University Chairs and nurse recruitment, to the organisation of experimental refresher courses in hospital catering.

Thus, from the very beginning the Trustees adopted the long-term policy derived from their interpretation of the other major objective of the Trust Deed namely, the improvement of hospital and ancillary medical services by whatever means they felt their actions would contribute to that end.

Better education for the newer specialties was an attractive objective. It was for this purpose that the Trust helped to found **Chairs of Social Medicine in Oxford** (9) **and Birmingham** (12), **a Chair of Plastic Surgery in Oxford** (10), **the Chairs of Child Health in the University of Durham** (8) **and Queens's University in Belfast** (14), and a substantial grant (for that time), to the **University of Leeds** towards the expenses of a full time **Chair of Psychiatry** and a **Psychiatric Unit** (11).

The likelihood of the after-effects of war injuries was shown in the support given for **orthopaedic and rehabilitation ventures** (16,17) as well as the development of a neurological service based in Oxford for head injuries (25).

The problems of children were to the fore and help was given for research in **Dietetics** (4) **and a study of Rheumatism in childhood** (5).

As a complement to the Social Medicine Chair in Oxford, the Trust also founded an **Institute of Social Medicine** (9) there. As a means of securing better information, **Bureaux of Health and Sickness Records** were set up in **Oxford and Glasgow** (2), forecasting the consistent interest of the Trustees in information.

Because of the later study in 1960 and more recent official reports on the subject, a special mention must be made to the

report of the Medical Advisory Council of the Trust on **accident services** (incorporated in the memorandum on the co-ordination of hospital services), although it was of a different nature and had an entirely different topic from those already referred to. The Council felt that the practice then existing, whereby the treatment of patients in the casualty departments of hospitals was left largely in the hands of junior and recently qualified medical officers, was unsatisfactory. They commented that:

> on the whole, treatment of major injuries has been efficient, but the treatment of minor injuries leaves much to be desired. A wound of the finger may throw a man out of work for two or three months, whereas with efficient treatment from the start, healing may take place in a few days.

They were of the opinion that an accident service organised regionally was necessary for the whole community and recommended that such a service should be designed to treat fractures, joint injuries and their complications, lacerations and contusions, burns and scalds, and sepsis resulting from injury.

This is an example of how recommended action followed 'study'. Thus as a result of the conclusions reached by the Council, the Trust made various grants towards the establishment and improvement of accident services. A grant was made to the **Radcliffe Infirmary, Oxford** (17), for the equipment and adaptation of accommodation necessary for the development of an **accident service**; a grant was also made to the **Birmingham Accident Hospital** (16) which was establishing itself as an outstanding hospital for emergencies.

Again, the Trustees, although concerned primarily with the service aspects of hospitals, gave important support by a grant at a crucial time to the team of research workers in Oxford who under the leadership of Professor Howard (later Lord) Florey (23), had been investigating during the previous three or four years the effects of extracts of *Penicillium Notitum* in the cure of various bacterial diseases in human beings. The therapeutic value of penicillin had been recognised but it was thought it was appropriate that the clinical use of limited amounts should be carefully controlled by experienced researchers at a small number of centres throughout the country.

7. THE SHAPING OF A TRADITION

(i) Towards a Liberal Outlook

The decision to support Florey's team is of general interest: but also in a review of Trust History, an indication of how policies in general terms, which have become part of the tradition of the Trust, owe some part of their direction to early decisions to broaden the base of activities regarded as relevant to the Trust's purposes. This support for studies and enterprising research ventures sometimes lay in the broader social and educational fields of which health services are a key element. Such areas may appear distinct from health services, but they cannot really be isolated from the other constituent elements contributing to the quality of health services, all of which are interdependent.

Thus it is, that almost from the beginning a decision was taken, even in spite of the stress in the purposes of the Trust about the overriding service aspect, that opportunities should not be missed, within reason, to be flexible in approach and to support projects which might sometimes appear to lean more to the clinical side if they indicated possible important applications to service. It was also of course relevant to the time that the prospect and reality of the casualties of War and in noteworthy advances in their treatment almost certainly provided an added note of urgency as well as a rationalisation of the decision.

Nowhere was this more evident than in the case of the support given to the uses and development of *penicillin*. It is interesting to note in this, that it was the Trust which in the face of the withdrawal of direct support by the Medical Research Council possibly partly because of their policy of not committing themselves to long-term support, and partly because penicillin had got to the development and application stage, helped Florey's distinguished team to continue their research not only into the application of penicillin to combat bacterial infection, particularly in relation to meningitis, but also to help experiments by Dr Norman Heatley, designed to assist commercial application and the consequent impetus on supply.

The Trust through a grant to Oxford University from 1943 to 1945 paid the full time salaries of Dr (later Sir Edward) Abraham, Dr Heatley, Dr Jennings (subsequently Lady Florey) and Dr Sanders and provided a substantial supplement to the salary of Dr (later Sir Ernest) Chain as a University demonstrator.

Thus as has been noted by Sir Edward Abraham *et. al.* in

addition to the substantial basic facilities provided by Oxford Universities

> ...for the research on penicillin and, from 1942 onwards, for a gradually increasing amount on collateral work on other antibiotics, the Medical Research Council contributed £8,287 in the years 1939 to 1945, the Rockefeller Foundation £6,140 between 1940 and 1945, and the Nuffield Provincial Hospitals Trust £5646 between 1943 and 1945.

Subsequently the Trust at the behest of Professor (later Sir) Hugh Cairns made a further grant of £5000 over five years for the development of penicillin treatment of meningitis, brain abscesses, and other pyogenic diseases of the nervous system (25).

It is of more than passing interest that there was some doubt whether these actions were indeed *ultra vires*. This appears from correspondence between Hyde and Goodenough which deals with the question of whether this kind of grant was contrary to the spirit of the Trust Deed. In particular it was decided not to refer the matter to L F Herbert, the Trust's lawyer, who had drawn up the Trust Deed, since it was held to be not strictly a legal issue, depending as it did on the Trustees' discretion under Section 6 (iv) of the Trust Deed. This application of the Nelson Touch is of wider historical interest, in that apparently Herbert had earlier queried the grants setting up the Bureaux of Health and Sickness Records, the Institute of Social Medicine and the first Chair of Social Medicine in Oxford, to which Dr John Ryle had been appointed.

It was obviously easier because of the information policy to rationalise the decisions concerning Social Medicine, than the action in respect of Penicillin. Nevertheless, this episode is indicative of how there was marked uncertainty in those early days of how the Trust Deed should be interpreted, but the Trustees came down finally on the side of liberal interpretation. It is perhaps a reasonable assessment now, but still relevant to decisions on policy, that it is almost certain that the Trustees then paid attention to the particular clause in the Trust Deed (Appendix I.6.IV) that it was up to them to interpret the purposes as far as the application of funds was concerned as widely as they cared, provided it could be related to the Trust's purposes.

There is some mystery about the whole question of the penicillin support. It is not clear why the Medical Research Council withdrew at that particular time, nor is it clear how the Trust was approached although it came initially through the Regius Professor, Buzzard. The files concerning the Medical Advisory Committee of the Trust have few references except to a range of interesting cases treated and the site visits to the individuals concerned, as well as, of course, to the importance of their work, but it would be of some interest how an important issue like applied research concerning the important clinical application of penicillin, found its way to the Trust at a crucial, indeed almost critical time in its development.

In applying the question of interpretation of how to achieve the purposes in the Trust Deed to Foundations in general, it seems that it is precisely this kind of flexibility which is their basic strength and has to be defended at all costs. Further, it does underline, if there is some provision in the Trust Deed, that Foundation Trustees should be allowed to interpret Trust Deeds liberally, provided there is a marked relationship between their actions and the overall purposes of the Trust Deed. It is of course helpful if the ultimate result is good!

(ii) The Search for Facts

As far as the specific actual decision taken by the Trustees to break into the general field of research, a clue can be seen in the memorandum from Goodenough to Lord Wigram and the accompanying letter which indicates first of all, that while the concept for setting up of the Trust owed something to the idea of establishing a fund for the Provinces as a provincial complement of the King Edward's Hospital Fund of London, the Founding Trustees at the same time, did not wish merely slavishly to follow the Fund's general policy of existing largely to subsidise hospitals in London.

Again, it is evident that the idea of supporting research into issues fundamental to the effectiveness of services probably came out of the early support by Lord Nuffield to the Oxford, Berks and Bucks Hospital Council in which Hyde, a layman but steeped in the problems of social welfare services was a key figure, soliciting direct grants from Lord Nuffield. It was almost certainly the experience of this Council which led the triumvirate of Goodenough, Buzzard and Hyde to the conclusion that it

was important to get more facts about hospital activities in the community they serve. Buzzard's role in this must have been of immense importance.

Buzzard's far-seeing attitude may be seen in his Harveian Oration of 1941 *Reconstruction in the Practice of Medicine* which followed closely with what is known of Wilson Jameson's views and which seems to have influenced the appointment of Goodenough as Chairman of the Inter-Departmental Committee on Medical Education.

Some impression of the general hunger for facts about Health Services before 1948, is also given by Sir John Brotherston in his introductory Chapters of *Improving the Common Weal* (1986) published by the Trust, about Scottish Health Services in the run up to the NHS Acts. It had became evident that it was important to establish relevant information about the way in which hospitals operated and in which they sought clients through the medical practitioners who used them from the catchment areas they served and the frequent coincidence of which made them often more competitive than was prudent.

It is perhaps difficult now after 40 years of the NHS to recall that in those days there were few influential bodies concerned with health affairs which could be readily identified other than those on the clinical side, the Royal Colleges etc., which were the bastions of higher education and specialist practice, and on a more worldly plane the loosely organised British Hospitals Association and the British Medical Association. There was not quite the distinction between specialities as exists now. Many hospital 'specialists' were also engaged in general practice, although attached to particular hospitals for the 'privilege' of admitting patients.

The hunger for facts about hospitals was expressed at an early stage of the Trust's being, by the setting up, in 1943, **of the Bureaux of Health and Sickness Records in Oxford and in Glasgow**, two grants made in the early days in respect of seeking to establish information lines to services. The setting up of the **Chairs of Social Medicine in Oxford, and in Birmingham**, were innovative attempts to put an extra dimension to information gathering, by founding Chairs in Universities with the objective of breeding medical scientists capable of interpreting the relevant facts which it was hoped would guide public policies.

8. THE DILEMMA PRESENTED BY THE NHS ACT 1946

The creation of the National Health Service in 1948 introduced a situation differing widely from that which had determined the Trust's activities hitherto. In consequence, the Trust was faced with two questions. First was whether the creation of a National Health Service meant that the major purpose of the Trust had been fulfilled and that, thereafter, there would not be any useful work for it to do? If the answer to this question was in the negative, the second question arose. What work should reflect the policy of the Trust in future in pursuance of how it now conceived its purposes, and what machinery would it need for this work?

The issue of whether or not what was termed in the discussions 'the mission' of the Trust had been completed or frustrated by the passing of the National Health Service Act was one of such importance that it is perhaps of interest to recapitulate briefly the facts as seen at issue.

It will be recalled that the purposes of the Trust as defined at the time seemed somewhat restrictive

> the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of financial provision for the creation, carrying on, or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination.

While, clearly, the betterment of the hospital and ancillary medical services was the underlying aim, the work undertaken by the Trust, and any schemes initiated by other bodies that it had financed, had to be related to 'co-ordination on a regional basis'. Since the National Health Service Act 1946 provided for the re-organisation and full financial maintenance of the hospital services on a regional basis, there was no longer any need - as there was when the Trust was formed - for the Trust to organise and finance regional co-ordination between various elements of the hospital service. The responsibility now rested with the Government.

In so far, however, as there was clearly still work for the Trust to do, it was decided that such work would be related to two objectives:

(i) the **betterment of regional co-ordination** between those hospital and ancillary medical services provided for in the Nationl Health Service Act

(ii) the **development and improvement of co-ordination on a regional basis** (between themselves and in relation to hospitals) of those medical services to which the Act did not extend.

As far as the first object is concerned, it was already clear that the Government's acceptance of the principle of regional co-ordination of the hospital service, and the statutory reorganisation of the service on that basis, still left unsolved a large number of problems for which an answer had to be found before it could be claimed that a smoothly and efficiently working co-ordinated service as a fact. As for the second object, it was considered doubtful whether anyone would deny that the effectiveness of the services and the proper linkage to hospitals of the various ancillary services was a question bristling with a host of uncertainties and difficulties.

There was at that time little practical experience to serve as a guide on many of these problems and it seemed very doubtful whether, in a number of cases, the solutions would be likely to be found, still less fully applied, for some years to come - a chronic problem in any service of whatever kind. It was felt that the major planning bodies, the Regional Hospital Boards, would have their hands full creating hospital and specialist services in a period of restricted finance. Careful study, and also practical research experience, was clearly needed. Yet looking towards the Universities there was little activity by way of research on health services and the techniques required.

It was in the area of studies that the Trust decided to stake its future financing policy and that is why it did not hesitate to be positive in answering the question whether the creation of the National Health Service had made its purposes redundant. As an independent body, which had shown in the past its capacity to co-operate fruitfully with Government agencies, it felt it possessed a standing, an objectivity, a freedom of approach, and a sense of what was required to establish strong bases of policy, which gave value to any studies or inquiries it was likely to conduct or sponsor.

Some of these could be identified along with interested researchers. This was the reason for support for the **Hospital and Community studies** based on Glasgow University, the reports of which are classics of observation which also posed the need for complementary **rehabilitation services**.

The comprehensive nature of health care in the ancillary sense was never far from the Trustees' idealistic minds. Thus at the base of an important aspect of service, on a less ambitious but still important scale, **the experimental mobile meals service** (19) which the Trust, in co-operation with the Essex County council and the Thurrock Urban District council, had recently established in Thurrock, Essex, was intended to provide a working example of co-ordination between hospital, general practitioner, and local health authority services. Under this scheme, meals - cooked in the kitchen of the local hospital and specially prescribed when necessary - were delivered on medical recommendation to invalids, convalescents, and feeble old people in their homes. It was hoped that the scheme, supplementing the domiciliary nursing facilities provided by the local health authority, would indicate one of the ways in which existing pressure upon hospital beds and services could be relieved by an important service for the community in general.

In other cases it was decided that in the absence of identifiable research groups in Universities, progress could best be made through the setting up of in-house units. Thus before the Appointed Day the Trust embarked upon two special in-house studies relevant to major problems then recognised – **a Hospital Nursing Job-Analysis** (7), and an **Investigation into the Functions and Design of Hospitals** (4.2). The Trustees felt that if these two inquiries matured in anything like the way that it was hoped, they would bring to light a volume of badly needed facts which might lead to constructive proposals for improvements and economies, as well as the development of operational research techniques. One reservation made by the Steering Committees set up for these groups was that it was also felt that it was probable before they were completed that some practical **experiments** would be almost certainly required to give them credibility.

9. In Conclusion

Following the passing of the NHS Acts 1946 the Trustees reached the following conclusions:

(i) That, notwithstanding the changes brought about by the National Health Service Acts, the Trust still had plenty of work to do.

(ii) That, for the stage which could now be foreseen and for

which plans could be made, the work of the Trust could be summed up in three words: study, experiment, and demonstration.

First, the fullest scientific study of the hospital and ancillary medical services.

Second, the conduct of practical experiments when they appear necessary as a means of finding the true facts or the testing of promising ideas.

Third, the demonstration of new methods believed to be an improvement on the old, as being often the quickest way to gain their acceptance.

It was hoped that sometimes these studies, experiments, and demonstrations might be conducted directly by the Trust. It was likely that more often, they would be conducted by other bodies with financial support from the Trust. In the event increasing cost and organisational problems of experiments and demonstrations frustrated this hope, and studies became the major thrust.

It was hoped, however, that the Trust would find opportunities to assist the search for means of ensuring that any new knowledge gained by scientifically obtained evidence was given general application in the shortest possible time. Any reduction in the long time-lag which had undoubtedly existed in the past would be a gain to humanity.

This reorientation of the policy and activities of the Trust necessitated certain alterations in its administrative and advisory machinery to cozen and assess some of the current and future studies. This involved the appointment of Steering Committees for in-house studies, the membership of which was drawn from the academic and scientific communities.

SUPPLEMENT TO CHAPTER 3
1939–48

CLASSIFICATION OF MAJOR RESEARCH and DEVELOPMENTS etc. SUPPORTED BY THE TRUST

Pages (31) – (54)

HEADINGS

1. STUDIES etc.
2. EDUCATION (Medical, Nursing other)
3. EXPERIMENTS and DEMONSTRATIONS
4. SEMINARS etc.
5. MISCELLANEOUS

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENT ETC., SUPPORTED BY THE TRUST
1939–48

	Principal Authority	Subject	Trust Reports	Other References
	STUDIES ETC.			
	1941			
1	Ministry of Health & Nuffield Provincial Hospitals Trust Teams	Surveys of hospitals services	I,12–15	*The Hospital Surveys,* The Domesday Book of the Hospital Services (NPHT, 1946)
	1943			
2	Nuffield Provincial Hospitals Trust	Oxford & Glasgow Bureaux of Health & Sickness Records	I,27–30.II,55–7.III,55.	

	Principal Authority	Subject	Trust Reports	Other References
3	Manchester University, Dept of Education for the Deaf 1946	Research programme	I,38–9	
4	Edinburgh University, Dept of Child Health	Research into infant dietetics	I,35	
5	Belfast Hospital for Sick Children	Study of rheumatism in childhood	I,35	
6	Glasgow University, Dept of Public Health & Social Medicine 1947	Hospital and community studies	II,56.III,15–16	*Hospital-Treated Sickness amongst the people of Stirlingshire* (NPHT,1948) *Hospital-Treated Sickness amongst the people of Ayrshire* (NHPT, 1950) *Hospital and Community* (OUP for NPHT,1954)
7	Nuffield Provincial Hospitals Trust	Hospital Nursing job analysis	I,41–2.II,12–14.III,35–6	*The Work of Nurses in Hospital Wards* (NPHT, 1953)
	EDUCATION (Medical, Nursing, other) 1942			
8	Durham (Newcastle) University	Chair of Child Health	I,34.III,17–18	*A Thousand Families in Newcastle-upon-Tyne* (OUP, 1954)
9	Oxford University 1943	Chair & Institute of Social Medicine	I,25–7.II,52–4.III,54–5	
10	Oxford University 1944	Chair of Plastic Surgery	I,38	
11	Leeds University 1945	Chair of Psychiatry	I,35–6	
12	Birmingham University 1946	Chair of Social Medicine	I,25	

13	British Orthopaedic Association	Study of the design of orthopaedic appliances	I,39	
	1948			
14	Queen's University, Belfast	Chair and Department of Child Health	I,34	
	EXPERIMENTS/DEMONSTRATIONS			
	1941			
15	Regional & divisional hospitals councils set up or 'recognised' by the Nuffield Provincial Hospitals Trust	Planning for regional co-ordination	I,12–15	*A National Hospital Service:* A Memorandum on Co-ordination of Hospital Services (NPHT, 1941)
	1941			
16	Birmingham Accident Hospital	Adaptation, equipment, and Rehabilitation Unit	I,22	
17	Radcliffe Infirmary, Oxford	Adaptation & equipment of the Accident Department	I,22	
	1946			
18	Nuffield Health & Social Services Fund	Slough Industrial Health Service	I,31–3.II,58–9.III,51–2	*Venture in Industry,* a History of the Slough Industrial Health Service (Lloyd Luke Medical Books Ltd, 1965)
	1947			
19	Essex County Council	Thurrock mobile meals service	I,45	

	Principal Authority	Subject	Trust Reports	Other References
	SEMINARS ETC.			
	1947			
20	Representatives of Universities & Medical Schools	Student Health service Conference	I,30–1.II,53	
	MISCELLANEOUS			
	1941			
21	King Edward's Hospital Fund	Extension of the work of the Nursing Recruitment Centre to the Provinces	I,40	
22	Department of Health for Scotland	Nurse Recruitment Centre, Edinburgh	I,41	
	1943			
23	Oxford University	Continuation of Professor Florey's team for the co-ordination of clinical trials in penicillin research	I,39–40	
	1945			
24	Royal Maternity Hospital, Glasgow	Appointment of a dietitian	I,35	
25	Radcliffe Infirmary, Oxford	Department of Neurology	I,37	

CHAPTER 4
SETTLING ON COURSE
1948 and AFTER to 1960

Settling on Course

1948 and AFTER to 1960

This period covered three phases of the Trust's activities:

first, *the alignment of the Trust's work to the new conditions since the 'appointed day' on 5 July 1948 for the coming into force of the provisions of the NHS Act 1946;*

second, *the initiation and development of a general policy for action summed up originally in the three words 'study, experiment, and demonstration' with special accent on 'study' in relation to the function and design of hospitals, the work of nurses, hospital costing and general practice; and the*

third *after 1955, when it was decided by the Trustees to return to the situation where there was a separate Secretariat instead of the Joint Secretariat arrangement with the Nuffield Foundation.*

The immediate action in the ruling circumstances then, was to mount a reconnaissance to explore the potential opportunities for the Trust to develop a programme of suitable initiatives aimed at scientific measures to fulfil the purposes set out in the Trust Deed.

One major outcome of the policy of exploration was eventually the initiation of a publication policy. A number of reports of studies and experiments had already received wide attention not only at home but also overseas - on the job-analysis of nursing, on the function and design of hospitals, on cost accounting in hospitals and on the survey of good general practice. It was believed that such a policy would help in the establishment of a corpus of knowledge based on the scientific evidence from studies of questions believed important for the evolution of effective and economical health services. A basic presumption was (and remains, however optimistic or mistaken) that such knowledge would be applied by the authorities concerned to improve services

1. OBSERVING THE NATIONAL HEALTH SERVICE

(i) In the Beginning

In 1990s in which there is an uneasiness about the future of the NHS and in particular about its viability, certainly of the capability of its services meeting the expectations of the public, it is difficult to give a vivid impression to a population accustomed to 40 years of the NHS which has become so much part of British life, of the anticipation engendered by the 1946 NHS

Act and by the arrival of the Appointed Day in July 1948 for its coming into force.

The immediate post-war economic exhaustion was tempered by the hope of the dawning of a brave new world in which there would be social justice in which health care would be an important ingredient: and the order promised by the Act was an exciting prospect.

This excitement was particularly feverish in the Boards and Management Committees set up by the Act for the planning and operation of the hospital and specialist services which were recognised as by far the most expensive part of the NHS. The administrative changes designed for the co-ordination and integration of these services on the basis of geographical areas were traumatic to those concerned with administration of individual hospitals which saw their local freedom jeopardised. The logistical problems involved in filling the more obvious gaps in specialist services in certain areas, which formerly had little or none, were not easy of solution and the changes necessary took time to be brought into effect.

The new Authorities responsible for the planning and operation of non-teaching hospital services, that is the Regional Hospital Boards (RHBs) and the Hospital Management Committees (HMCs), had more than enough problems without being concerned with scientific studies for the future. They had the difficult task of setting up the operational structures for the new services; and the clamour from the operational hospital levels for the financial support which the NHS Act seemed to herald, to the Regional Planning Authorities which were the sole source of finance, begat all sorts of pressures. At the base level of hospitals and HMCs it seemed that the Boards were dilatory in paying attention to what were seen as the real and immediate requirements for maintaining, far less improving services.

The snags in 'sole service' funding by Government; which originally had been looked upon as a constant spring of resources, began to be exposed. Thus the estimates for the cost of running the Service made at the time when the legislation was going through Parliament were in the event proved to be unsatisfactory, so that the actual budgets of the RHBs which were the means of controlling expenditure by the HMCs, had frequently to be recast for the Ministry, and eventually cut back at the behest of the Treasury.

The Central Government had many problems in connection with the financing, some of them arising from an over-extended economy, and political in the party sense; and the imposition of the 'Cripps Ceiling' in 1950 with its cutbacks had effects going down to the smallest unit in Hospital Management Committees. With no experience of nationalisation, Boards looked to the Ministry of Health for leads which soon turned into constraints on action.

Some of the Trustees had some experience of the problems being experienced in the hospital field. Thus for example Sir Frederick Messer was the Chairman of the Central Health Services Council as well as the Chairman of the NW Met RHB and Sir Noel Mobbs was the Chairman of Windsor Hospital Management Committee where planning ideas were subject to the policies of the North-West Metropolitan RHB. Another Trustee, Sir George Hayter Hames was the Chairman of Devon County Council which was a Local Health Authority, responsible for the Preventive and After Care Services under Part III of the NHS Act 1946, which in practice required untangling from the services for the chronic sick, previously provided by hospitals.

As far as the Trust was concerned almost from its inception, it had already decided to be concerned with future problems related to improvement, on the thesis that the immediate problems of organisation would be solved but many more problems in improving the many elements of the infrastructure would soon be identified as requiring analysis.

(ii) Reviewing the Position

In reviewing the position in the years immediately following the Appointed Day in 1948 it was specially evident to the Trust that the removal of financial barriers and the creation of a national and planned service were potent, but still largely potential advances; the former released what appeared to be an unlimited (and in some cases unrestrained) appetite and demand, which the service had still to learn how to meet from resources which, since they could not be magically increased, had to be rationally disposed to the best advantage of the patient and with true economy to the State. Nor was it, in reality, a single health service that had been arranged but in the tripartite state created by the Act, three services *viz.* the general medical, the hospital etc., and local authority services; and it was soon evident that the

infrastructure of health care services to which an important part of the nation's resources was committed for effectiveness needed constant and much deeper study than it had yet received. Good information relative to the problems was not available.

That the arrangements within and between the several services were still so frequently debated and discussed meant that in many instances there was likely always to be a plethora of conflicting opinions and a paucity of accepted facts. The natural cry, for example, for more beds and new equipment after the wartime years of austerity and the promise of a brave new world was understandable; but it was evident then that it was not yet understood or agreed what was really required, and how the scarce resources and manpower could be best deployed, or whether alternative arrangements should be attempted with the existing somewhat restructured means. Indeed the inevitable and demonstrable demand for more services of all kinds was in danger of obscuring the lack of objective findings and tested experience about the working of the health and hospital services. Yet it was clear to the Trust that it is only on data painstakingly sought, and on experiments and demonstrations designed to try and to prove new methods, that rational improvements could be planned.

This was particularly true in the light of the Cripps financial ceiling for the NHS in 1950, which placed a considerable emphasis on the settlement of priorities and even then, a cry for 'value for money'. It was at that time in the state of flux in developing a reasonably integrated system of services that it became strikingly apparent that when a service is provided and controlled by the State there is an obvious advantage in the existence of private bodies with the means and inclination to subject that service to independent scrutiny. The Trust became conscious of the opportunity and responsibility which such a body enjoys, to contribute in its own way, to the better ordering of the service.

This was the objective of the support given to the **Acton Society** (7) whose six pamphlet series published between 1955 and 1958 was the first exhaustive study of the organisation and administration of the NHS. These together constituted a position paper of high quality.

(iii) Internal Organisation

During the early part of this period the organisation of the Trust

was adapted specially to enable the in-house studies of nursing and function which had been added to by studies of **Costing** (1) and of **General Practice** (3), to be supervised effectively.

In its general deliberations and discussions the Trustees continued to be advised by a Medical Advisory Panel and by Regional Committees in Scotland and Northern Ireland.

It was decided, however, that the in-house units which had been set up should have special arrangements. Thus, expert advisory panels were appointed for the particular studies on which its teams were engaged. Altogether the Trust drew heavily on a great deal of voluntary and institutional help for both counsel and collaboration. The 2nd Report of the Trust which covered the period 1948-51 remarked specially on this feature which has been common to all periods since:

> The work could not have gone forward without the ready co-operation of individual universities and hospitals, of medical, nursing, and administrative staffs, of general practitioners, and of local authorities. Without the goodwill of the Minister of Health, the Secretary of State of Scotland, and the Minister of Health and Local Government for Northern Ireland much of it cannot be put to the test of practice. If this public collaboration and consent were withheld - as it could be - the labours of a private body like the Trust would be in vain; it says something, perhaps, for both sides that the Trust's endeavours have almost invariably been helped instead of hindered. Thus the counterpoise and balance of private initiative and official responsibility is sensibly maintained.

(iv) Exploring Issues in the Infra-structure

While *prima facie* it seemed the purposes of the Trust were largely made redundant by the National Health Service Act 1946, it had become evident that the Government's acceptance of the principle of regional co-ordination of the hospital service and the statutory re-organisation of the service on that basis still left unsolved a large number of problems to which an answer had to be found before it could be claimed that an efficient and effective co-ordinated medical care service is a fact. This was the basis of the conclusion by the Trust in 1948 as a fundamental policy issue that, as there was little practical experience serving as a guide on many of the problems raised by the application of the National Health Service Act, there was a distinct requirement to study the facts, experiment with methods and demonstrate possible solutions. The Trust based its programme on this

policy and attempted to make a special contribution as an independent body, co-operating with Government agencies, in the field of enquiry and research into practically all aspects of health services.

In 1952, in order to give more precision the purposes stated in the original Trust Deed were varied by a scheme approved by the Charity Commissioners by the addition of the words:

> and the promotion of improved organisation and efficient development of hospital and ancillary medical services throughout the Provinces.

In taking action to fulfil the purposes of the Trust Deed it was agreed to continue to interpret the Trust Deed as widely as possible. Thus the general policy included the making of direct grants for demonstrations as well as the support and promotion of enquiries and investigations, although it was becoming evident that the cost factor in these meant the health authorities had to be drawn in to such studies.

Primarily, however, the policy was embarked upon to seek to add to real and useful knowledge. Fact-finding through research had been an early decision. It now became the keynote and was pursued with the objective of applying and demonstrating the results practically in methods of improved care for the patient. Indeed it was soon the experience of the Trust that even innovations - which clearly had to be tried if the service was to advance - could not immediately be selected and designed, because often the basic data did not exist. Reliable preliminary soundings are the prerequisite of any 'pilot' experiment. For this reason the first step was to seek the essential facts by survey and research over a fairly wide field. Only then, when some of the missing information had come to light, did the Trust begin to develop the thesis that experiments would be a profitable means of achieving improvement.

The Trust's programme as a consequence began to narrow down from the earlier wider considerations of the basis and means of co-ordination to specific issues related to those major component parts of the infra-structure of health services, which seemed fruitful for study. It became a main strand of policy that with a developing service and changing needs, those elements consisting of studies ranging over the field must precede the experiments and demonstrations to which studies pointed. The RHBs and HMCs were all too aware of their problems,

but there was no research policy in the NHS, or even at the Ministry.

It had been said that many hospital beds were out of use because of a shortage of nurses. Consequently, this was the reason for the study to discover and analyse what a nurse actually did in her daily work which was the objective of the Trust's **job-analysis of hospital nursing** (3.7), from which it was believed that facts and conclusions would emerge about the better use of the contemporary scarce resource of nurses. This was confirmed by the study, as rediscovered by the National Audit Office in their study in 1991! This study was later extended to the work of the **Public Health nurse** (4).

It was also strongly believed that the physical environment in which doctors, nurses, and others work - the hospital, and especially the ward - could be planned to economise and assist their tasks. This was why the Trust had initiated a radical re-examination of hospital design. It was recognised that as soon as the work of the Trust's team became already sufficiently advanced the enthusiastic co-operation of hospital authorities would be required to enable experimental ward-units to be built to test theories. Hospitals were recognised to be by far the most expensive part of the National Health Service, and the objective of the Trust's hospital study was to analyse the **functional requirements of design, construction, and nursing care** with a view to giving optimum effect to resources. A subsidiary aim was to discover as scientifically as possible what the **case-load** was for a hospital's catchment area, an important statistic surely for Planning Authorities.

At the same time it was felt that some index of cost and efficiency was needed for existing hospitals, and the Trust therefore became engaged, with the approval of the Ministry of Health, on an investigation into **hospital accounting** (1) for the necessary **information** for management. The Trust's study was concerned with the applicability of 'standard' costing - common in industry - to hospital accounting, a problem area discovered 40 years on by the Department of Health!.

Nobody wishes to go to hospital unless he or she have to, and it was often asserted that the then pressure on hospitals - and especially on out-patient departments - could be relieved by giving to general practitioners better facilities for diagnosis and treatment. The National Health Service was originally intended and provision was made in the NHS Act 1946 to include, for this

purpose, **health-centres** where the services of consultants from hospitals and general practitioners (and of local-authority clinics also) could conveniently meet to provide a comprehensive local 'health' service for patients. This - originally the most novel proposal in the NHS Act - has indeed for various reasons never fully, even in 1990, been implemented. In the earliest days of the NHS it was felt that if this feature was ever to win its way into the policy for the service, and into the hearts of the medical profession, some working examples of different kinds of health-centre would be needed. The Trust using the services of The Nuffield Health and Social Services Fund put three such experiments in hand (91, 92, 102), and planned for others, to see what benefits could be obtained - for the patient, the doctor, and the overburdened hospitals - from different types of health-centres.

However successful health-centres might prove to be, it was evident it would be a long time before they could be generally provided, and in the meantime the Trust proceeded to examine the position of general practice as the first line of medical care. This was the basis of study financed by the Trust designed to establish the current position of general practice, by Dr. J S Collings a physician from New Zealand (3). His report was approved by the Trust provided it was edited by Dr.(later Sir) Theodore Fox, Editor of *The Lancet.* The version which appeared in *'The Lancet'* caused something of a sensation as it presented a sombre picture of the state of the general medical services immediately post-1948. The Trust did not however leave it at that since it was felt it would be important to discover how the standard - and status - of general practice could be raised.

To that end, Dr Stephen (later Lord) Taylor (6) was commissioned to undertake a study of the constituent elements of 'good' general practice. The advantage, to patient and practitioner, of group practice was later studied in some working examples where doctors had grouped themselves so as to be able not only to afford better-adapted premises, secretarial and nursing help, and a little more leisure, but also to provide a better range of skills for their patients. It was estimated that if the benefits of this kind of co-operation could be demonstrated it would possibly become more common among general practitioners.

During this period therefore, the Trust was engaged in many essential studies affecting different parts of the health service; it

was also still hoped that some demonstrations and working models, based on these studies, would round off this policy. Indeed one further study in East Anglia (5) was directed to seeing whether and how in a Region the arrangements for medical care could be improved and interlocked to give something nearer the ideal of a comprehensive service to the patient.

This was the period when as part of a grand thesis the Trust's programme, therefore, began to be conceived albeit in a minor way to include studies of important elements of the infrastructure. Many of these were inter-related, many of them indeed interwoven, and all of it intended to advance a single purpose; the study and solution of some of the questions that were believed as being needed to be answered before the National Health Service could provide the best possible service to the patient - medically, socially, and economically - that the community can afford.

In its attempt to apply the private resources at its disposal to the improvement of a great publicly provided service, the Trust had become conscious of the need to be thorough in its approach to assessing applications for grants and so to build on such prestige which it had come to enjoy as an independent and impartial body; this consideration alone made it necessary to seek for studies, development, peer review etc., the willing co-operation and welcome help of many like-minded official and private individuals and bodies - an ever expanding group which indeed came to be seen as an all-important part of its constituency.

In the National Health Service itself perhaps the most notable happening was the appointment by the Minister of Health in 1953 of the Guillebaud Committee to consider certain aspects of the Health Service. The Trust was invited to give evidence to the Committee and in submitting a short note, set out for public information the policy of the Trust since the advent of the National Health Service. It felt it was important to point out that amongst other things because it was concerned with the future of the Health Service as a whole, the Trust's programme was conceived as a unity; many of its policies were interrelated and all of them directed to the study and solution of some of the problems that need to be solved if the National Health Service is to give each individual in the nation the care which is medically and socially as sound as the nation's means allow. Its general policy was expressed thus:

The Trust thought it could best serve the community by establishing data in those fields where complete information has not hitherto been available and then either publishing the facts so that others could use them as the basis for experiment and innovation, or else using them as a background to its own demonstrations.

The evidence was concluded by an offer to undertake any special studies which the Committee, at the conclusion of its deliberations thought useful. This offer reflected the general policy of the Trust which has been a feature during its life, in its attitude towards the various problems raised in the operation of the National Health Service and the special part which private bodies such as the Trust can play in investigations, experiments and demonstrations towards improving services. This did not raise a claim to plough a lone furrow, and then as always, the point was made that eventual success to improvement depended on the numerous people in the various Ministries, Universities, Boards, and Committees who helped initially in the activities of the Trust and such to apply any lessons learnt from the results of research.

2. THE MAIN THRUST

The early part of the period particularly saw not only the completion of the studies which have been already specially noted above (together with the continuance or initiation of some experiments based upon them) but also the development of the health-centre projects as demonstrations, principally those concerned with Group General Practice.

The most important of these developments was the enlargement of the Trust's contribution of the provision of health services in the New Town of Harlow (102). In 1954 the Trust decided to provide the **Nuffield Health and Social Services Fund** with sufficient finance to enable that Fund to build three permanent group practice health centres in Harlow. Subsequently the Trust reserved a considerably larger sum for the Fund to complete the building of all the health centres needed for the whole of Harlow (102) when the New Town was fully developed. At the same time drawing on the lessons of the Slough Industrial Health Service and the existence of the corps of general practitioners based in the GP Centres, finance was made available for two clinics for an **Industrial Health Service** (101) in Harlow.

The classified list at the end of this chapter indicates the range of studies financed, the most notable of which are referred to later.

The new schemes supported by the Trust during this early part of the period were roughly divisible into two categories.

In the first were investigations carried out by individuals or other bodies with Trust help.

In the second there were those practical experiments which hospitals or other authorities wished to try with the support of grants from the Trust.

Two of these latter ventures merit special attention for they indicated both the wide range of the Trust's interest and the continuity of its policy.

The grant to enable a **new hospital to be built in Alderney** (96) was more than for mere bricks and mortar; it was designed to assist the only part of the United Kingdom which was totally occupied during the 1939-45 war with the expulsion of all its inhabitants - and which suffered grievously as a result - to provide a centre for the health services of the island. The building was designed by the **Nuffield Foundation's Division for Architectural Studies** which was the wider-based successor of the Trust's **Investigation into the Functions and Design of Hospitals**, which had as demonstrations already designed accommodation at Greenock and Belfast at the request of the Department of Health of Scotland and the Northern Ireland Office.

The other notable grant for an experiment of a different character was one towards the cost of the **experimental two-year nurse training scheme in Glasgow** (80) which was carried out in partnership with the Department of Health for Scotland. It is of special interest that the Trust's job-analysis of the work of nurses in hospital wards in great part influenced the initiation of this scheme.

Other grants in this category were made for pioneering schemes such as **day hospitals for elderly psychiatric patients** (99,100), **a day hospital for mentally handicapped children** (104), **a training scheme for higher grade handicapped** (98), **a day attendance centre for spastic children** (106,116), **and better facilities for the diagnosis of deafness in children.** (97). Because of the importance of after-care, promising experiments in **rehabilitation services** (95,108,109,110) were also supported.

3. A CHANGE IN INTERNAL ORGANISATION

The administration of the Trust had been combined with that of the Nuffield Foundation in 1943 soon after the Foundation came into being. Although there was a common Chairman and Secretariat there were separate Boards of Trustees and the Trust Funds as well as the financial and accounting arrangements were kept separate. Because of the decision to set up in-house groups, each with its own Advisory Panel, there had been a special emphasis since 1948 on those particular activities, with a consequential evolution with regard to new policies and new ventures. Most of the staff common to both Foundations had a natural bias of interest if not loyalty to the wealthier Nuffield Foundation which with its wider purposes was probably immediately post-War the most powerful body in the Foundation field. The effect of this bias is reflected in the irregularity of Trustees' Meetings against which eventually the Trustees rebelled.

Because of representations to the Chairman, Sir Geoffrey Gibbs, who had succeeded Sir William Goodenough on his death in 1952 it was decided in 1955 to have separate administrative arrangements for both bodies, and the following year when the author succeeded Mr Leslie Farrer-Brown as Secretary regular meetings of Trust Trustees were re-instituted. Shortly afterwards to widen the interests represented the Board of Trustees was increased with the appointment of Lord Cohen of Birkenhead, not only a distinguished Physician but also Chairman of the Central Health Services Council and a legendary figure in healthcare circles; Mr.(later Sir) Evan ag. Norton, Chairman of the Board of Governors of the outstanding Teaching Hospital in Birmingham; and Dr. John Fry one of the best-known young General Practitioners of his generation.

4. THE INVESTIGATIONAL FIELD

While its income was relatively small compared to that of the Nuffield Foundation, the Trust operated in a smaller universe and through its published work on hospital function and design, costing, nursing and general practice had by 1955 acquired some prestige as an independent research body concerned with aspects of the infra-structure of health services. It had become to be recognised as having an important function as a commentator on and apolitically a prompter to a Health Service which it was becoming evident was subject to the

dangers inherent in a relatively remote government controlled operation. The Trust had had some success with the reports resulting from the enquiries undertaken hitherto and there was no doubt that the probing of many of the problems of the infrastructure was well suited to this kind of enquiry by an independent body.

It is notable that this view was confirmed by the opinion of the Guillebaud Committee who, in recommending the establishment of a Research and Statistics Department of the Ministry of Health, concluded

> ... we have in mind that once the Research Department has established that an enquiry into a particular aspect of the Service was desirable, such bodies as the Medical Research Council, the Nuffield Trust, the King Edwards's Fund, the Social Survey or the National Institute for Social and Economic Research would normally be invited to do the necessary research work ...

This to some extent, however, was not as accurate observation as it might have been, since it had never been part of the policy of the Trust to wait for invitations from Government to carry out studies or investigations.

5. THE IN-HOUSE ACTIVITIES

There had been originally four in-house research groups financed by the Trust which had been set up to look at major issues at a time when there were few research groups in the Universities concerned with Health Service Research and practically no Ministry support for such research. These were the **'Investigation into the Function and Design of Hospitals (IFDH)', the 'Nursing Study', the 'Costing Study' and the 'Good General Practice Study'.**

By 1955 all of these had completed their original objectives and indeed had published their reports, all of which had had a great deal of public attention.

By 1956 the scope of the Trust's direct activities was broadly:

(a) Division for Architectural Studies

The Trust was then making an annual grant towards the cost of a study by the Foundation's Division for Architectural Studies of children's hospitals, and a series of other minor activities in the health field.

(b) **Operations Research**
A small group led by Brigadier J D Welch was investigating the organisation of Central Syringe Services. Requests for this kind of service had also been made by other hospital authorities, for example, Charing Cross Hospital, for its new out-patient department.

(c) **Nuffield Research Fellowship**
Dr Stephen (later Lord) Taylor, the Nuffield Visiting Research Fellow, was with the approval of the Trustees engaged in working up the Harlow Industrial Health Service of which he was the Director. Dr Taylor had a half-time appointment with the Trust and was about to resume the survey of mental hospitals he began the previous year.

(d) **Health Centres, Diagnostic Centres, Industrial Health Services**
This group of subjects was being handled through the **Nuffield Health and Social Services Fund,** which has fairly wide objectives in the health field; it is a company limited by guarantee and in effect controlled by the Trust in that from the beginning the majority (and later all) of its Directors were Trustees. It owned **Farnham Park,** the centre-piece of the Slough Industrial Health Service (93), the general practitioner part of the **Corby Diagnostic Centre** (92) which was shared with the Oxford Regional Hospitals Board as a demonstration of a comprehensive Health Centre. It also planned to own all the **Health and Industrial Health Centres at Harlow** (101,102), most of which properties had been or would in time be financed from Trust funds. The Fund had no revenue of its own other than the rental of Farnham Park which it had been the practice to return to the Slough Industrial Health Service by way of grant. The Fund also had an income from the rents of the health centres at Harlow but it had an obligation to repay to the Trust the capital utilised to build and equip those centres.

Through the Fund the Trust kept closely in touch with developments in **Industrial Health Services** generally as well as the experiments at **Corby** and **Harlow.**

6. THE SERVICE-CREATING ASPECT OF POLICIES

(a) Reviewing Policies
The decision in 1955 to separate the administration of the Trust

and the Nuffield Foundation was to allow for more intensive studies in the field of health. In addition to concentrating more on the Trust's purposes, this involved a change in the mode of working with the adoption of a deliberate policy of seeking suitable external projects to support through a development of the grant-making function. It was expected that the reports of such ventures would develop a firm base for future policies.

Apart from such exceptional projects as **industrial health services** which while essentially forming a part of health policy not subject to the Ministry of Health, and experiments in **health and group practice centres** (which can be said to have grown out of the Trust's belief in the indivisibility of health care) the Trust tended primarily to make grants concerned directly with hospital and specialist services, but at the same time interpreting liberally the term 'ancillary medical services'.

With regard to policies involving grants for **experiments** by way of developments, perhaps the most important aspect of the changes which occurred in hospital administration since 1948 was that it had enabled serious planning and an improvement in the deployment of resources to be carried out at all levels of the Health Service. Regional and other authorities in the Health Service worked to annual programmes which were geared to capital and revenue estimates which allowed for a slow but steady rate of development in the services. Because of restrictions in finance, manpower and materials there were many more projects of such a nature approved by the various authorities than could be put in hand, and consequently most new ideas concerned with the Service found themselves placed in a system of priorities for funding.

It was decided as an issue of policy that applications acceptable to the Trust would be mainly of the following kinds:

1. Where the proposition was on the border of responsibility between two different statutory bodies, each of which felt it a matter for the other

2. Where the idea was experimental, and not too attractive to the public authority which feared the cost was great and there was a risk of failure

3. Where the sponsor of the idea was dissatisfied with the official priority his project had got, and wanted to speed its support by getting finance from outside sources

4. Where the statutory body concerned supported the project but was having difficulty in finding the capital, although it could bear the maintenance expenditure, or vice versa.

It was clear therefore that, except possibly at times of financial strain when developments normally tend to be cut right back, the pressure of applications coming to the Trust in respect of developments was never likely to be constant. Nor were they always of the highest quality, for the most important experimental projects deemed the most important invariably got a high priority from the hospital authorities themselves. On the other hand, at the particular time there was little by way of Trust publications indicating its policies and the number of applications being received was so slender that the question posed itself as to whether or not there was really a fund of good ideas or embryonic schemes in the Provinces ready to be discussed and which would find their way to the Trust if there was wider appreciation and knowledge of the Trust's range of interest and general policy.

This was the basis of the approaches by the Trust to Regional Hospital Boards and Universities in 1956 and 1957 to discover what was required in the way of research and what arrangements existed. The result was the paper 'Potential Opportunities for the Trust' and the approaches from the Trust to those bodies had an added bonus of stimulating some applications subsequently.

(b) The Move to External Research Capability

By 1957 with the accent on helping to set up research units in Universities only two 'in-house' units remained. It had already been decided that the 'Nursing' and the 'Costing Studies' would be terminated, and the continuing 'Investigation into the Function and Design of Hospitals' would be incorporated into the more widely orientated **Division of Architectural Studies** which had come directly under the Nuffield Foundation, although the cost of further hospital research by the Division was to be financed by the Trust.

The Operational Research Group of the IFDH study was however hived off to to be administered by the Trust and was engaged into what became an illuminating and much praised study of **sterilising practice in hospitals** (21,30).

The other study which had already been completed under the Trust's sponsorship was Dr Stephen (later Lord) Taylor's

study of *Good General Practice* (1954). Following its publication the Trustees agreed to finance Dr Taylor as a **General Practice Fellow** so that he could oversee particularly the development of the Health Centres in Harlow as an experiment and demonstration of what could be done by way of custom built group practice centres.

In the review of policy it had become obvious that there were problems concerning in-house studies. Their very nature meant that they had to be limited in scope and length of life, and after the initial objectives had been attained there were always doubts and sometimes no agreement with the researchers about the kind of directions their research should take. The problems were very much bound up with the personality of the principal actors in the particular studies and above all, the question of tenure of appointment. Short-term support for in-house groups meant there could be no security of tenure, such as was enjoyed by successful academic groups.

In considering the general principle of the effectiveness of in-house studies it was decided that on the whole, it would be better not to have in-house groups at all, but to free the administration of the Trust to be mainly concerned with the implementation of grant-making and other policies related to their purposes. Where special commissions were required it was helpful to identify suitable external bodies, mainly University Departments, which might be interested in particular lines and where there was some chance at least of the individuals concerned in time gaining security of tenure and finding appointments in career structures.

By 1962 when the separation from the Nuffield Foundation became complete by the move of the Trust headquarters to Prince Albert Road and the Trust was enabled to concentrate on its policies to fulfil its main purposes, Dr Stephen Taylor had finished his work with the Trust, but the ground work he had carried out ensured a continuing Trust interest in the subject of **general practice.**

The **Operational Research Group's** latest study of **sterilising practice** (30) had been a successful venture which showed what could be done by an external investigative group with the close co-operation of a hospital authority. It had followed the initial report in 1958 *Sterilising Practice in Six British Hospitals* which showed an appalling situation. At this time the distinguished consultant members of the lively Steering Committee of

the sterilising study decided that the best thing to do was to look at the potentiality of **Central Sterile Supply**. Accordingly the next few years were spent in research which resulted in the publication in 1962 of *Central Sterile Supply* which immediately became a standard work of reference. The Operational Research Group having achieved its major purpose, were finding it difficult to find a new suitable line of investigation and it was wound up in 1962.

By this time the principle had been adopted that as far as possible research of all kinds should be commissioned from suitable external groups, mainly in Universities.

7. THE DEVELOPMENT OF FUTURE POLICY

As an attempt to stimulate discussions with a view to producing a guide for future action, the general line of policy adopted by the Trust was along these lines:

(a) To be prepared to receive and encourage applications for grants for projects related to hospital and health services which, while coming within the objects of the Trust, were only those of an attractive experimental nature, falling broadly into categories (1) and (2) of the policy noted on page 75 of this Chapter. As a general rule the Trust would not support applications which should clearly be financed out of Exchequer money and which had no special feature.

(b) To continue to seek by enquiries and studies, either directly or by commissioning other bodies such as University Departments, etc., to bring light on the many problems identified in the organisation and evolution of the health services, at the local level as well as nationally. It might be necessary as a corollary of this to finance practical experiments and demonstrations.

(c) In order to ensure that the Trust got the right flow of applications of a) and b) above, to maintain the closest contact with Universities and Hospital Boards in the Provinces where there might be suitable individuals who had ideas but who, for some reason or another, were not receiving the attention and support their views merited. The continual question was how to discover such individuals and, if so, to encourage them to come forward seeking the Trust's support.

Fundamental to this line of thinking, it was generally felt that there was still a great way to go before the National Health Service was the model which all wished it to be, and that the

Trust could continue to play an important part in finding and promoting worthwhile projects and ideas to back, not only those which concerned hospitals directly but also those which had a close bearing on the use of hospitals.

Two fields in this connection in which there seemed to be relatively little research and were closely related to hospital use were those of **community** and **preventive services**. With its promotion of the health centres in Harlow, the Trust had indicated its interest outside the hospital in a specialised way and under rather extraordinary conditions, but it was felt that this interest and participation could be developed further and otherwise, to embrace these aspects.

Another field which demanded attention and in which the Trustees had already shown general interest was that of **mental health**. In addition to the survey being undertaken by Dr. Stephen Taylor, it was felt there might be opportunities for the Division for Architectural Studies, at the conclusion of their hospital programme, to look at the problems of mental hospitals. Most of the contemporary interest in mental health stemmed from the revelation of the state of and conditions in mental hospitals, but apart from physical improvements, as a series of 'Lancet' articles had recently shown, there was probably a mood for further study and experiment in the functional role of the mental hospital.

8. CHARTING THE WAY AHEAD

The *Potential Opportunities* paper was the result of the attempt to discover principally from Universities which had Medical Schools, as well as the Regional Hospital Boards and some major Local Authorities, what the opportunities were for the Trust in developing policies with regard to grant-giving and other actions in pursuit of its purposes. There was unanimous agreement by all the bodies consulted that there was an important function for the Trust, particularly since notably there was at that time no discernible government research policy for health care.

An important relevant point in the emphasis on seeking University Departments to support was that in those days of heady University expansion, the grants Universities received from the University Grants Committee (UGC) were on a quinquennial basis, which usually meant that if for example, a Foundation set up a research group in a University, and during

the quinquennial period it proved successful, there were strong pressures on the University administration to provide for the continuance of that group in the next quinquennial estimates. An added attraction was that this meant that to a large extent the Foundations were assured that their own period of support was limited usually up to a maximum of five years, after which it would be evident whether the venture was successful or not. If it was, the University made provision for it through the quinquennial demand to the University Grants Committee. This meant that from the Foundation viewpoint virtually all research was conceived in management terms as a form of action research with a limited period usually up to five years, and successful research was likely to entail the continuation of the research groups in a University setting.

As the development of this policy contained the hope that research would stimulate the hospital authorities, it also became normal procedure in relation to grants to try and associate the hospital authorities with a unit in a University carrying out a particular piece of research that required action following any recommendations that might be made as a result.

This line of policy of co-operative action research was relatively short-lived, because once the University Grants Committee stopped the quinquennial grant system as a result of the tightening of financial controls following the slowdown in University expansion, it became much more difficult to recruit people into the shadowy area of what was coming to be known as Health Service Research.

It was already evident, however, by 1960 that Health Service Research had to be encouraged and that the Universities were virtually the only institutions in which research units could be sited. It therefore became part of Trust policy in addition to supporting applications from Universities for research, to press for a central policy for the public financing of research and in particular its consequences, and for the establishment and nurturing of such units and in particular their relationships with the health authorities. The NHS with the principle of its Regional bases hinging on Universities with medical schools, was likely in the long run, to benefit from such a policy.

9. THE POTENTIAL FOR TRUST ACTION

Yet little of the future limitation confining research and its production was apparent in 1957 when the Trustees considered

and agreed a programme based on the paper *Potential Opportunities for the Trust* which was in effect an extensive review based on issues in the Health Service infrastructure which appeared to be neglected by the health authorities.

It was decided that the main interests of the Trust for the immediate period should be along the lines of various operational research studies in the hospital field in areas where little or no research was being initiated viz., **central sterile supply** (30), **efficacy of service departments, catering services** (64,76), **commissioning new hospitals** (37), **mental health studies** (34,35,41,42,43,44,46,57), **a variety of investigations e.g., casualty services** (40), **health service finance including costing** (28,49), **the use of social services as complements to medical based services** (53), **further education for administration and nursing** (84), **general practice** (45,61,88) **and industrial health** (115).

Most of these lines were pursued in the immediately ensuing years and reported on in publications which were well received: *Portrait of Social Work* (1960), *Commisioning a New Hospital* (1961), *Towards a Clearer View* (1962), *Costing and Efficiency in Hospitals* (1962), *Central Sterile Supply* (1963), *Hinges of Administration* (1963), *Food in Hospitals* (1963), *Standards for Morale* (1964), *Waiting in Out-Patient Departments* (1965), *Focus on Nurse Recruitment* (1965).

As a corollary it was also decided to see how far the results could be used as a base for deciding the priorities which should be adopted for the limited resources of the Trust applied to important issues which seemed to be neglected, but which were at the heart of the search for improved quality in health care services.

In the health care field most of the initial teething troubles of organisation in the NHS had been surmounted and by the last years of the decade pressures were emerging for a general debate concerning what seemed to be required in the future for a better use of resources. The future of the NHS looked promising particularly because it seemed there was likely to be a release of capital for hospital building.

As for Trust policy in general, in the inevitable spirit of optimism, it was felt that in looking ahead it would be useful to determine the general trends in health care. With this in mind it convened a small private week-end gathering to which a number of those, who in various influential capacities (medical, adminis-

husband its resources so that they could be deployed to the best advantage at weak points. Above all, it had a duty to be far thinking and try to interpret its objectives in relation to the requirements of the times. Its policy, if not wholly opportunistic, must be as flexible as its Trust Deed permitted.

11. THE 'INTELLIGENCE' APPROACH and THE PUBLICATION FACTOR

The report of the 1957 Christ Church seminar was not published, but it pointed the way to the Trust initiating two important studies, those of **Casualty Services** (40) and of **Outpatient Services** (19,20). At this time too, because of the welcome given to the publication on the **Case Load and Sterilising Studies,** it was decided to develop a publications programme, mainly because there did not then exist any major means of building up a **corpus** of knowledge of important details concerning health services through the written word outside of the major Journals concerned with health affairs, which for reasons of space were unlikely to accept lengthy articles.

There had been a number of Trust publications in the earlier years particularly *Hospital Costing* (1952), that on *Hospital and Community* (1954) from the Group led by Professor Thomas Ferguson who was the Trust's Scottish adviser, *The Investigation into Function and Design of Hospitals* (1955), Stephen Taylor's *Good General Practice*, and *The Work of Nurses in Hospital Wards* (1954), but these were sporadic and not related except for Ferguson's, to in-house group work.

The scandal of inadequate **Casualty Services**, identified as a major service problem at the 1957 Christ Church conference was highlighted by a Report on the results of an OR enquiry (40) specially mounted by a Trust based team, *Casualty Services and their Setting* (1960). Two of the proposals, the first for the rationalising of casualty services (which meant the unpopular but desirable policy of the closure of inadequate local services and the concentration on fully staffed Accident and Emergency Centres); and the second, because of the requirements of treating trauma following accidents, for the recognition of a speciality of Accident and Emergency consultant, have since been implemented, although perhaps not so widely as is deemed necessary.

The non-elite services such as those for the **mentally ill and handicapped** had been candidates for special attention resulting

in publications since the Royal Commission Report in 1959, especially the importance of the too often neglected community services as part of the seamless robe of health care.[1]

In the same area of neglect, yet another important policy for the care of the specially vulnerable which was recognised as being desirable to come under geater scrutiny by the policy-makers was that for the **elderly** (29,50). In this it had long been evident that close working arrangements should be developed (again more than legislation is required) between the Health Authorities and Local Authorities which have responsibilities for providing in one way or another, appropriate care, accommodation and services, as was indeed laid upon them in the 1946 NHS Acts.[2]

The 'Planning Chapter (V)' of *the IFDH report* in 1955 showed how necessary it was for the techniques of **operational research** to be developed, to help Regional Hospital Boards in their overall planning function if they were to make best use of their Capital (and Revenue) Resources. This was the origin of the research supported which resulted in *Demand for Medical Care* (1960) the report of the case-load studies in Barrow and Furness hospitals.

1. It has taken a long time for the importance of these to be recognised with appropriate action. The special policies advocated in the Griffiths' Report on Community Care in 1986 have only been partly (and even much belatedly) responded to in the White Paper *Caring for People* but effective action will be another matter. Long before Griffiths' powerful report, it was evident that urgent and imaginative action is needed if we wish to believe we are a civilised country. The obvious agents to co-ordinate the action required are the local authorities but it will need more than legislation to achieve adequate comprehensive local services.

2. The great expansion of private residential and nursing homes in this sector likely to be given a boost under present policy may in time pose questions of regulation. The past Chief Medical Officer of the Department Sir Donald Acheson (in a previous job) was the Chairman of the Trust-assembled Group which studied this issue. The resultant publication *The Impending Crisis of Old Age* (1981) had some important observations and recommendations, largely ignored hitherto, but some of which transcend legislative action and will in time still have to be addressed if we are to improve quality of care for this specially vulnerable group. These observations were reinforced by the results of a specially commissioned study by Sir Ivor Batchelor who examined the major aspects of DHSS policies for the care of the elderly and mentally ill and pithily recorded them in *Policies for a Crisis* (1984). He particularly pointed to the quite inadequate policies of the Health Departments in respect of domestic and nursing home accommodation which should be integrated with the responsibility placed on Local Authorities' policies for the **care** of the elderly etc.. Above all he pointed to the need for close monitoring of services for these specially vulnerable groups.

The report *Casualty Services and their Setting* (1960), a study mounted by the Trust itself, as a result of the Oxford *Trends in Medicine* seminar, was an instant success in that immediate public and widespread attention was given to its pinpointing of the problems faced by **Accident and Emergency services,** a subject which the Trust had originally identified for study in the 1940s.

The success of the publications made it evident that there might be an advantage in having a more definite publishing policy not only to round off its research sponsorship policies, but in time to contribute empirically with other research publications based on research results, to the development of a literature designed to improve an understanding of what constitutes those elements in the infrastructure which have to be taken into consideration in moving towards the optimum in health care.

12. THE CHANGING BACKGROUND

(a) A Confident NHS but without a Research Policy

There was a second notable anniversary at the end of the decade providing a special reason for reviewing the work of the Trust, with an eye to the future.

Thus, 1960 marked the celebration of the twentieth anniversary of the date of the Trust Deed entered into by Lord Nuffield to set up the Trust, and an occasion for reflecting on the faith and farsightedness of the Founder on that day, 25th June 1940. The hospitals then were stayed on their great traditions, but their future was uneasy, and if there was no apparent disarray, the fact was that the exigencies of war-time organisation papered over cracks which were revealed with all their jagged edges when the emergency was over. It was relevant that looking back over the past 20 years the creation of the Trust could be seen more clearly, as a great act of faith. It was a particular manifestation of the human spirit's belief in ideals, and an optimism of a better future, as ever the key-note of the Trust's activities, but given fresh stimulus by the improved economic conditions in the UK which seemed to promise greater things for the NHS.

Since 1940 the hospital services had gone through many vicissitudes, but the extraordinary degree of cohesion of hospital and specialist services, largely brought about since 1948, by the very regionalisation urged in the Trust Deed, was undisputed.

The health care scene as summed up by the NHS could be counted, beyond any doubt, a solid achievement in providing comprehensive health services.

By 1960, it was evident that the economic state of the country had improved to the extent that the Service was likely to have a strong infusion of capital for development in the next few years. It was therefore deemed by the Trustees more important than ever that there should be thorough scientific examination of the range of beliefs and hypotheses on which the operation of the service, its branches and even its constituent elements, such as hospitals, was based.

It was indeed argued by the Trust that the Government itself should initiate studies and experiments, and indeed the scale of operational research required, if the Health Service was to fulfil its potential, seemed to demand special action from government. The sceptical among commentators believed that government-promoted research might inhibit boldness in line and candour in comment. It seemed to some then, as it still does now, that there might be indeed, a positive disadvantage if the executive had exclusive rights in service research, for it is important in the application of results that such research to be effective must above all be seen to be judicial and impartial both in approach and in communication of results. The scale and cost of research deemed necessary made it inevitable that Government had to come strongly into the field.

If this was to be the case, it made all the more necessary the lustiness of comment by independent bodies devoted to the ideal of improvement. There was indeed support in certain places for the theory of a separation of research and executive function, but there was an underlying feeling in the Trust that for efficiency no organisation can afford to dispense with research as part of its managerial function. Ultimately to establish an effective research input would be a test of managerial competence. Indeed the seeds were already there for it had been the Trust's observation and experience, and it was deemed unworthy not to say it, that the degree of co-operation given and the co-operation and counsel readily made available by the Central Government Departments and the various health bodies in enquiries such as, for example, that of casualty services, where criticism rather than praise could be expected as an outcome, was in the best tradition of public administration and could hardly be bettered.

(b) Summing Up The Trust Programme

The Supplement lists the major schemes supported during the decade which concerned many important facets of the health services.

The review of the previous 20 years spurred by the two Anniversaries supported the fundamental belief of the Trustees that while hospitals are at the core of the Trust's activities, health is indivisible. The implications of the expanding hospital development programme were reflected in the special studies and experiments into function, and deriving from that the initiation of the enquiry into the neglected subject of **engineering in hospitals** (48).

Again the more the hospital services are studied, the greater is the revelation of the complementary role of the other medical and ancillary services. Hence the importance of the band of studies on the **effectiveness of health care in its various aspects,** and the area studies of **mental illness**, which seem a prerequisite to a better understanding of the **community mental health services** needed in the future, if the ideal of the Mental Health Act 1959 was to be achieved.

In both of these quite different kinds of pioneer studies, the Trust's role was to sponsor and sometimes initiate: but it was now recognised that to complement this function there was also an important **educational requirement** (56,84), for unless the bases of the work were understood and the results applied, the full value of such research is never likely to be realised.

It would be to expect too much to hope that the lessons of service research, experiments, and demonstrations are ever noted and quickly applied by those concerned with management, and there could only be speculation about the attention paid by the authorities to the published results of such work. It was felt the Universities had an important part to play outside degree courses, and this was the reason for the support given in 1957 to the Department of Adult Education at the University of Leeds for a pilot course in **management studies** (84), which with further support later burgeoned into the Nuffield Centre for Health Services Studies.

In a different context, in 1954, in *Hospital and Community*, Ferguson and MacPhail drew attention to the inadequacy of the **after-care and rehabilitation services**, responsibility for much of which lay with the NHS, and how the failure of this part of comprehensive health care services was vitiating much of

the good work by other parts. It seemed from the follow-up studies that these services were still poor, or non-existent in other areas as well, and much apparently successful hospital treatment is nullified as a result. In 1955 to draw attention to the need for these services, grants were made to develop the work of the excellent **Physical Medicine Departments** at Winchester and Salisbury (95, 110, 121). These were examples of what the character of rehabilitation services should be, and of the dividends of close co-operation between hospitals, local authorities and a Department of State separate from that of Health, the Ministry of Labour. The Trust's sponsorship of developments in the work of these Physical Medicine Departments was designed to give further demonstrations of the necessity of regarding treatment of patients as a whole, up to resettlement.

There is some evidence that past research and development supported had been noted by the Authorities as well as Government and subsequent action taken. The reaction to the report on the *Investigation into the Functions and Design of Hospitals* had been welcoming, and to the report on *Central Sterile Supply*, dramatic, to judge from the demand for copies and the setting up later in most major hospitals of Central Sterile Departments.

The response to the report *Casualty Services and their Setting* had also been excellent and it was heartening to note that at least one Regional Hospital Board had decided to embark on a similar study of the services available in its own region, to the depth needed.

Yet it was borne on the Trustees that the communication of ideas and the results of research, both for the information of the public and the administrators, was an important issue requiring special consideration and it remained a matter of great concern at the conclusion of every study.

Indeed its experiences confirmed a brokerage as well as publication role for the Trust to help the expansion of the integral part of research in this most complex of services and the bringing together of those concerned with service with researchers since as was noted in the *Fifth Report.* 'for it is they who are the sinews of the work of the Trust: without them there could have been no enterprises to support and nothing to report'.

13. TWENTY YEARS AFTER - RETROSPECT AND PROSPECT

At the end of the decade the Trustees reviewed the lessons of the 20 years of the Trust's existence. The independent outlook of

the Trust is derived from its purposes and the order of its resources. When it was founded in 1940 it was clear that there was need for some body external to Government with appropriate resources to be in a position of taking an independent position on improvements based on studies and research, on the rationalisation of hospital resources in the Provinces.

The NHS Acts in 1946 provided the base and structure for the nationalisation of hospital and specialist services which has still never been altered in principle. The very fact of the regionalisation of hospital and specialist services seemed to fulfil the main original purpose of the Trust which was to promote the policy of the co-ordination of hospitals; but since Government stood aloof from a research policy concerned with improvement, the Trust sought opportunities to develop a research programme aimed at improving **the quality of health care.**

Having experimented with in-house units carrying out research, it was decided a better mode of working would be to concentrate on selecting subjects for study and look to a grant-making programme to selected University Departments to carry out research.

It was concluded that part of the **'intelligence'** drive would be best accomplished through the means of private forums/seminars. The 1957 Christ Church forum which was the 'pilot' experiment showed that it was possible to glean from such a method priorities for research based on the position papers commissioned and discussions on a number of subjects raised by a group of leading figures in health care, and fundamental to the development of health services in the UK. The private forum/seminar method has been used to great effect over subsequent years not only as a method of exploring key issues, but also as a general means of further education and influence.

The success of the Christ Church forum had another important effect. The original Medical Advisory Committee had withered away and it was decided by the Trust to revive the idea and appoint a new, small active **Medical Advisory Committee**[3] all of the members of which had participated in that gathering. It was to prove an inspired decision not least for the role the Committee played especially during the next decade in shaping and supporting Trust policy and action.

3. Sir George Pickering (Chairman), Sir Hedley Atkins, Sir Martin Roth, Sir John Revans, Sir Charles Stuart-Harris.

The decision in 1960 to institute the **Fellowship** named after Sir Ernest Rock Carling who had suceeded Sir Farquhar Buzzard as Chairman of the Trust's first Medical Advisory Committee from 1945-58, was to strengthen the identification process of highlighting important issues suitable for research and to commission position papers on subjects which it was felt were of contemporary importance but not getting adequate attention. This policy which complemented the grants programme entailed a policy which envisaged the publication of the considered views of distinguished members of the health professions related to their own experiences, and drawing on the best of published material. It was also a further recognition that there was no simple solution to the problem of health care provision but involved explorations of many aspects.

This was an important decision in Trust policy, for in time the monographs which were published projected the views of many individuals who had leading roles in health matters of various kinds, and given the dual distinction of the Fellows and of the Panels which chose them, the major features of these Monographs since their inception are unique indications of contemporary issues of major concern: and inevitably some have had an influence on views and on lines of thinking about health care. This too was another step in laying the foundations of an expanded 'intelligence' policy which was immediately strengthened with the appointment of Mr E T (now Sir Edgar) Williams as a Trustee and subsequently Chairman.

The idea was developed of seeking to base the Trust policies on **'intelligence'** arrangements, in the sense of focussing sharply on the major issues identified by various means, introducing as necessary evaluation exercises of contemporary initiatives in health matters to give effect to the Trust's major purpose which had become the improvement of the hospital and associated medical services as a whole.

With the grant-making programme for studies and complementary forum/seminar and publications policies, this has played an important part in exposing the complexity of some of the major issues of health care in the UK. This mode of working with the accompaniment of a distillation of ideas from the developing literature from **all** sources, exploring fundamental issues concerned with effectiveness of health care services over the years, has formed the background of the Trust's actions virtually *qua* Institute and impresario for the many talents it has

been able to enlist in the search to illuminate important trends in health care policies, and the reactions to them.

The review also correctly forecast the virtual drying up of applications for **experiments** and the difficulties in setting up studies concerned with the structure of the NHS other than those of the descriptive type, albeit important as position papers, as exemplified by those of the Acton Society. It was recognised that to be fully effective research on 'structure' invariably requires to be complemented by careful **action research** which tends to be costly and depends on the wholehearted co-operation of the Department of Health and the Health Authorities capable of financing practical experiments and demonstrations.

It was believed the fruits of the overall policy of research and intelligence would be likely to give an extra dimension to health service problems and provide an appropriate perspective on the various services which make up the complexities of the health care infra-structure.

SUPPLEMENT TO CHAPTER 4
1949–60

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENTS etc., SUPPORTED BY THE TRUST

Pages (61) – (92)

HEADINGS

1. STUDIES etc.
2. EDUCATION (Medical, Nursing, other)
3. EXPERIMENTS and DEMONSTRATIONS
4. SEMINARS etc.
5. MISCELLANEOUS

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENT ETC., SUPPORTED BY THE TRUST
1949/60

	Principal Authority	Subject	Trust Reports	Other References
	STUDIES ETC.			
	1949			
1	Nuffield Provincial Hospitals Trust	Investigation into hospital costing	II,29–34.III,38–41	*Report of an Experiment in Hospital Costing* (NPHT, 1952)

	Principal Authority	Subject	Trust Reports	Other References
2	Nuffield Provincial Hospitals Trust	Investigation into the function and design of hospitals	II,17–28.III,29–34 IV,63–4.V,103–4	*Studies in the Function and Design of Hospitals* (OUP for NPHT, 1955)
3	Nuffield Provincial Hospitals Trust	Survey of general practice by Dr J S Collings		*Lancet* (1950),i,555 '*General practice in England today: A reconnaissance*'
4	Nuffield Provincial Hospitals Trust	Job analysis of the public health nurse	II,15–16	
	1950			
5	Cambridge University, Dept of Ecology	Survey of hospital, and specialist services in E Anglia	II,50–1	
6	Nuffield Provincial Hospitals Trust	Surveys of good general practice by Dr Stephen Taylor	II,48–9.III,42	*Good General Practice* (OUP for NPHT, 1954)
	1952			
7	Acton Society Trust	Studies of the administration of the hospital service	III,11.IV,11–12	*Background and Blueprint, Impact of Change,* Groups, Regions, and Committees (Acton Society Pamphlets, 1955,56,57)
8	Belfast City Hospital, Geriatric Unit	Survey of elderly men in common lodging houses in Belfast	III,16–17	*Growing Old in Common Lodgings* (NPHT, 1954)
9	United Oxford Hospitals	Enquiry into the value of laboratory investigations	III,12	
10	National Councils of Social Service for England, Scotland, and Northern Ireland	Enquiries into the provision of services for the handicapped and disabled	IV,42–4.V,86–7	*Help for the Handicapped* (National Council of Social Service, 1958). *The Handicapped Person, and Jobs for the Handicapped.* (Scottish Council of Social Service, 1958 and 1960). *Handicapped Persons in Northern Ireland* (N Ireland Council of Social Service, 1962)

	1953			
11	London School of Economics	Study of certain aspects of prescribing by GPs	III,14	*The Social Aspects of Prescribing.* (Heinemann Medical Press, 1957)
12	Hengrove Child Health Centre, Bristol	Analysis of morbidity records in childhood	III,10–11.IV,45.V,77	*Med. Offr.* (1959) 101, 337, '*Studies in social paediatrics, I*: starting school', and (1960), 104, 219, *Ibid. II*: 'the first year of life'
13	Northern Ireland Hospitals Authority	Pilot study of the integration of the Northern Ireland maternity services	III,13–4	
	1954			
14	South-western Regional Hospital Board	Survey of the working of maternity services in the region	II,12–13.IV,10–11	*Maternity Services: A Report on some Aspects of the Maternity Services in the South-western Region* (South-western Regional Hospital Board, 1957)
	1955			
15	Dr G W Ireland's Practice	Study of general practice in its social setting of a rural Scottish community	IV,46–7.V,77	
16	Aberdeen City Health Department	Study of the causes of accidents in the home	IV,25–6.V,21	*A Study of Home Accidents in Aberdeen.* (E and S Livingstone, 1960)
17	Radcliffe Infirmary, Oxford	Research section to accident service	IV,23–4.V,26–7	
	1956			
18	Glasgow, Aberdeen, and St Andrew's Universities, Departments of Public Health & Social Medicine	Further studies in hospital and community	IV,14–15.V,22–3.VI,21	*Further Studies in Hospital and Community* (OUP for NPHT, 1962)
19	Manchester University, Dept of Social Administration	Case-load study of the Barrow-in-Furness Area	IV,12–13.V,18–19	*The Demand for Medical Care* (OUP for NPHT, 1960)

	Principal Authority	Subject	Trust Reports	Other References
20	Newcastle, King's College, Dept of Industrial Health and Economics	Case-load study of Tees-side	IV,12–13.V,18–19	*The Demand for Hospital Beds* (Newcastle Regional Hospital Board, 1962)
21	Trust Operational Research Unit	Investigation of the organisation of Central Syringe Services	IV,66	*The Planning and Organisation of Central Syringe Services* (NPHT, 1957)
22	United Oxford Hospitals	Neurological Research Departments at the Churchill Hospital	IV,20–1	
23	Queen's University, Belfast, Department of Social Medicine and Public Health	Study of accident proneness among bus drivers in Belfast	IV,24–5.V,26	*The Causation of Bus Driver Accidents* (OUP for NPHT, 1963)
	1957			
24	Queen's University, Belfast, Department of Social and Preventive Medicine	Study for improved methods of keeping hospital records	IV,20	
25	College of General Practitioners	Study of Chronic bronchitis	IV,47–8.V,78	
26	Manchester University, Dept of Social Administration	Study of the use of health and social services in the County Borough of Rochdale	IV,16–17.V,19–20	*Portrait of Social Work* (OUP, 1960)
27	National Association for Mental Health	Study of the care, education, and treatment of maladjusted adolescents	IV,34–5.V,47	
28	Cheadle Royal Hospital and Manchester University, Department of Social Administration	Study of the cost of mental illness	IV,34.V,46	*Mental Hospitals at Work* (Routledge & Kegan Paul, 1962). *Med. Offr.* (1960) 103, 219
	1957			
29	Aberdeen University Department of Public Health and Social Medicine	Survey of the needs of the aged in the Aberdeen Areas	IV,38–9.V,84	*Age and Need: A Study of Older People in North-east Scotland* (E and S Livingstone, 1964)

30	Trust Operational Research Unit	Study of the organisation of central sterile supply departments	IV,66.V,104–5.VII,68	*Present Sterilising Practice in Six Hospitals* (NPHT, 1958) *Central Sterile Supply* (OUP for NPHT, 1962)
	1958			
31	Oxford University Institute of Social Medicine	Environmental study of leukaemia in adults	IV,22–3.V,27–8	
32	Cambridge University Department of Ecology	Enquiry into sudden death in infancy	IV,21–2.V,25–6.VI,24	*Immunology*, 3, 296, 307. *Lancet* (1960) ii, 1106
33	Farnborough Hospital, Kent	Study of the effect of tonsillectomy and adenoidectomy in children	IV,23.V,24–5.VI,24–5	*Proc. Roy. Soc. Med.* (1961), 54, 399. *Brit. J. Prev. Soc. Med.* (1963), 17, 49, 133. *Medical World* (1964), 1, 113
34	Oldham County Borough Health Department	Study of mental health in the Oldham area	V,56.VI,46.VII,56	
35	Manchester University, Dept of Social Administration	Comparative study of day Hospitals for the mentally ill (Secondment of Mr Farndale)	V,99	*Day Hospital Movement in Great Britain* (Pergamon Press, 1964)
36	Cheadle Royal Hospital	Study of the effect of incentives in the rehabilitation of long-stay patients.	IV,33–4	*Lancet* (1961), ii, 594
		Day centre for long-stay patients, and industrial workshop	V,50–1.VI,43	
37	Oxford Regional Hospital Board	Study of the commissioning of the Princess Margaret Hospital, Swindon	IV,18–9.V,21	*Commissioning a New Hospital* (Oxford Regional Hospital Board, 1961)
38	Birmingham University, Dept of Social Medicine	Assessment of the medical, nursing and social needs of inpatients in Birmingham Hospitals	IV,15–16.V,23–4	*Brit. Med. J.* (1959), I, 122. *Lancet* (1961), i, 815
39	Manchester University, Dept of Industrial Administration	Investigation into ward problems in the training of nurses	IV,58–9.V,93–4	
40	Survey Group (NPHT)	Survey of casualty services	V,37–8	*Casualty Services and their Setting* (OUP for NPHT, 1969)

	Principal Authority	Subject	Trust Reports	Other References
	1959			
41	Anglesey County Health Department	Survey of mental health needs	V,56–7.VI,47	*Problems and Progress, I.* 205 (OUP for NPHT, 1964)
42	Netherne Hospital	Study of the value of active work in the rehabilitation of mental patients	V,62–4.VI,41–2	*Brit. J. Psychiat.* (1963), 109, 463
43	Manchester University, Dept of Social Administration	Study of the employment and training of adult mentally handicapped (Secondment of Miss Straton)	V,64	*The Occupation and Employment of Mentally Subnormal Adults* (University of Manchester, 1963)
	1959			
44	Crichton Royal Hospital	Study of a mental hospital and the community	V,57–8.VI,47.VII,57–8	
45	College of General Practitioners	Study of the incidence of diabetes in the community	V,79–80	*Brit. Med. J.* (1962) I, 1947 *Brit. Med. J.* (1963) 3, 655
46	Aberdeen University, Dept of Mental Health	Epidemiological Studies of mental health	V,58–9.VI,54–5	*Burden on the Community* (OUP for NPHT, 1962)
		Operational studies of Scottish mental health services	VI,54–5.VII,61	*J. Mental. Sci.* (1962) 447. *Scot. Med. J.* (1963) 227
		Collection of data for the psychiatric case register by special interviewers	VI,55.VII,61	*Brit. J. Prev. Soc. Med.* (1965) 19, 38. *J. Ment. Subnorm.* (1965) II, 76. *Health Bulletin* (1966) 24, 19. *Computers in the Service of Medicine, I. No. 4* (OUP for NPHT, 1968) *Operational Research Reports*, 1–9
47	British Epilepsy Association	Study of epileptics in colonies	VI,35	*Problems and Progress, I,* 353 (OUP for NPHT, 1964)

48	Glasgow University, Hospital Engineering Research Unit	Hospital engineering research programme	V,106–8.VI,69–70.VII,93	*Hospital Engineer* (1962) 16, No. 6; (1963), 17 No. 3; (1966) 20, Nos. 1&2; (1968) 23, No. 5. *Hospital Engineering Research Unit Reports,* 1963–7. *Ministry of Health Hospital Engineering Data Sheets,* 1965. *J. Inst. Heating Vent. Eng.* (1965) 33, 165; (1967) 34, 327. *Problems and Progress, II,* 187 (OUP for NPHT, 1966). *J. Med. Microb.* (1969) 2, 335
49	Manchester University, Dept of Social Administration	Study of departmental costing in the hospital service	V,31–2	*Costing and Efficiency in Hospitals* (OUP for NPHT, 1962)
50	Barrow-in-Furness Hospital Management Committee	Survey of geriatric services in the Barrow-in-Furness area	V,85.VI,98	*Medical Care* (1963) i, 202, & (1964) ii, 7
51	Operational Research Unit (NPHT)	Study of the organisation of X-ray departments	V,105.VI,68–9	*Towards a Clearer View* (OUP for NPHT, 1962)
52	King's College, Newcastle	Enquiry on which to base a Student Health Service for Newcastle	V,76	*A University Health Service Enquiry* (King's College, Newcastle, 1962)
53	London School of Hygiene	Survey of social work in Buckinghamshire	V,35–6.VI,26	*An Anatomy of the Social Welfare Services* (Michael Joseph, 1965)
54	Institute of Psychiatry	Study of emotional disorders among schoolchildren in Buckinghamshire	V,61–2.VI,49.VII,59	*J. Child. Psychol.* (1966) 7, 39 *Problems and Progress 5,* 89 (OUP for NPHT 1971); *Childhood Behaviour and Mental Health* (University of London Press, 1971)
55	Aberdeen University, Dept of Mental Health Services	Studies of Scottish Mental Health Services	VI,54–5.VII,60–1	*The Mental Hospital in the Psychiatric Service* (OUP for NPHT, 1971)
56	Leeds University, Nuffield Centre for Health Services Studies	Study of hospital administrative staffing structure	V,98–9.VI,105	*Hinges of Administration* (OUP for NPHT, 1963)

Principal Authority	Subject	Trust Reports	Other References
57 Littlemore Hospital, Oxford	Study of the prevalence of mental illness in the community	V,55.VI,46–7.VII,56–7	*Problems and Progress, I,* 267 (1964) *Brit. J. Prev. Soc. Med.* (1962) 16, No. 2. *Int. J. Soc. Psych.* (1962) 8, No. 4
58 London School of Economics	Reconnaissance of the problems of dental health services	V,111–12.VI,111	*Dental Health and the Dental Services* (OUP for NPHT, 1962)
59 Slough and District Care Committee	Survey of handicapped people in the Slough area	V,90–1	
60 Manchester University, Medical Care Research Unit	Survey of outpatient departments	V,38–41.VI,28.VII,18	*Problems and Progress, I,* 3 (OUP for NPHT 1964). *J. Roy Coll. Gen. Practit.* (1976) 18, 243. *Gateway or Dividing Line* (OUP for NPHT, 1968)
61 College of General Practitioners	Statistical advisory service	V,81–2.VI,78–9	*J. Coll. Soc. Med.* (1963) vi, 195. *J. Prev. Soc. Med.* (1964) 18, 1.
62 Manchester University, Dept of Industrial Administration	Study of the hospital as an organic unit	V,29–30.VI,21–2	*Problems and Progress, I,* 55 (OUP for NPHT, 1964). *Standards for Morale* (OUP for NPHT, 1964)
63 Musgrave Park Hospital, Belfast	Prototype operating tables for testing anaesthetic procedures	V,103	
64 West Cornwall Hospital Management Committee	Survey of the nutritive value of meals in West Cornish hospitals	V,101	
1960			
65 South-western Regional Hospital Board	Study of the work of the Plymouth Community Mental Health Centre	V,48–9.VI,43–4	*Br. J. Psychiat.* 118 (1971), 305
66 Nottingham University, Dept of Social Science	Survey of nurse recruitment	V,94–5.VI,103	*Focus on Nurse Recruitment* (OUP for NPHT 1965)
67 Fulbourn Hospital, Cambridge	Study of the discharge of chronic psychotic patients	V,59–60.VI,48–9.VII,58	*Problems and Progress, I,* 293 (OUP for NPHT 1964). *Brit. J. Psychiat.* (1966) 112, 997. *Int. J. Soc. Psychiat.* (1966) 12, 98

68	South-western Regional Hospital Board	Plymouth Community Health Centre, & study of its work	V,48–9.VI,43–4	
69	Welsh Regional Hospital Board	Swansea Community Mental Health Centre	V,49–50.VI,44	
70	Salford Mental Health Service	Study of the selection of patients for mental hospital admission. Industrial workshop	V,61	
71	Political and Economic Planning	Studies of community mental health services	V,65.VI,42.VII,55–6	*Problems and Progress, I,* 319 (OUP for NPHT 1964)
72	Manchester University, Dept of Social Medicine	Study of the work of Darbishire House Teaching Health Centre	V,72	
73	University College, London, Bartlett School of Architecture in association with the United Birmingham Hospitals	Studies for the development of a comprehensive community health service based on a teaching hospital centre at Birmingham	V,35–5.VI,22–3	*Lancet,* 1958, i, 701. *Trans. Bartlett. Soc.* (1964), 35. *A Balanced Teaching Hospital* (OUP for NPHT, 1965)
74	Manchester University, Dept of Social Administration	Study of medical record statistics at Clatterbridge Hospital	V,31	
75	Edinburgh University, Dept of Social Medicine	Survey of outpatient services in the Edinburgh hospitals	V,40–1.VI,27–8.VII,24	*Problems and Progress, II,* 3 (OUP for NPHT 1966)
76	London School of Hygience, Dept of Human Nutrition	Study of the nutritive value of meals in hospitals	V,101.VI,108–9	*Food in Hospitals* (OUP for NPHT, 1963)
77	Royal Edinburgh Infirmary	Review by the King Edward's Hospital Fund Catering Advisory Service of the hospital group's catering services		
78	United Newcastle Hospitals	Enquiry into waiting lists at Newcastle	V,30.VI,25	
79	University College of North Staffordshire	Enquiry into the economics of the health service	V,33	*Health Through Choice, Hobart Paper No. 14* (Institute of Economic Affairs, 1961)
EDUCATION (Medical, Nursing, other)				
1955				
80	Department of Health for Scotland & Glasgow Royal Infirmary	Two year nurse training scheme	III,21–1.IV,57–8.V,92–3	*Experimental Nurse Training at Glasgow Royal Infirmary* (Scottish Home & Health Dept.)

	Principal Authority	Subject	Trust Reports	Other References
	1956			
81	Royal College of Midwives	Educational Endowment Fund	IV,59–60	
	1957			
82	Trust/Nuffield Foundation residential course at Oxford	Hospital architecture	IV,61–2.V,97	
83	Winchester Group Hospital Management Committee and	Training scheme in social casework		
84	Leeds University, Dept of Adult Education	Pilot training scheme for hospital administrators, pilot courses in management studies at the Nuffield Centre for Health Service Studies, and exchange visit of the Deputy Director with Ann Arbor University	IV,60–1.V,97–8 VI,106.VII,102	
	1958			
85	Queen's Institute of District Nursing	William Rathbone Staff College, Liverpool	V,94.VI,103.VII,98	
86	The Retreat, York	Nurses training school	V,94	
	1959			
87	Pewsey Hospital, Wiltshire	School for mentally subnormal children	V,53–4	
88	British Postgraduate Medical Federation	'Nuffield Practitioner' experiment in training for general practice in the Wessex Region	V,82–3.VI,78.VII,68	*Interim and Final Reports on an Experiment in Training for General Practice in the Wessex Hospital Region* (Brit. Postgraduate Med. Federation, 1962 and 1966)
	1960			
89	King Edward's Hospital Fund for London	Courses for Assistant Catering Officers from the Provinces	V,101–2.VI,108	

90	Edinburgh University, Dept of Public Health and Social Medicine	Secondment of senior administrators to the Diploma Course in Medical Administration	V,99–100.VI,105	*Health Services Administration: A Source Book* (E and S Livingstone, 1965) Department, 1963)
EXPERIMENTS/DEMONSTRATIONS				
	1949			
91	Manchester University	Darbishire House Teaching Health Centre	II,37–40.III,44–6	*Brit. Med. J.* (1952) 2, 490. *Lancet* (1959) i, 1235. *Brit. Med. J.* (1954) I, Supp 316.
	1950			
92	Nuffield Health and Social Services Fund	Nuffield Diagnostic Centre, Corby	II,40–5.III,46–8. IV,48–9.V,67	*The Hospital* 273. *Lancet* (1954) i, 871
	1951			
93	Slough Industrial Health Service	Occupational hygiene team	IV,55–6	
	1953			
94	National Institute of Houseworkers	Experimental training scheme for domestic workers in hospitals	III,27–8	
95	Odstock Hospital, Salisbury	Rehabilitation service and sheltered workshop Wessex Rehabilitation Association	III,26.IV,40–1.V,88–9 VI,101.VII,96	
	1954			
96	Mignot Memorial Trust	Mignot Memorial Hospital, Alderney	III,19–21.IV,64	
97	Belmont Hospital, Surrey	Research unit for emotionally disturbed deaf children	III,25.IV,27	*Deafness, Mutism and Mental Deficiency* (Heinemann Medical Books Ltd., 1957) *Non-Communicating Children* (Butterworth 1970)
98	St Lawrence's Hospital, Caterham	Training scheme for high-grade mental defectives	III,24–5.IV,30	
99	Mapperley Hospital, Nottingham	Nuffield House Day Centre for geriatric patients	III,23.IV,36–7	

Principal Authority	Subject	Trust Reports	Other References
100 Cowley Road Hospital, Oxford	Day Centre for psychogeriatric patients	III,23–4.IV,37	
101 Nuffield Health and Social Services Fund	Harlow Industrial Health Service	III,50.IV,54–5.V,73–4. VI,110	
102 Nuffield Health and Social Services Fund	Harlow Group Practice & Clinic Centres	II,45–7.III,48–50. IV,49–52.V,66–7. VI,65–6.VII,87	*Lancet* (1955) ii, 863
103 Manchester Family Welfare Service	Extension of the service to Darbishire House Health Centre	IV,26	
104 Borocourt Hospital, Oxon	Day hospital scheme	III,24.IV,29.V,43–4	
105 South-west Metropolitan Regional Hospital Board	Graylingwell District Mental Health Service	IV,31–2	*The Burden on the Community,* 69 (OUP for NPHT, 1962)
106 Queen Alexandra's Hospital, Cosham	Portsmouth Cerebral Palsy Unit	III,27.IV,28	
107 Belfast City Hospital, Geriatric Department	Experiment in the domiciliary care of elderly invalids in the Belfast area	IV,37–8	*Rehabilitation of the Elderly Invalid at Home* (NPHT, 1957)
108 Queen Alexandra's Hospital, Cosham	Rehabilitation and assessment unit	IV,41–2.V,87.VI,100	
109 St Margaret's Hospital, Swindon	Rehabilitation retraining flat for disabled housewives	IV,42	
110 Royal Hampshire County Hospital	Daily living unit	III,26.IV,40	
1956			
111 Coppice Hospital, Nottingham	The Gateway Social Psychotherapy Centre	IV,32–3.V,45	
112 Glasgow Western Infirmary	Staff location system in hospitals	IV,19	
113 Belmont Hospital, Surrey	Development of speech and visual training methods	VII,49	
1957			
114 University of Southampton Dept of Sociology			

115	Newcastle University, Dept of Industrial Health	North of England Industrial Health Advisory Service	IV,56.V,74–5.VI,110	
116	Harperbury Hospital, Herts	Unit for the treatment and training of children suffering from cerebral palsy and mental subnormality	IV,30–1.V,44–5. VI.,42–3.VII,48.	
117	Birmingham University	Institute of Child Health	V,68–9.VI,34	
118	Department of Health for Scotland	Edinburgh Family Doctor Centre	IV,52.V,68	*Problems and Progress, I,* 113 (OUP for NPHT 1964)
	1958			
119	Lichfield Group Practice	Lichfield Health Centre (Loan)	IV,52–3	
120	Staffordshire County Council	Experiment in the use of a social worker in the Rugeley Group Practice	V,80–1	
121	Royal Hampshire County Hospital	Handicapped women's hostel	V,87–8	
122	Central Hospital, Warwick	Domestic rehabilitation unit	V,51–2.VII,44	
123	Oldham Mental Health Service	Hostel for mental defectives	V,54	
124	St Matthew's Hospital, Burntwood	Rehabilitation, research, and assessment unit	V,52.VI,45	
	1959			
125	Oxford Regional Hospital Board	Stoke Mandeville Research Centre	V,70.VI,66.VII,87	
126	Musgrave Park Hospital, Belfast	Prototype operating tables for testing anaesthetic procedures	V,103	
127	Cardiff Royal Infirmary	Social casework service for general practice	V,81.VI,77	*Problems and Progress, I,* 133 (OUP for NPHT, 1964). *Social Casework in a General Medical Practice* (Pitmans, 1965)
	1960			
128	Slough Industrial Health Service	Poyle Industrial Health Centre	V,75–6.VI,110	
129	Leeds University, Dept of Extra-Mural Studies	Nuffield Health Centre for Health Services Studies	V,98.VI,105	

	Principal Authority	Subject	Trust Reports	Other References
130	Nurses Memorial Fund to King Edward VII	Fonthill Home for Elderly Nurses, Reigate	V,84–5	
131	Dryburn Hospital, Durham	Experimental Pre-discharge ward	V,109.VI,70–1	*Problems and Progress, II.* 107 (OUP for NPHT, 1966). *Nursing Times* (1967) 63, 723
132	Rivermead Hospital, Oxford	Rehabilitation workshop	V,89–90.VI,100–1	
133	Sunderland Royal Infirmary	Central Sterile Supply Department	V,105.VI,71–2	*Brit. Med. J.* (1963) ii, 912
SEMINARS ETC.				
	1949			
134	London School of Hygiene	Conference on social workers in hospital and medical services		
	1951			
135	Conference of representatives of Universities and Medical Schools	British Student Health Officers Association		
	1952			
136	Conference of regional architects at Magdalen College, Oxford	Hospital building for the future		
137	Association of Medical Records Officers	International Congress in London		
138	Scottish Nursing Recruitment Service	Conference of student nurses at St Andrew's		
	1957			
139	Conference at Christ Church, Oxford (NPHT)	Future trends in medicine	IV,8	
140	Conference at the CIBA Foundation (NPHT)	Epidemiology of mental illness	V,42–3	*The Burden on the Community* OUP for (NPHT, 1962)
	1960			
141	Conference at Magdalen College, Oxford (NPHT)	Operational research in the health services	V,17–8	*Towards a Measure of Medical Care* (OUP for NPHT, 1962)

CHAPTER 5

YEARS OF ANALYSIS AND REVIEW

1960–1970

Years of Analysis and Review

1960–1970

The period opened with the psychological boost to the NHS of the promise of greater resources in the announcement there would be a Hospital Plan which was eventually published in 1962.

As for the Trust the decade saw a significant development of the research and 'intelligence' arrangements and the publication policy was embarked upon in 1960. This involved the deliberately empirical policy of focussing on the several problems identified in the infrastructure of health services where many of the real and prospective influences on quality of care lie and where it was felt that the Trust could best use its resources to help illuminate for both general and special discussion the major issues in the provision of services. These activities were helped considerably by the move of the headquarters from Nuffield Lodge to 3 Prince Albert Road where the facilities enabled greater flexibility in action.

The mechanisms developed and the measures specially taken by the Trust to fulfil its purposes in this direction included the commissioning of position papers and the convening of private symposiums/forums and groups to identify some of the major problems and what could be done about them by way of research. These mechanisms were also used to indicate some basic organisational needs if health service research was to flourish. Thus a case continued to be made for the building up and establishment of research units in universities utilising a variety of disciplines as well as the means for the critical examination of research methods and results as a preliminary to publication.

Questions raised as a result of all these activities were posed in many of the publications of the Trust and in the periodic Reports, three of which were published during the period, the Sixth (1961/64), the Seventh (1964/67) and the Eighth (1967/70). These Reports were particularly used to draw attention to major matters raised in the publications.

Towards the end of the decade it seemed from the Government's First Green Paper that some reform of the NHS was likely in the early Seventies. The Trust took stock of how it should react and in particular initiated an exercise which lasted more than two years which produced the collection of essays ***Challenges for Change*** *(1971) which identified some important problems in the complex infrastructure of health services which would continue to bulk whatever reforms were in time implemented.*

1. RESEARCH AND THE HOSPITAL PLAN

The beginning of this period was marked by the enthusiasm engendered by the prospect of the Ten Year Hospital Plan which was published in 1962. If time has wrought a more sober view of what this collation of administrative aspirations actually meant in practical terms, the years immediately prior to and following the actual announcement possibly saw the greatest optimism and activity in the National Health Service since the boisterous days around the Appointed Day in 1948 when it was hoped optimistically that the organisation of hospitals into groups based on Regions and Districts with identifiable catchment areas would be the entrance to a golden era of comprehensive health care.

There is no doubt that the Trust's IFDH Study (1955) with its concentration on scientific research on hospital design and service planning was seminal in the ensuing period of capital development not only in influencing design but also the provision of services. Thus the results published in the Planning Chapter V of the Report, the first scientific evidence of the real 'demand' for hospital and specialist services, based on the Norwich and Northampton studies indicated that considerably fewer acute beds were required than had been previously assumed. This study was cleverly used by the Ministry of Health in launching the Hospital Plan to dampen the exaggerated concern about the shortage of beds which had been rife since 1948, inasmuch as attention was drawn to the results of these Trust studies without giving them actual endorsement. The IFDH group was also the model for the Architectural Group set up by the Ministry in the 1950s.

Since the authorities responsible for drawing up and implementing the Plan had had to choose priorities between competing claims, those individuals and authorities involved in the administrative processes had become more conscious of the lack of information as the problems of deciding the rationale and explaining the decisions taken, multiplied. The cheering factor, albeit with long-term dividends, was that more Governmental resources had become available for what it was hoped would be eventually a scrutiny through research by the scientific approach of policies adopted for the improvement of services, a state of affairs which the Trust, based on a continuous review of the research it had sponsored and funded, had long urged.

Prominent in this respect therefore was the entry into the

field of the Ministry of Health during this decade. In time, it was to become the major grant-making body for Research and Development (R and D) and as begetter of studies. The fact that it was a Conservative Government in power which now supported the policy of initiating research was a significant and hopeful feature, since it emphasised the common political ground about the importance of health research.

The Trust welcomed this new departure, and the principle of making substantial grants to bodies external to the Department, such as the Universities, for research and experiments, gave promise for future development in the area of enquiry. This R and D policy was important not only because of its immediate effect, but because the burgeoning competition it introduced in the growing research community, was stimulating. In the event, it did not follow that there were large funds available at once for the kind of operational research which was likely to indicate to management how health services could be made more effective, or whereby resources could be deployed in a better way. Nor were there conjured up at once, very many skilled personnel and units capable of undertaking research of the standard required. Yet the implication was that the country was entering a period of more intensive scientific enquiry into its health services and there was general optimism that ultimately wise investment would follow from which excellent dividends could be expected in the future.

One effect, which had already become apparent to the Trust, was that there was generally more sophistication about research and its methodology. Thus each year the criteria by which proposals for research and experiment should be judged, came into sharper focus through the system of peer review, which became standard practice in the grant-making process. There was also on the whole as a result, a more realistic approach to methodology on the part of applicants for grants; and the improvement in the presentation and discussion of results of completed studies and of research methods was promising to provide a useful and sharper perspective for the critical appraisal of new applications.

Time is a notorious deceiver, but it was not altogether fanciful for the Trustees to conclude, as they did in the *Sixth Report* (1961–1964), that the sharper criticism of the methodology and objectives made it more difficult for applicants for grants for research and development to be successful in attracting

support than had been the case a few years before. In any event there seemed to be emerging a demand from the authorities at every level for the fruits of research, and the techniques now used in the multitude of disciplines involved made it essential that the methods and hypotheses behind proposals for research should be subjected to more critical examination than ever before.

The peer review external mechanism which depended on so many individuals for criticism, helped to add to the Trust's growing identification of those in the research community and the NHS, capable of undertaking research and interested in its application. This, added to the growing success of the publication programme, also helped to bring the attention of the research community to the Trust's activities, and as a corollary on the part of the Trust, to fashion means of tapping the ideas and the experience of those actively engaged in the health services on specific matters and on important issues fundamental to the objectives of the Trust.

Above all, the transfer of the Trust's headquarters with the establishment of a specialised Library and Archive from Nuffield Lodge to 3 Prince Albert Road, with the consequent ability to convene private forums/seminars there, was an important spur to the development of what in time gave the Trust the opportunity to undertake a role in the spirit of an 'Institute'.

2. CHANGING ATTITUDES TO THE COMPLEXITY OF HEALTH SERVICES

Experience was also making for a sharper vision on the part of the Trust of the health service field.

While the range of activities during previous years had covered the whole field of hospital and associated medical services, experience during the Sixties was pointing to the desirability of concentrating principally on the **operational problems** of the vast range of services which comprised the NHS and specially in highlighting the relative poverty of reliable **information** on which to base rational policies; particularly on **mental health questions;** on **post-graduate medical education;** on **general practice; and on community health problems.**

The pre-eminence given to these particular sectors was based on the special importance on arriving at more rational decisions to improve services than hitherto and on key problems concerned with the infrastructure.

At the same time it was possible to detect significant changes in attitudes to the National Health Service which were giving a fuller perspective to its several problems. Hitherto much of the public debate about the health service had been on such a broad front, 'good' or 'bad' according to political or professional ideology, as to seem unreal to many who perceived the advantages as well as the disadvantages in the system of medical care which obtains in Britain. It seemed specially important (as it still does in 1990 and will always do), to distinguish those problem areas which are always likely to present difficulties and will need special attention and understanding whatever the system, framework and funding of the health service system.

Thus the absurdity of laying the blame for all the faults in 'the delivery of medical care' which could be discerned (and regrettably is still abroad in 1990) in a multitude of places across the nation, on the abstract notion called the 'National Health Service', was patently obvious. As the 1960s proceeded it was evident that the common tendency to do so, made for an over-simplified polarisation of attitudes to the abstraction, which too easily directed attention away from certain key problems concerning the actual services to individuals which are not peculiar to the British scene or system. Questions such as the **lack of good information, basic** and **continuing education and training of everybody concerned with health services,** the **better deployment of manpower** and **other limited resources,** and the **relationship of health care to other sectors of the economy** and **society** which bear on health questions, are indeed universal, whatever arrangements obtain in systems concerned with health care.

It was becoming evident that the manifest difficulties of the 'Health' problem was rooted in the complex arrangements for health care, including the prevention of ill-health. The belief on the part of the Trust was that the objectives of research and experiment in health care must be to lead towards a better appreciation of how the significant advances in medical science and care can best be made widely available to all the population.

With the limited reserves available to the Trust, this made for a strengthening of the realisation that an empirical selective approach to the problems observed in the infrastructure was necessary.

3. AN EMPIRICAL BUT INTEGRATED APPROACH

This was the basis of the Trust's conclusion that it should rarely be concerned with the nebulous question of the shape and machinery of the superstructure of the National Health Service. There are no simple organisational answers to the problems of shape and mechanics, and the lengthy period required, logistics and cost of worthwhile experiments in those areas, meant these could virtually only be mounted by the health authorities themselves as part of the evolution of public policy for improvements. It was obvious that the real difficulty lay in the confusion arising from the complexity of issues; and taking a realistic view, changes of substance were only likely to be successful if based on a series of pragmatic compromises on political ideologies and the deeply rooted professional practices which exist in all developed societies. Without such compromises, the mixture of dogmatic beliefs and the taking of positions posing as fundamental truths, tend to provoke confusion in the eyes of the beholders.

During the 1960's, it was becoming obvious that in today's world even the question of Government, as against private and voluntary action presented difficulties of definition and shading. It may be obvious to some that an inflexible, over-bureaucratic, over-centralised organisation should be avoided, but equally it is difficult for those unattached to political ideology to see how the effective co-ordination and rationalisation of hospital and associated medical services can be carried out without some form of central lead involving regulation, and occasional direct action by Government towards change, preferably by way of experiment. It seemed to the Trust that the best way to any reform would be incremental and could best be illuminated by selective research over the wide area covered by health issues.

Hence the empirical approach to service research which had now become the touchstone of the Trust's policy-trident; 'intelligence', 'analysis' and 'research' leading to the publication and discussion of results. Ideally of course that should be followed by experiment by the health authorities who should be directly associated with the research.

The basic hypothesis in this was the recognition that research itself to be effective could not just be an academic exercise. If the results of research are to mean anything, there must be a stage of

practical application, sometimes of experiment which is expensive; consequently the principal players in the service authorities must be deeply involved from the outset.

This indeed was another reason for the call from the Trust for a Government lead in research policy which it was hoped might eventually result in the close association of integration of research with management.

The inability to finance a policy which would include complementary experiments had led in the case of the Trust to the development of the seminar method of participative 'education', with the discussions based on the analysis of reigning concepts and on the results of research. The expectation was that by this means further debate would be stimulated leading to experiments by health authorities. There was some evidence in the late 1960's that this objective might in time be realised. The setting up of 'organisation and management' (O and M) service groups in certain Regional Hospital Boards meant there seemed to be emerging the means for a more formalised introduction of research into the management process.

Even if it consisted of no more than hope, the increasing stake of the Ministry of Health in the service research field seemed also to be a significant pointer to the eventual acceptance of the need for more sharply defined research into issues fundamental to efficient management by health authorities. It was felt that the Trust's policies in identifying worthwhile areas of research,organising private seminars and publishing results would provide important machinery for the improvement of services.

There was also at the same time an evident need for a more critical approach to research and 'research' results. As the idea of research as an essential ingredient in the progression to greater effectiveness took root, the Trustees continued to seek through the private forum/seminar method to develop a sharpened focus on the more fruitful areas for research, on the relationship of research to its objectives, and on the various methods used; indeed on the course and progress of the research itself. This entailed a continuous review not only of the issues chosen and the methods used but also of the means by which the techniques and experience of those principally but not exclusively in the Universities, could be applied for the improvement of research.

4. 'INTELLIGENCE' MACHINERY

To facilitate this informal 'intelligence' approach appropriate means were developed to ensure not only the tapping of original ideas as well as the initial identification of the problems which seemed suitable for investigation but also to take account of and assess the progress of research, and to communicate the results.

(i) The Symposium

Founding on the success of the 1957 Christ Church Conference about the future of health services, during the early 1960s the Trust developed the private conference, or symposium, method to initiate and develop discussions on issues which it seemed should be aired at the most influential level possible. These seminars, which were based on commissioned 'position' papers from acknowledged experts, were complemented where appropriate by publication of the proceedings. It was felt important to ensure frankness that these essentially private high-level meetings were by invitation only, the Trust paying the expenses of the participants; that no papers would be published without the agreement of authors and that there would be no attribution in the proceedings.

One of of the most important of these private conferences - that on **post-graduate medical education** (110) held in Christ Church, Oxford in 1961 is widely regarded as having had a powerful influence on policy at the right time. This initiative which fired the educational policy of the Trust, was based on the thesis that **good service** was related to good and comprehensive post-graduate and **continuing medical educational arrangements.**

The story of this successful venture in a key section of the infrastructure for the maintenance and improvement of quality of health care is part of the history of postgraduate medical education in the UK. The actions of the Trust based on the conference not only illustrate the powerful triggering effect of a policy conceived on sound principles, but amply demonstrate the need for the kind of catalytic action which can be effectively initiated by uncommitted and independent bodies. The publication in both *The Lancet* and *The British Medical Journal* of the general agreement achieved at this relatively small but powerful gathering which was attended by most of the influential members of the medical profession, had an instantaneous effect. An immediate result was that the Trustees allocated a large sum

of money to **initiate or support local educational schemes** (113-134 etc. to 166). This caused a chain reaction in the stimulation it gave to the setting up of Postgraduate Institutes and Centres all over the country. In time it led to a comprehensive national policy for the continuing education of doctors.

The clear success of this conference and its aftermath including an extensive review (146) culminated in a substantial grant by the Trust to help set up a **Central Committee** (161) to provide a much needed focus for **post-graduate medical education,** the case for which was first argued in the report of the Christ Church Conference. This Committee in time was the predecessor of the Central Councils for Post-Graduate Medical Education.

The widespread attention given to the report of the conference and the subsequent rapid development of health centres in Hospitals, initiated by the seed money given by the Trust, but whose success owed much to the enthusiastic efforts of the medical profession on the general thesis of the importance of continuing medical education for all professional staff as a major ingredient in the improvement in the **quality** of health care.

On the medical side, grants were made to the Royal College of General Practitioners for its further training arrangements which were characterised as the Nuffield Training Scheme (8). It also influenced Trust Policy on the non-medical side and the support given to the University of Leeds helped establish the Nuffield Management Centre there.

Yet another symposium, sponsored and organised by the Trust in association with the CIBA Foundation, brought together a number of psychiatrists to discuss a series of papers on the **epidemiology of mental illness** relating it to current mental service practice. An edited collection of the papers and proceedings *The Burden on the Community* (1962) was published by the Trust to sketch a picture of what was good practice and where the gaps were in the psychiatric services of the time.

An important conference on **operational research** was held in Magdalen College in Oxford. The publication which resulted in *Towards a Measure of Medical Care* (1962) helped to set out the techniques available and to define the scope and potentiality of the scientific method in health care organisation and operation.

Another special conference was based on the research

conducted by Professor Thomas McKeown and his colleagues in Birmingham in connection with the scheme for a **balanced comprehensive teaching hospital concerned with the community** (252) it served at Birmingham, which preceded by more than a dozen years the administrative changes affecting Teaching Hospitals contained in the 1974 reforms. The special publication *A Balanced Teaching Hospital* (1965) was based on the papers presented. The universal interest aroused by this publication suggests that the concept underlying the plan for a Balanced Teaching Hospital might well have had an effect well beyond the United Birmingham Hospitals and the University of Birmingham.

The private conference/symposium method was but one of many through which the ideas backed up by papers from a wide sweep of health professionals with much experience and in influential positions were subjected to review, and the results given prominence through later publications. They had a secondary but important effect too of leading subsequently to a number of the studies supported as shown in the Supplement, concerned with the functions and organisation of health care.

(ii) Linked Seminars

Drawing on the experience of this kind of private forum, and utilising the facilities, albeit cramped, at 3 Prince Albert Road where the Trust had moved in 1962 from Nuffield Lodge, specially convened small groups were also formed, whose members were drawn from various disciplines to discuss aspects of medical care of current importance. Some of the participants in such groups were members of other Trust sponsored groups and for the most part meetings took place over lengthy periods. From the discussions of such groups it was hoped to procure indications of particular problem areas and to stimulate relevant research studies or experiments. Such groups had already been the source of informal advice not only for the kind of research which should be commissioned or supported but also who could be approached to undertake it. Examples of particular subjects which were dealt with in this way were those concerned with **operational research** (259), with the **application of computers to medicine** (256), with the **maternity services** (255) and with the problems concerned with **screening** (258), the latter deemed a subject particularly appropriate for Trust initiative, since it involved the analysis of the problems which

arose from a lack of co-ordination of the various branches of the service. Other important subjects reviewed in this way were **policies for health services research** (267) and for the recruitment and training of **manpower** (261) in the health services, and **management training** (266).

(iii) External units

This activity of the Trust, concerned with procuring a sharper focus on what was required, confirmed the need to develop not only the direct financing and sponsoring of research in general but to encourage through project grants the development of those units in Universities with special interests in health care .

Thus the group supported at the **University of York** (62) was mainly concerned with the study of **economic aspects,** whereas **operational research** was the main interest of a unit financed at the **University of Reading** (231).

It is of course inevitable that units set up for broad purposes would be likely to involve themselves in specific issues of immediate local and topical interest; thus the **Medical Care Research Unit at the University of Manchester** had as a major task the **enquiry into the health services** available in a particular geographical area, that of **Liverpool** (42).

It was , however, felt that criticism of research was not all it should be and it was, therefore, decided that there was also a need to look searchingly at the methods of research in progress. There is, after all, an application of the principle behind Gresham's Law in the currency of ideas and research: and the art of scientific criticism of the techniques and of the occasional misuse of inadequate results to make some special point, is not quite of the same standard in health services research as that attaching to the 'purer' sciences. Accordingly, as a corollary to the development of a sharper focus on ideas on research, a technique of **critical seminars** began to be developed as part of the ongoing seminars. Researchers were invited to test the framework and the results of their research at private meetings attended by their peers in a number of allied disciplines. The need for the development of this technique approach had been demonstrated by reviews perhaps on occasion more sympathetic than were warranted, of some of the more established interests of the Trust, including **operational research, mental health** and **general practice.**

(iv) The Publications Policy

A new feature in the publication policy of the Trust was the Rock Carling series of monographs commissioned annually as position papers from distinguished individuals concerned in one way or another with Health Services. The list of the commissions during the Sixties gives some flavour of the classical and catholic nature of the problems seen then, many of which remain.

CHARLES in 1962 showed the importance of a well integrated health care system in civilised societies as part of social and thus of economic health, placing the evolution of public health policy into an historical and social context which has still lessons for today.

PLATT (1963) reaffirmed the need for a common understanding of roles amongst the specialists, general practitioners and public health doctors about how to ensure in a complex of services, comprehensive provision for patients. He also exposed the danger which still exists in 1990, in his account of the run up to the National Health Service Act, of the confusion of health care objectives by the entry of political and professional issues irrelevant to health care. These are both still live issues.

MAYNEORD (1964) showed the constant need for a sensible scientific approach to place in perspective problems which are given a great deal of prominence in the media with a minimum of critical review of the scientific data available and consequently inadequate assessments of their implication.

MILNES WALKER (1965) while dealing specifically with medical education gave a reminder of how much advances in the practice of medicine depend on basic education continually updated. Education is fundamental to health care practice and policies should reflect the fact that well educated professionals whose education is continuously refreshed are the best means of educating the public in health matters.

DOLL (1967) showed what can be done by epidemiological methods to trace the the origins of disease with particular reference to cancer, so putting one of the great scourges of mankind into perspective, and indicating as well what this could mean for policies for prevention. In this he touched on a universal problem, illustrated by the international acclaim for the book, and its translation into many languages. The development and use of epidemiological methods are priorities for good management.

BUTTERFIELD (1968) underlined the urgency for a better attitude of mind and understanding of what is required to achieve better health for populations. He urged the recognition of the need to look forward and not to be diverted by immediacy. A philosophy of health care is a priority for the civilised development of all societies. This is something which was missing from the White Paper in 1989.

HILL'S (1969) *Psychiatry in Medicine, Retrospect and Prospect* was a book ideal for its time, placing Psychiatry and Psychiatric services in the historical context, as well as setting out the great variety of psychiatric disorders and the patterns of psychiatric care to deal with these. It did not slur over the practical problems which still beset the field including provision for the hard core of patients who will always require institutional care. It ended with an appeal not only for better data but also for an overall assessment of the burden which the Psychiatric Services have to carry and the resources they should have. This echoed a significant passage in the Seebohm Report, which was in effect not taken up. It also warned of the circumstances which stimulated the enquiry into Community Care by Sir Roy Griffiths, nearly 20 years later.

ILLINGWORTH (1970) pointed to the problem of over-emphasis on dramatic issues and firmly put the concept of 'heroic' surgery into perspective. As an outstanding and influential clinician and teacher of surgical methods his appeal for a single seamless profession, is an important reminder that in practice, health care is indivisible and the practitioners in health care form a single profession. The question for today is whether the directions of reform are symptoms of an attitude which ignores history and the evolution of services largely conservative and vocational in nature, and the antidote to which requires the elite bodies of the medical profession to act in unison.

All the subsequent monographs have dealt with important contemporary issues with specific references in the text.

In general however, one result of the publicity given to these monographs together with the many reports submitted to the Trustees on completed projects, was to cause the Trustees to look even more closely at the details of the dissemination of the information arising from the research and development etc. it had sponsored. The results of many of these studies merited as wide a circulation as possible, and it became Trust policy to

publish them without regard to the popularity of the subject as measured by the likely demand for them, as long as they were judged after peer review as contributing to knowledge which might lead to the improvement of the quality of health care.

Apart from full-length books, during this period a new form of publication was initiated, consisting of essays on the results from current research supported, which the Trust felt either did not require book form for exposition of the conclusions, or contained important interim results which it seemed desirable to make known as soon as possible. The eponymous title of these collections of essays was *Problems and Progress in Medical Care* all twelve of which are denoted in the publications list, some under special titles.

It is notable and the Press cuttings (too many to mention in an outline of history such as this) confirm, that nearly all those books and most of the essays which are listed in Appendix 3 received much attention in a wide range of journals and in the serious Press. The widest dissemination of information and comment on them, on matters of public interest is most important and there should always be opportunities for the results of serious research to be published and subjected to informed criticism. This policy involved subsidising the publications on a modest scale, but it was recognised as important that as many people as possible should not only be enabled to study the results but also to see at what depth those concerned with research had been operating. Above all, it seemed certain that in time there was a likelihood that there would be increasing public pressure for more and better research with the ultimate possibility of the results being put to good use. This belief needs continually to be stressed.

It is no less true in 1990 that it is essential that there should be informed discussion and criticism about the state of the various elements making up a national health service designed to be comprehensive, and to allow for assessments of the weight which should be given to the 'research' carried out on the issues and to the published findings.

As the Sixties had proceeded there had been a need for the Trust to pause and consider the lessons of the past and both the demands and opportunities of the new situation. As a result the Trust's programme was continually being adjusted to focus more sharply on essential problems of health services which a relatively small private independent body could reasonably

probe. At the same time the fact that the Trust had in a sense become a publisher with it own imprint, principally to communicate the results of the research it supported, meant that specific accounts of the highlights of its programme were from time to time being specially presented for public consumption in a more satisfactory form, than by way of the precis of intent which tends to some extent to be a feature of annual reports of many Foundations.

To a large extent therefore the publications illustrate the consolidation and the accelerating growth of the activity following this decision and constitute a biography of the Trust during this period. Thus to underline this, it was noted in the *Eighth Report* that during the previous three years to 1970 in addition to the full length books taking into account the essays incorporated in the collections, *Screening in Medical Care* (1968), *Problems and Progress in Medical Care* (1968 & 1970), *Computers in the Service of Medicine* (1968), and *In the Beginning* (1970), some 60 separate manuscripts had been published by the Trust.

Yet, this again is only part of the story, for the material presented in the publications of the Trust represent only a part of the harvest of the Trust's activities. Some of this harvest has always had only a private circulation to a wide sweep of interested parties.

Thus, as a principle, the Trustees having satisfied themselves as to **bona fides** and quality, invariably left it to the beneficiaries of the grants made to publish as they willed. Accordingly, some accounts of projects were published through the normal channels of learned journals and societies or by other publishers. Some of the more notable of these earlier, had been the *Acton Society pamphlets* in the 1950s, and in 1965 the Institute of Economic Affairs (IEA) Hobart Paper *Health Through Choice* which incidentally was the first health service publication of the IEA. The survey of the Liverpool hospital services was also published externally (42).

Altogether, this in practice, meant less need for the periodic Reports of the Trust to include detail, but more a need for key references and for a sketch of the background to current policy which indeed is the general procedure followed in this History. Additionally therefore, an attempt was made in the *Eighth Report* covering the years 1967–70 to give more of a perspective than before, by including a short account of the current scene against which the Trust operated, as well as listing the main activities of

the period under review, in order to trace the tangled skeins of policy development.

It will be obvious that the publications and the reviews on them were bound to have a profound influence on the evolution of Trust policies.

5. EVOLUTION IN POLICIES

During the period there had been a marked increase in the total amount of research, experiment, and demonstration in many sectors bearing on the delivery of medical care financed from a number of official public sources. The proportion of the Trust's share of total health services research support in financial terms had thus declined since the time it was almost alone in this important area of activity so necessary to advancement and improvement in care. It is indeed because of this that the 'intelligence' activities of the Trust had been stepped up, to focus attention on issues which seemed to be in danger of being missed, yet were of prime importance in implementing its major purposes.

It is in this way that the effect of the increasing amount of money for research which was being made available principally from central government sources, had a bearing on Trust action. There was a clear need for the development of both strategic and tactical policies. The paramount justification of independent Foundations, which is the ability quickly and fearlessly to take non-political initiatives in pursuit of their purposes, and where necessary to take action in effect to draw attention to, and accordingly co-ordinate, the various elements of thought and action in particular sectors, had become crucial.

It was specially noted in the *Eighth Report* that this entails a continuous critical review of strategy and general principles in the sectors of activity chosen by the Trustees to have the greatest priority. This indicated the increasing emphasis on the commissioning of special studies in neglected areas and the further development of the special seminar mechanism as a means of covering the field.

Since it would be a foolish investor who had no regard for his existing portfolio of investments, a number of sectors in which the Trust had long been active had been more effectively developed and probed: and to bring sense and perspective to the canvas on which the Trust worked, an attempt was made to relate all these areas of action to one another and to current

official policies in the National Health Service, which in so many key sectors still seemed haphazard and unrelated.

The list of Grants etc. and Seminars in the Supplement at the end of this Chapter sets out the major activities under the broad categories of Studies, Education, Experiments etc. and Seminars, all of which reflect the policy of looking ahead at some of the challenges likely to remain after the changes forecast in the first Green Paper in 1968.

In the review of these at the end of the decade a number of major issues began to stand out

The largest portion of the activities were concerned with **Studies** broadly concerned with **Operational Research** (*OR*).

Some operational research studies were mounted directly by the Trust. Two of these were concerned with pressing and immediate **managerial problems**: the **efficacy of X-ray Departments** (4:51) as essential logistical supports to diagnostic services, and the reasons for **undue waiting in Out-Patient Departments** (28), problems which are still with us, were other matters which were subjects of research and analysis in subsequent publications, viz. *Towards a Clearer View* (1962) and *Waiting in Outpatient Departments* (1965) because as problems they were not getting the attention they deserved. O R techniques are not easily acquired, nor applied to some of the difficult problems in the health field, yet the potentiality of such an approach for management is great and a deliberate policy for developing O R applied to health services is desirable if we really wish the 'value for money' exercises for which the Audit Commissions and the National Audit Office (NAO) are now apparently aiming.

It had become evident that a basic problem was the **shortage of groups and individuals** which could undertake research of sufficient quality: which also raised questions about the **training in basic research skills**, preferably on practical studies.

In 1960 the Conference on Operational Research in the Health Service which produced *Towards a Measure of Medical Care* (1962), had pointed to the useful opportunities for the application of these methods in studies of the National Health Service, and led directly to support being given by the Trust to the **Oxford Regional Hospital Board's Operational Research Unit** (34). Because of the attendant problems, the establishment of a number of such units was also supported, some in Scotland

(51.52.55.56 etc.). While it was clear that better methods of communication to management, especially for the application of results, were needed, there were also problems of adequate expert staffing.

Clearly this whole question could not be disassociated from the policy which had to be adopted if it was to be ultimately effective, towards helping the establishment of **academic research units** generally, for the real limitation in practice normally arises from the shortage of trained personnel engaged in research, rather than ideas of what was required.

In this respect it was also concluded it would be prudent to look at the whole question of **how researchers could be trained** and what their career prospects were likely to be. Accepting that there was a scarcity of good bases for research into specific aspects of health service problems, it was decided by the Trust that if opportunities arose, multi-disciplined units mainly concerned with health service research, should be supported in University Departments and the best results would be achieved if these worked closely with service authorities. This was the rationale for the grant to help the launch of the **Institute of Social and Economic Research at the University of York** (62) and co-operative studies in the health service field.

This principle was also adopted for seeding grants which resulted in the establishment of the **Institute of Biometry and Community Medicine at the University of Exeter** (59,75,88,237), the **Nuffield Operational Research Unit at the University of Reading** (231) and the **Health Services Research Centre based on the Department of Social Medicine at the University of Birmingham** (38,89,98).

It was evident too, that there was a need for establishing a unit concerned with a broad approach to the whole problem of **recruitment, training and deployment of professional manpower engaged in research** in the National Health Service. While it was the expectation of the Trust that some of these units would concentrate on groups of studies of special interest for much needed personnel management, it was hoped that some central policy on training would be adopted and the necessary action taken.

Social work and its importance for medical care was brought out in a publication of the results of research in Rochdale, *Portrait of Social Work (1960)*. This was subsequently

followed up by an experiment in social work in general practice and later publication of the report *Social Casework in General Practice* (1968).[1]

The original costing study of the Trust (1953) was followed up by a commission to and publication of the book written by Charles Montacute *Costing and Efficiency in Hospitals* (1962), a leading Hospital Management Committee Treasurer. Its recommendations for the institution of effective costing systems in hospitals were completely ignored in practice, and the failure to install them has in 1990 come back to haunt management at all levels including the Health Departments!

Morale in hospitals, a chronic problem, possibly made worse over the years by the seemingly endemic ten-year itch for structural reform, became a subject for special research, since any lowering of morale has a corresponding effect on efficacy; but the work of Professor R W Revans, originally begun through a grant from the Trust, while widely recognised abroad has never been fully appreciated here. Some of the observations of his team in *Standards for Morale* (1964) on the place of vocation and motivation are fundamental to health care quality, but do not seem to have made an effective impact on the policies of the Health Departments, far less for Health care generally.

Nursing which is particularly affected by conditions making for reduced morale was another subject identified for attention. A number of studies were taken into the programme over the years. This interest started with the *Work of Nurses in Hospital* (1954), was continued through support given for **the Glasgow experimental 2-year nurse training scheme** (1962), the report of which was seminal (162, 168) and **the first scheme for training in nursing specialties** (1968).[2]

In the late 60's the Trust published the influential book *Screening in Medical Care* (1968) which reviewed the evidence for the **validation of a number of screening procedures** (258), an important matter in the management of resources, which will

[1] Illsley's (1980) Monograph *Professional or Public Health?* later explored the closer association of social work and medical practice which even allowing for the new policy for community care still requires a more definite policy leading to integration if we are to have effective care.

[2] More recently there has been *'Hospital Medicine and Nursing in the 1980's'* (1984), and the support by a major grant from the Trust for the study which produced *'Project 2000'* (1985).

always require a continuing 'intelligence' appreciation and managerial attention.[3]

Mental Health has always held a special place in the Trust policy concerning studies, even pre-dating the Royal Commission Report of 1959. The 1960 Conference on the Epidemiology of Mental Illness which on the basis of *The Burden on the Community* (1962) was important in its widespread effect in drawing attention to the state of the art. It had a later follow-up in 1969 in the RMPA/WPA sponsored conference in Aberdeen (265) on the Epidemiology of Psychiatric Illness, the papers of which were published by the Trust as *Psychiatric Epidemiology* (1970).

Both the fields of mental illnes and mental handicap were subjects which continued to be of keen interest to the Trustees who were ever-ready to be sympathetic to good applications for grants in this field.

Sir Denis Hill's analytical Rock Carling Monograph *Psychiatry in Medicine* (1969) was in continuance of this interest. Support was directed to special areas requiring special attention. Thus **community mental health services** (4,5,11,36,68 etc) for the mentally ill and mentally handicapped, **children's and adolescent services** (39,49 etc), and **epidemiological studies of mental illness** (30,44 etc), emanated from a series of policy papers, but only few of the many applications submitted to the Trustees following these ventures succeeded in passing the peer review tests which indicates the poor quality of the scientific basis of many of the applications.

In the **Special Services sector,** the programme into research in the **Maternity Services** begun in 1966 was a special 'research and intelligence' operation developed through a series of policy papers and a grant programme. A continuous review of progress in sponsored projects was carried out through regular seminars and the results were published under the title *In the Beginning* (1970). The important aspect of this initiative was that it resulted in improvements being made in the basic maternity record. It also raised questions on the general problems of Medical Records services.

The special importance of the quality of comprehensive **information** which should be the major element in strategic

[3] 15 years later, Jennett's Rock Carling monograph *'High Technology Medicine'* (1983) complemented the results of this study, and taken together they show the need for a technology assessment policy.

policy-making has always been recognised by the Trust as a subject neglected by the policy-makers as a priority. The lineage of this interest goes back to the setting up by the Trust of the Health and Sickness Bureaux in Oxford and Glasgow pre-NHS in the early 1940s; and subsequently in the 1950s it was given even greater point as a result of the Planning Studies in the Investigation into the Function and Design of Hospitals. At the fundamental level, support was given to the Oxford based study on linked records (57) carried to a successful conclusion (although its potential has never been given the widespread testing and application it merits) in the publication *'Medical Record Linkage'* (1967) by Dr (now Sir) Donald Acheson *et al*, the Chief Medical Officer (1984-1991).

At the beginning of the revolution in information technology, the question of the potential of **computers in medicine** was explored and the result was to direct attention to the desirability of a **composite policy in both hospitals and general practice** (3) for the provision of better data for the 'intelligence' arrangements required for management. Because there has not been an effective policy, it was a subject for Trust monitoring which continued into the Eighties. The need for a comprehensive information system is indeed paramount in the drive for management policies designed to achieve better **quality**. Government action hitherto to take up the challenge of the supreme importance of comprehensive information was identified as paltry, halting, unco-ordinated and completely inadequate; and especially so, considering the NHS has been a major Government backed utility for over 40 years. Because of the lack of a central policy, the subject of comprehensive **information** including the technology for gathering and processing it, particularly for epidemiological and management purposes was taken as a special sector of policy in 1964.

Subsequently a series of policy papers on the subject of **computers** concerned with medical affairs resulted in major grants, the first of which produced *The Flow of Medical Information in Hospitals* (1967) and most of which were reported in the essays in the two-volume *Computers in the Service of Medicine* (1968).

A number of special seminars were also held on this subject which the Trust has always emphasised, with regrettably little reaction from the ultimate decision-makers, is inseparable from the fundamental question of the development and use of

Medical Information Services for both clinical and management use. This will always be an enormous and confidential subject which has constantly been treated gingerly because of the divisional structure of Civil Service Departments which in effect restricts effective development of a comprehensive information system. The Trust felt that effective policy might benefit from the kind of monitoring approach sketched in the publication in 1970 of *Focus on Medical Computer Development* (1970).

The need for more comprehensive and better arrangements for both **education and training** (110, *et seq*) was becoming more obvious than ever before.

A series of policy papers on *Postgraduate Medical Education* followed the report of the 1961 Christ Church Conference and the decision to enter this field with substantial support for regional postgraduate schemes was on the thesis that this was the basis of good quality medical care. The **assessment** of such schemes in 1964-65 and the subsequent convening of the Working Parties in **Vocational Training** (150–1), followed by the publication of *Vocational Training in Medicine* (1967) indicate the main stepping stones suggested by Trust policy.

In the early years of this programme, Trust policy was specially guided by frequent meetings of the reconstituted Medical Advisory Committee of the Trust under the chairmanship of Sir George Pickering, culminating in the recommendation to commission a review of postgraduate medical education eventually published as *Postgraduate Medical Education* (1967). Grants were made to finance **surveys of regional and speciality training facilities** and the Central Councils for Postgraduate Medical Education, later recommended by the Royal Commission on Medical Education and agreed in principle by the Secretary of State, were able to draw on the experience (and nucleus) of the **Central Committee for Postgraduate and Continuing Education** (161) which had been financed by the Trust.

Because of its profound influence on **quality of service**, postgraduate medical education was clearly likely to be of continuing interest and the need for outside stimulation was indicated by the initiative exemplified by the Christ Church Conference and the subsequent setting up by the Trust of the Central Committee. It was felt there could be new opportunities presenting themselves when it was seen how far Government action with regard to the all-important vocational training stage,

met the urgent requirement for improvements in educational arrangements essential for improved services.

The **General Medical Services** had long been a sector of interest as part of the clear need to build up **the community** services: and this was the reason for the support to schemes concerned with the improvement of **postgraduate and continuing education for general practice** although the question of training for the whole range of professions concerned with all aspects of **community care** could not be forgotten.

The Trust's interest in the elements of how best to achieve **good general practice** as the base of the NHS, including research support to the young (Royal) College of General Practice (RCGP) (8,22), was already twenty years old; and **postgraduate medical education** as a whole had been a major policy sector since 1961. It was all too evident that although many interested people in the Departments of Health, Universities, the Royal Colleges and the British Medical Association, wished to 'do something for general practice', there was a wide interpretation of what this was likely to mean, not least where the Universities are concerned.

There was already a great deal of activity in the field of general practice over a wide front (1,2,3), with fairly large financial support available from a number of sources. A striking feature of the previous years had been the rapid increase in the number of **group health practice centres** being built, many based on the experience of the Harlow Centres, and the growth of interest in the **teaching of general practice,** two specialist areas in which the Trust had long had influential interests, but the second of which the Royal College of General Practitioners felt needed special attention. More highly disciplined research into the content of general practice was recognised as a prime necessity. The Trust's role for the future was seen as designed to help the appropriate bodies such as the Royal College sharpen the focus about what was needed, including evaluations of what lessons had already been learnt.

The Trust's interest in **management training** in the health services had been developing since 1962. This sector was originally entered through the help given to establish the **Nuffield Centre for Health Service Studies at the University of Leeds, and the Diploma in Medical Services Administration Courses at the University of Edinburgh.** The aim of both of these ventures was to attract the Universities

to contribute to raising the quality of training for health service administrative staff (medical as well as lay). In addition to supporting such training schemes, the management problems had been examined at various private seminars as well as by the **Working Party on the Training of Doctors in the Administration of Hospital and Public Health Services** which produced *Vocational Training in Medicine* (1967). A series of questions had been raised on this subject in commissions and seminars which had pointed to the need for continuing education and training concerned with management issues and that more probes were called for. Altogether a comprehensive policy on management training and its necessary concomitant, an attractive career structure, was long overdue and it was stressed in the relevant publications of the Trust that there was need for a strong focus to give better definition to the whole management process in the National Health Service.

The subject was, of course, strongly related to other matters taken up by the Trust such as drawing attention to the need for adequate supporting services to the **Medical Executive Committees.** This culminated in the publication in 1971 *In Low Gear* which was a critical review of the widespread failure to provide appropriate backup arrangements for Medical Executive Committees which were set up in 1968 following the **'Cogwheel' Committee's** recommendations. This was part of the deliberate Trust policy for the provision of good, academically based units concerned with **health services research: centres of advanced studies** as forums for discussion: and of **further education on 'management' matters for clinicians.** The framework and efficient mechanisms for clinical work on which the effectiveness of the NHS relies still in 1990, presents the major challenge to the health service manager.

There was by the late Sixties no sign of an official policy being developed to bind these various strands together but the need was seen as urgent and never more so then, when the National Health Service seemed to be poised at the end of the decade for organisational change. Particularly, there was an immediate requirement to co-ordinate the lay and nursing administrators training with that of doctors who had management responsibilities, and to have a management training policy which took account of, and utilised the operational research units which were being established then. The fact that these were being set up mainly through official funds, made it all the

more curious, indeed sad, that there was no comprehensive national policy.

In the same way it was difficult to distinguish the approach to management problems from that of the probing exercises by the Trust in what were in effect new directions, all of which include a strong operational research element. The more eye-catching of these, such as **screening** or the follow-up series in train involving **evaluation of medical care for cost-benefit** purposes, were problem-orientated. The question of where such research was to be carried out, or even the mechanism for experimenting with methodology needed to be regarded as problems directly related to the organisation of health care. This again confirmed the thesis that a pre-condition of a management policy was the establishment of suitable bases for research which could be applied by management.

A field of study identified as close to this was that of **the application of technology to medicine.** The Trust's roots in that went back to the *Investigation into Function and Design of Hospitals* (1954) but the difficulty was in finding suitable bases of action to fit the real requirements of the then current situation. It is hardly an appropriate subject **wholly** for academic departments, because development is an integral component which essentially needs a business approach. Some initial support was given to the **Bath Institute of Medical Engineering** (244) and to the **Department of Mechanical Engineering at Queen Mary's College, London** (246).

One aspect of the subject which was raised by the Bath Institute which regrettably was not pursued by Government was that of an 'intelligence' role to evaluate specific ideas regarding technology raised by health service professionals. It seemed to the Institute there was a need to define and carry out surveys into potential opportunities in the whole field, since it was questionable whether the activity was suitable for a central government department which might shy away from the difficulties presented by the application of results by commercial entrepreneurs. It was undoubtedly the case that pressures for particular studies from technologically-minded doctors were building up at the time, but there appeared to be little enthusiasm at Departmental level to back the idea of evaluation exercises.

Lastly there was also the continuing question in the forefront of the Trust's consideration of policy of the improvements necessary in **communication** through the printed word, of the

results from the widening scope of research initiatives now being funded from many sources.

6. PREPARATION FOR NHS REFORM: THE ROLE OF THE TRUST

In summarising their conclusions at the end of the decade the Trustees felt that experience showed that the Trust should relate its actions to the situation in which increasingly larger sums of money were being made available from a variety of sources for R & D in the NHS, which itself seemed from the Green Paper already published, to be poised for change through attempts to rationalise its organisation.

It had to be accepted that Foundation money was relatively small compared to that from public sources. Yet it seemed to be no part of public policy to make arrangements to increase the supply of a cadre of skilled researchers. This in effect made for a dispersal of talent and consequent dissipation of effort.

There was also clearly a need for a closer independent evaluation of research objectives, approaches, methods and results, which influenced the Trust to concentrate on the 'Intelligence' role designed to show up the less obvious gaps in research. This was the reason for attention being drawn in the *Eighth Report* in 1970 to the fact that there was a shortage of resources going into practical innovative action research. There was additionally an appeal for applications in the Service of the more promising research results.

The experience of thirty years had also begun to express itself in a more detailed consideration about a Foundation's role and obligations particularly with respect to communication. Thus the *Eighth Report* began:

> The periodic Report is an obvious requirement. It will probably always be with us . . . as a summary account of stewardship . . . but there is probably an obligation to keep its particular form under review in order to recognise the changed circumstances in which the organisation functions.
>
> Thus what is appropriate in an age in which a Foundation is establishing its peculiar role . . . may have little relevance to the announcement of grants made. The hunger of the mass media for more copy means almost instant publicity which too frequently alas, have more attraction in the first flush of prospect than when the results are presented in the sober light of experience or scientific reality.

The previous seven Reports had changed subtly in character

over the years although the *Seventh* in form and content had reflected more acutely the changing background against which the Trust operated. The establishment of the NHS in 1948 had accepted the principle of the regionalisation of hospitals and thus had virtually made redundant the phase of Trust policy concerned with the superstructure of services implicit in the charge to promote co-ordination of hospitals.

The scale of the publication policy of the Trust which was not confined to showcase projects, meant that there now was a constant and swelling stream of publications which involved a realistic reappraisal of the form of the periodical report to make it in essence a summary indication of the overall results taking precedence over the intent of its programme.

The amount of funds from Government and other sources supporting the kind of projects which the Trust had been financing for some years had escalated considerably even more than the trend specially remarked upon in the early 1960s. The increasing availability of public funds for research and development meant that contemporary applications for grants for projects of demonstrable merit rarely failed to attract support somewhere. Failure to do so was more often due to diffuseness in clarifying objectives, and occasionally in the frailty of the methods proposed for the particular research related to its objectives.

SUPPLEMENT TO CHAPTER 5
1961–70

CLASSIFICATION OF MAJOR RESEARCH and DEVELOPMENTS etc., SUPPORTED BY THE TRUST

Pages (109) – (135)

HEADINGS

1. STUDIES etc.
2. EDUCATION (Medical, Nursing, other)
3. EXPERIMENTS and DEMONSTRATIONS
4. SEMINARS etc.
5. MISCELLANEOUS

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENT ETC., SUPPORTED BY THE TRUST
1961–70

Principal Authority	Subject	Trust Reports	Other References
STUDIES ETC.			
1961			
1 Liverpool University, Dept of Pharmacology and Therapeutics	Study of prescribing in general practice	VI,85	*Problems and Progress, I,* 173 (OUP for NPHT 1964). *Brit. Med. J.* (1963) 3, 599. *J. New Drugs* (1963) 3, 376. *Practitioner* (1964) 192, 388

2	Nuffield Provincial Hospitals Trust	Study of diagnostic facilities available to general practitioners by Dr H M C Macaulay	VI,76	*Lancet* (1962) i, 791
3	Institute of Community Studies	Study of relationships between hospitals, general practitioners, and patients	V,36–7.VI,26	*Human Relations and Hospital Care* (Routledge and Kegan Paul, 1964) *Proc. Roy. Soc. Med.* (1968) 170, 561
4	Runwell Hospital, Essex	Comparative study of mental health services	V,60–1.VI, 49.VII,59	*J. Neurol. Psychiat.*, 26, 262
5	Devonshire County Council, Mental Health Research Committee	Study of community mental health services in Devon	VI,58	*Bit. J. Psychiat.* (1968) 114, 739
6	Belfast City Hospital	Study of nursing in geriatric wards	V,95–6	*Geriatric Nursing* (OUP for NPHT, 1963)
7	Building Research Station	Study of hospital building processes	VI,75.VII,92	
	1962			
8	College of General Practitioners	Studies by the Practice Organisation Committee	VI,80–1.VI,81	*Reports from General Practice, No. 2* (College of General Practitioners 1965). *Brit. Med. J.* (1968) 2, 420
9	Aberdeen University, Dept of Public Health and Social Medicine	Use of hospital facilities by general practitioners in North-east Scotland, and health service research in North-east Scotland	VI,83–4.VII,79	*Problems and Progress, II,* 77, 235 (OUP for NPHT, 1966). *Lancet* (1969) ii, 564
10	Liverpool University, Dept of Psychiatry	Enquiry into the psychological effect of physical illness in hospital patients	VI,50.VII,59–60	*Nursing Times* (1964) 60, 1679. *Brit. J. Soc. Clin. Psychol.* (1965) 4, 114 & 1966, 5, 207. *Medical Care* (1966) 4, 34. *Social Work* (1966) 23, 3.
11	Wessex Regional Hospital Board	Regional survey of mental subnormality	VI,61–2.VII,62	*Proc. Roy. Soc. Med.* (1965) 162, 375. *Soc. Psychiat.* (1966) 2, 1. *Brit. Hosp. J. Soc. Serv. Rev.* (1976) 77, 188
12	Odstock Hospital, Salisbury	Research into central sterile supply equipment	VI,72.VII,91	

Principal Authority	Subject	Trust Reports	Other References
13 Bristol Royal Infirmary	Studies of low temperature steam disinfection	VI,73	*J. Clin. Path.* (1961) 14, 515 *Lancet* (1962) ii, 509
14 London School of Hygiene, Dept of Human Nutrition	Study of the application of modern catering techniques to hospitals	VI,109.VII,105	*J. Develop. Med. Child Neurol.* (1965) 7, 377. *Proc. Nutr. Soc.* (1965) 24
15 London Hospital Medical College	Survey of dental health and dental services in two areas	VI,111–12	*Brit. Den. J.* (1965) 5, 118, 199. *Problems and Progress, II,* 311 (OUP for NPHT, 1966). *The Demand and Need for Dental Care* (OUP for NPHT, 1968)
16 Birmingham University, Institute of Child Health	Survey of child health services in the City of Birmingham	VI,34–5.VII,21–2	
17 London School of Economics	Study of the deployment of doctors	VI,36–7	*British Doctors at Home and Abroad* (Codicote Press 1964)
18 Birmingham University, Board of Medical Graduate Studies	Studies of the deployment of Birmingham medical graduates	VI,36–8	*Lancet* (1963) ii, 874; (1969) i, 667, 882. *Postgrad. J.* (1964) 40, 175
19 South-western Regional Hospital Board	Case-load study of the Bath clinical area	VI,35–6.VII,24	
20 Queen's University, Belfast, Dept of Social & Preventive Medicine	Fellowship in general practice for the study of arteriosclerotic disease	VI,85.VII,82–3	
1963			
21 St Andrew's University, Dept of Social Medicine	Comparative hospital morbidity study between Arbroath and Waterville, US	VI,38–9.VII,22	*Custom and Practice in Medical Care* (OUP for NPHT 1968)
22 College of General Practitioners	Research Advisory Service	VI,79–80.VII,81–2	*J. Roy. Coll. Gen. Practit.* (1969) 17, 119
23 Oxford University, Unit of Biometry	Study of appointment systems in general practice	VI,81.VII,82	*Appointment Systems in General Practice* (OUP for NPHT 1967). *Brit. Med. J.* (1967) 2, 542

24	London School of Hygiene	Study of dissemination of information between general practitioners and other health services	VI,81-2	
25	Guy's Hospital, Social Medicine Unit	Study of ancillary work in general practice	VI,83.VII,80	*Med. Offr.* (1968) 119, 295. *Nursing Times* (1969) 65, 40, 82, 114
26	Leeds General Infirmary, Casualty Department	Investigation into and prevention of home accidents	VI,31.VII,23	
27	Brighton & St Olave's Hospital Management Committees with Guy's Medical School General Practice Research Unit	Study of outpatient services in Brighton and Bermondsey	VI,31-2.VII,24	*Problems and Progress, 11,* 43 (OUP for NPHT 1966)
28	Trust Operational Research Unit	Study of hospital outpatient appointment systems	VI,96	*Waiting in Outpatients* (OUP for NPHT 1965)
29	Sheffield University, Dept of Preventive Medicine and Public Health	Geriatric case-load survey at Barnsley	VI,98.VII,23	
30	Edinburgh University, Dept of Psychiatry	Study in following-up discharged patients from a psycho-geriatric ward	VI,56-7.VII,61-2	*Gerontologia Clinica* (1965) 7, 286
31	Edinburgh University, Dept of Psychiatry	Research and treatment service for alcoholism	VI,57-8.VII,50-1	*Brit. Med. J.* (1966) 4, 1171. *The Management of Alcoholism* (E & S Livingstone 1970)
32	National Book League	Survey of book and journal services	VI,96-7.VII,72-3	*Book and Journal Services* for Doctors and Nurses (NPHT 1966). The Planning and Organisation of *Medical Book and Journal Services in Regional Services* (NPHT 1966)
33	Aberdeen University, Dept of Public Health & Social Medicine	Academic sub-unit for the study of medical records	VI,32-3.VII,20-1	*Lancet* (1967) i, 668. *Computers in the Service of Medicine I & II,* Nos. 4, 5, 11, 16, & 20 (OUP for NPHT 1968)

	Principal Authority	Subject	Trust Reports	Other References
34	Oxford Regional Hospital Board	Study of the records system at the Nuffield Health Centre, Witney	VII,88	
35	Nottingham University, Dept of Social Science	Analysis of the professions supplementary to medicine	VI,38.VII,22	
	1964			
36	London School of Economics	Study of the effectiveness of hostels for the mentally ill	VI,59	*Problems and Progress, II,* 155 (OUP for NPHT 1966). *Psychiatric Hospital Care* (Bailliere, Tindall and Cassell 1965)
37	Aberdeen University, Dept of Mental Health	Research into psycho-pathological art and diagnosis	VI,55–6	
38	Birmingham University, Dept of Social Medicine	Assessment of the needs of mentally subnormal patients	VII,65	*Brit. Med. J.* (1967) 3, 573
39	London School of Economics	Survey of waiting lists for child guidance clinics	VII,66	*Problems and Progress III,* 91 (OUP for NPHT 1968)
40	Oxford University, Unit of Biometry	Review of operational research information in the health services	VII,27	
41	Trust Survey Group	Assessment of postgraduate medical schemes	VII,73	*Brit. Med. J.* (1965) 3, 557
42	Manchester University, Medical Care Research Unit & Liverpool Regional Hospital Board	Study of the use of medical resources in the Liverpool region	VI,28–29.VII,18–9	*Lancet* (1968) ii, 559. *The Hospital* (1969) 65, (NPHT 1970)
43	Christies Hospital & Hole Radium Institute, Manchester Dept of Social Research in Malignant Disease	Study of the reasons prompting patients to seek medical advice	VII,90	
44	Aberdeen University, Dept of Mental Health	Collection of data for the Psychiatric Case-Register	VI,55.VII,61	*DHSS Statistical and Research Reports,* Series 7 (1974) 5

45	Queen's University, Belfast Dept of Therapeutics & Pharmacology	Study of Prescribing Patterns in Northern Ireland General Practices	VII,84–5	*Lancet* ii (1968) 96. *Computers in the Service of Medicine,* I, 10 (OUP for NPHT 1968)
	1965			
46	Guy's Hospital Medical School, Paediatric Research Unit	Genetic survey of congential malformations among infants in the South-east Metropolitan regions	VII,29–30	
47	Queen's University, Belfast Dept of Therapeutics and Pharmacology	Study of adverse drug reactions in Belfast hospitals	VII,27–8	*Brit. Med. J.* (1969) I, 531, 540
48	National Building Agency	Investigation into building for general practice	VII, 85–6	*Design Guide for Group Practice Centres* (National Building Agency and Royal College of General Practitioners 1967)
49	Wessex Regional Hospital Board	Survey of disturbed adolescents in the Wessex region	VII,63–4.IX,30	*Problems and Progress 5,* 109 (OUP for NPHT 1971); *Stress in Youth* (OUP for NPHT 1971
50	Liverpool University, Dept of Computational and Statistical Science	Nuffield Medical Data Processing Unit	VII,34	*Computer Systems Study* (United Liverpool Hospitals 1972)
51	Edinburgh University, Dept of Social Medicine	Review of data on medical manpower	VII,30	*Problems and Progress III,* 31 (OUP for NPHT 1968)
52	Scottish Hospital Centre	Study of supporting beds in hospitals	VII,25–6	*Hostels in Hospitals* (OUP for NPHT 19)
53	Wessex Regional Hospital Board	Survery of disturbed adolescents in the Wessex region	VII,63–4	
54	Corporation for Economic & Industrial Research	Study of the application of computers to medical records	VII,33	
55	Glasgow Western Infirmary	Study of medical records at ward and clinic levels	VII,35	*Practitioner* (1967) 199, 817; *Lancet* (1967) II, 932; *Brit. Hosp. J. & Soc. Rev.* (1967) 77, 2326; *A New Look at Hospital Case Records* (H. K. Lewis 1970)

Principal Authority	Subject	Trust Reports	Other References
56 Scottish Postgraduate Medical Association	Review of postgraduate medical facilities in Scotland	VII,75	*Report of a Working Party on Postgraduate Medical Education within the National Health Service in Scotland* (Scottish Postgraudate Medical Assoc. 1967)
57 Oxford University, Dept of Clinical Medicine	Oxford Record Linkage Study	VII,25	*Medical Record Linkage (OUP for NPHT 1967). Brit. Med. J.* (1967) 3, 612, 856; 4, 476; (1967) 2, 46. *Lancet* (1968) ii, 908. *Nursing Times* (1969) 65, 1063
1966			
58 St Martin's Hospital, Bath	Unit for Measurement of Medicine and Monitoring Equipment in Intensive Care	VII,95	*Br. Med. J.* (1973) 3, 227
59 Exeter University	Study of the Biology of Low Birth Weight	VII,39–40	*Br. J. Prev. Soc. Med.* (1974) 28, 10
60 Aberdeen University, Dept of Sociology	Studies of risk assessment in pregnancy and infant handicap	VII,41–2	*Vr. J. Prev. Soc. Med.* (1970) 24, 52; *J. Hlth & Soc. Behav.* (1972) 13, 115, 369; *Soc. Sci. & Med.* (1972) 6, 561; *Social Forces* (1973) 3, 275. *Problems and Progress IV,* 45 (OUP for NPHT 1970)
61 Glasgow University, Building Services Research Unit	Study of supporting services in hospitals	VII,94–5	
62 York University, Institute of Social & Economic Research	Unit for research into social and economic aspects of the health services	VII,32	*Problems and Progress III,* 51 (OUP for NPHT 1968)
63 Aberdeen University	General Practice Research Unit	VII,84	

64	United Oxford Hospitals	Survey of medical thermography in the diagnosis of breast cancer in Witney	VII,28–9	*J. Phys. Med. Biol.* (1970) 15, 178
65	Welsh National School of Medicine	Pilot study of medical care in Brecon	VII,85	
66	Glasgow Social Paediatric Research Group	Utilisation study of ante-natal services and hospital confinements and linked record system of child health and development	VII,44–5	*Scottish Health Bulletin* 27, 1969. *In the Beginning No. 5* (OUP for NPHT 1970). *Problems and Progress VI,* 145 (OUP for NPHT 1970). *J. Med. Child. Neurol.* (1970) 12, 3, 357
67	Welsh National School of Medicine, Dept of Child Health	Study of the survivors of spina bifida cystica	VII,28	*J. Develop. Med. Child. Neurol.* (1967) Supp 13, 1
68	North Wales University College, Dept of Social Theory	Comparative study of mental health needs in Anglesey	VII,64–5	
69	St Thomas's Hospital Medical School, Dept of Clinical Epidemiology & Social Medicine	Development of a medical dictionary for computer processing and data retrieval	VII,38	*Computers in the Service of Medicine II,* Nos. 18 & 19 (OUP for NPHT 1968)
70	Birmingham University & United Birmingham Hospitals	Joint computer service	VII,36	*Computers in the Service of Medicine, I & II,* Nos. 1, 2, 3, 9 & 15 (OUP for NPHT 1968)
71	Glasgow University, Dept of Surgery	Computer record and analysis of data from patients with peptic ulcers	VII,37	*Computers in the Service of Medicine I,* No. 6 (OUP for NPHT 1968). *Lancet* (1968) ii, 1230
72	English Electric Leo-Marconi Ltd	Study of the flow of information at two general hospitals	VII,34	*The Flow of Medical Information in Hospitals* (OUP for NPHT 1967). *Computers in the Service of Medicine II,* No. 13 (OUP for NPHT 1968)
73	Edinburgh University, Dept of Social Medicine	Study of the settlement patterns of general practitioners and consultants	VII,30–1	*Brit. Med. J.* (1967) 2, 796

Principal Authority	Subject	Trust Reports	Other References
74 Nottingham University, Dept of Applied Social Science	Analysis of statistical data on the midwifery services	VII,40	*Problems and Progress III*, 63 (OUP for NPHT 1968)
75 Exeter University	Study of the biology of low birth weight	VII,39–40	*Problems and Progress III* (OUP for NPHT 1968). *Brit. J. Prev. Soc. Med.*, 23, 154. *In the Beginning No. 6* (OUP for NPHT 1970)
76 Keele University, Nuffield Research Unit in Statistical Sociology	Study of perinatal and infant mortality data	VII,40	*In the Beginning No. 2* (OUP for NPHT 1970)
77 Southampton University, Dept of Sociology & Social Administration	Studies in the selection of cases for hospital confinement	VII,41	*In the Beginning No. 3* (OUP for NPHT 1970)
78 Newcastle University, Dept of Midwifery & Gynaecology	Survey of planned early discharge	VII,43	*In the Beginning No. 9* (OUP for NPHT 1970)
79 Newcastle University, Dept of Midwifery & Gynaecology	Studies of medical and sociological problems of high parity groups	VII,42–3	
1967			
80 Nottingham University, Dept. of Applied Social Science	Study of voluntary work in the health and social services	VII,31–2	
81 Barton-on-Humber Public Health Department	Study of late bookings for obstetric care	VII,44	*In the Beginning No. 4* (OUP for NPHT 1970)
82 Welsh National School of Medicine, Dept of Obstetrics and Gynaecology	Study of perinatal mortality in the West Monmouthshire mining valleys	VIII,28	*In the Beginning No. 7* (OUP for NPHT 1970)
83 Essex University, Dept of Computer Science	Study of programming languages	VIII,30–1	
84 Hull University, Dept of Social Administration	Study of the deployment of medical manpower in Hull & East Riding	VII,31	

85	Birmingham Regional Hospital Board	Study of the information flow through the outpatient department of the North Staffordshire Royal Infirmary	VII,36	
86	Glasgow University, Dept of Geriatric Medicine	Studies in the process of ageing	VIII,29	
87	St John's Hospital, Stone	Child mental health follow-up study	VII,64	
88	Exeter University	Computer System for Processing Community Health Records	VII,38–9	*Community Health.* (1971) 1, 5
89	Birmingham University, Dept of Medicine, transferred to Health Services Research Centre	Computer Analysis of In-patient Care	VIII,30.IX,95	*Nursing Times* 68, No. 17 (1792), 659–504; *Spectrum* (1971) 57; *The Future and Present Indicatives, Problems and Progress 9,* 157 (OUP for NPHT 1973)
90	York University, Dept of Social Administration	Survey of the provision of hospital and community care in Rural Areas	VII,32	*Problems and Progress* 7, 113 (OUP for NPHT 1972)
	1968			
91	Newcastle University, Dept of Child Health	Newcastle Child Development Survey	VIII,28.IX,30,91	*J. Develop. Med. Child. Neurol.* ii, 413, 423. 7 *Problems and Progress IV,* 29 (OUP for NPHT 1970). *The Formative Years* (OUP for NPHT 1974)
92	Sheffield University, Dept of Sociological Studies	Study of the care at home of the mentally subnormal	VIII,29–30	*Case conference* (1969) 16, 1
93	University College of South Wales & Monmouthshire, Dept of Economics	Refinement of cost-benefit analysis in medicine	VIII,35–6	*Problems and Progress 5,* 45 (OUP for NPHT 1971)
94	Kingston College of Technology, Dept of Management and Production	Study of the hospital supply system	VIII,35	*Brit. Hosp. J. Soc. Serv. Rev.* (1970) 80, 1181
95	Sheffield University, Faculty of Medicine	Study of regional postgraduate medical educational arrangements	VIII,32	
96	Royal Postgraduate Medical School	Computer record and analysis of data from hypertension clinics	VIII,31	

	Principal Authority	Subject	Trust Reports	Other References
97	British Committee for Standards in Haematology	Quality control trials of Haematological laboratory procedures	VIII,27	*Brit. Med. J.* (1969) 4, 253, 842
98	Birmingham University, Dept of Social Medicine	Method study for assessing costs of patient care	VIII,35	
99	Shotley Bridge General Hospital, Co. Durham	Research on adverse drug reactions	VIII,27	
100	Welsh National School of Medicine	General Practice Teaching and Research Unit at Cardiff	VIII,26	
	1969			
101	Welsh National School of Medicine, Dept of Child Health	Study of the Survivors of Spina Bifida Cystica	VII,28	*Archives of Disease in Childhood* (1971) 46, 246; *Hydrocephalus and Spina Bifida Supp. 27* (1972) 124; *Lancet* i (1974) 301
102	Glasgow University, Dept of Epidemiology & Preventive Medicine, transferred to Edinburgh University Medical School	Development of a reformed administrative Health Service structure in Scotland	VIII,35	*Doctors in an Integrated Health Service* (HMSO 1971); *In Low Gear?* 99 (OUP for NPHT 1971)
103	Accident Services Review Committee	Review of accident and emergency services	VIII,27	*Report of a Working Party* (BMA 1970)
104	Scottish Hospital Centre	Survey of voluntary services in Scottish hospitals	VIII,28	
105	Queen's Institute of District Nursing	Pilot study of the role of state enrolled nurses in community care	VIII,36	
106	London School of Hygiene & Tropical Medicine and Society of Medical Officers of Health	Working party for the establishment of a Faculty of Community Medicine	VIII,32	
107	Scientific Control Systems Limited	Study of medical computer development in Scotland	VIII,31	*Focus on Medical Computer Development* (OUP for NPHT 1970)

	1970			
108	University of Nottingham, Dept of Community Health	Studies of priorities in general practice	IX,87–8	*Hosp. & Hlth. Serv. Rev.* (1974) 70, 6
109	Leeds University, Centre of Transport Studies	Research into traffic generation and prediction at hospitals	IX,107	*J. Inst. Munic. Engin.* (1972) 99,35
EDUCATION (Medical, Nursing, other)				
	1961			
110	Conference at Christ Church, Oxford (NPHT)	On postgraduate medical education		*Lancet* (1962) i, 361. *Brit. Med. J.* (1962) I, 421, 466
	1962			
111	Camphill Village Trust	Training facilities for mentally handicapped young adults at The Grange, Newnham-on-Severn	VI,63–4	
112	Cornell University, US	Nomination of senior administrators to attend the Management Course	V,106–7.VII,102–3	
113	St Albans City Hospital	Medical Centre Library	VI,95,VII,71	
114	St Margaret's Hospital, Epping	Medical Centre Library	VI,95	
115	North Staffordshire Medical Institute (loan)	Medical Institute	IV,97,VII,71	*Brit. Med. J.* (1966) 3, 167
116	Birmingham Medical Institute	Medical Institute	VI,91	
117	Liverpool Medical Institution	Extension of Library facilities Hospital Administrators Development Program	VI,92	
118	Exeter University	Exeter Postgraduate Medical Institute	VI,93–4.VII,69	*Brit. Med. J.* (1966) 3, 103
119	Birmingham University	Preparatory courses at 'Commonwealth Schools' for overseas medical graduates	Vi,91.VII,71	*Lancet* (1963) i, 1318. *Postgrad. Med. J.* (1965) 42, 291
120	Ipswich & East Suffolk Hospital	The 'Friday Club'	VI,95.VII,72	

	Principal Authority	Subject	Trust Reports	Other References
121	Wessex Regional Hospital Board in association with the British Postgraduate Medical Federation	Establishment of PGME Centres	VI,88.VII,67–7	*Lancet* (1963) ii, 591
122	Oxford University in association with the Oxford Regional Hospital Board	Establishment of PGME Centres	VI,88–9.VII,70	
123	Newcastle Regional Hospital Board in association with Newcastle University	Establishment of PGME Centres	VI,89.VII,69	
124	Manchester University in association with the Manchester Regional Hospital Board	Establishment of PGME Centres	VI,89.VII,71	
125	Edinburgh Postgraduate Board for Medicine in association with the South-easten Regional Hospital Board, Scotland	Establishment of PGME Centres	VI,90.VII,69–70	
126	Glasgow Postgraduate Medical Board in association with the Western Regional Hospital Board, Scotland	Establishment of PGME Centres	Vi,90.VII,69	
127	Sheffield University in association with the Sheffield Regional Hospital Board	Establishment of PGME Centres	VI,90–1.VII,71	
128	Birmingham University in association with the Birmingham Regional Hospital Board	Establishment of PGME Centres	VI,9.VII,70–1	
129	Bristol University in association with the South-western Regional Hospital Board	Establishment of PGME Centres		

130	Liverpool Regional Hospital Board in association with Liverpool University	Establishment of PGME Centres	VI,92.VII,71	
131	Welsh Hospital Board in association with the Welsh National School of Medicine	Establishment of PGME Centres	VI,92.VII,71	
	1963			
132	St Andrew's University in association with the Eastern Regional Hospital Board, Scotland	Establishment of PGME Centres	VI,93.VII,70	
133	United Bristol Hospitals	Linked rotating internships with the general practice trainee scheme	VI,94.VII,68–9	
134	Royal College of Surgeons	Pilot scheme of surgical training	VI,94.VII,72	*Annals of the Royal College of Surgeons* (1967) 41, No. 1, 54
	1964			
135	Sheffield Regional Hospital Board	Survey of programmed learning and teaching machines for nurse training	VII,100	*Nursing Times* (1969) 65, 181. *Register of Programmes available for Nurses* (Programmed instruction Centre for Industry, 1968). *Nursing Times* (1970) 66, No. 27, Occasional Paper
	1965			
136	Plymouth Medical Society Ltd	Plymouth Medical Centre	VII,74	
137	Bath Clinical Society	Bath Medical Centre	VII,74	
138	Wessex Regional Hospital Board	Knowle Psychiatric Postgraduate Centre	VII,68	
139	Royal Society of Medicine	Domus Medica	VII,75	
140	National Society for Mentally Handicapped Children	Rural Training Unit at Lufton Manor for mentally handicapped young adults	VII,54	
141	Birmingham Regional Hospital Board	The Midland Post-registration Nurse Training Plan	VII,99–100	*Nursing Times* (1966) 62, 148

	Principal Authority	Subject	Trust Reports	Other References
142	Trust with the King Edward's Hospital Fund and the American Hospital Association	US Visiting Fellowship in Hospital Administration	VII,103	
143	Glasgow Western Infirmary School of Radiography	Experiment in programmed learning for Radiographers	VII,103–4	
	1966			
144	United Manchester Hospitals School of Nursing	Survey of nursing libraries	VII,98–9	*Nursing Times* (1967) 63, 1614
145	St John's Hospital, Chelmsford	Registrarship in teaching and research at the School of Obstetrics and Gynaecology	VII,76	
146	Trust commissioned review	Current position of postgraduate medical education in the United Kingdom	VII,78	*Postgraduate Medical Education, Retrospect and Prospect* (NPHT 1967)
147	Aberdeen University, Dept of Sociology	Social work training centre	VII,89	
148	Scottish Hospital Centre	Development of library facilities	VII,90	*Libraries in Hospitals* (Scottish Hospital Centre 1969). *Brit. Hosp. J. Soc. Serv. Rev.* (1967) 77, 2416
149	Wessex Regional Hospital Board	Postgraduate adviser in general practice	VII,77	
150	Working Parties (NPHT)	Vocational training for general practice and the psychiatric services	VII,76–7	*Vocational Training in Medicine* (NPHT 1967)
151	Working Parties (NPHT)	Training for administration of hospital and public health services	VII,76–7	*Vocational Training in Medicine* (NPHT 1967)
152	Chichester Postgraduate Medical Centre	Chichester Medical Centre	VII,74	
153	Leicester Area Department of Postgraduate Medical Studies	Leicester Medical Centre	VII,74	
154	Torquay and District Medical Society	Torbay Medical Centre	VII,74	

155	Kent Postgraduate Medical Centre	Medical Centre in Canterbury	VII,74	
156	Warwickshire Postgraduate Medical Centre	Medical Centre in Coventry	VII,75	
	1967			
157	Preston Postgraduate Medical Centre (loan)	Preston Medical Centre	VII,75	
158	Northern Ireland Hospitals Authority	Planned programme of vocational training and experience	VIII,32	
159	Queen's University, Belfast	Extension of medical library facilities to non-teaching hospital in Northern Ireland	VII,76	
160	Royal College of Obstetricians & Gynaecologists	Pilot scheme of postgraduate training	VII,76	
161	Central Committee on Postgraduate Medical Education (UK)	Central Committee on Postgraduate Medical Education	VIII,31	
162	Newcastle University, Dept of Psychological Medicine	Nurse training course in child psychiatry at the Nuffield Child Psychiatry Unit		*Nursing Times* (1968) 64, No. 14, Occasional Paper
163	British Student Health Officers Association	Development of library service	VIII,30	
164	Bolton Medical Institute (loan)	Bolton Medical Centre	VIII,33	
165	Rochdale Infirmary (loan)	Bateman Centre for Postgraduate Studies	VIII,33	
166	Colchester & North-east Essex Medical Centre Trust (loan)	Medical Centre at Colchester	VIII,33	
	1968			
167	Exeter University, Dept of Mathematics	Postgraudate training in information sciences in the health service	IX,102	*The Future—and Present Indicatives, Problems and Progress* 9, 57 (OUP for NPHT 1973); *Measuring for Management* (OUP for NPHT 1975)

	Principal Authority	Subject	Trust Reports	Other References
168	Aston University, Dept of Industrial Administration	Diploma course in nursing administration	VIII,34	*Nursing Times* (1967) 63, 1126. *Problems and Progress IV*, 179 (OUP for NPHT 1970)
169	Nuffield Provincial Hospitals Trust	Nuffield Travelling Fellowship in Health Affairs	VIII,34	
170	Royal College of Surgeons	Joint committee on higher specialist training in surgery	VIII,32	
171	Society of Medical Officers in Health	Training scheme in developmental paediatrics	VIII,32	
172	Dorset House School of Occupational Therapy, Oxford (Loan)	Hostel block		
173	Edinburgh University, Medical School	School of Community Care	VIII,26	
174	Glasgow University, Dept of Epidemiology & Preventive Medicine	Development of a teaching health centre	VIII,26	
175	Exeter University, Dept of Mathematics, Seminar	Health service teaching and research	VIII,36	
	1969			
176	Faculty of Anaesthetists, Royal College of Surgeons with Reading University	Review of educational facilities and manpower requirements in anaesthetics	VIII,32	
177	Joint Trust Seminar with the Nuffield Foundation	Teaching and research for general practice and community medicine		
	1970			
178	Edinburgh University, Dept of Nursing Studies	Unit for the study of nursing education and service	VIII,33–4.IX,101	
179	Association for the Study of Medical Education	Central unit for examination in medicine	IX,98	

180	Medical Recording Service Foundation	Collection of slides and audio-tapes as Aids to Medical Teaching	IX,98	*Nursing Times* (1971) 67, No. 17, 443
181	Royal College of Surgeons of England	Director of Postgraduate Surgical Studies	VI,94.VII,72.IX,98	
182	Nuffield Provincial Hospitals Trust	Intelligence and further educational activities at 4 Prince Albert Road	VIII,37	
183	Sheffield Regional Hospital Board	Management training courses for clinicians	IX,102	
184	Trust with the King Edward's Hospital Fund and the American Hospital Association	US (Crosby) Visiting Fellowship in Hospital Administration	VII,103.IX,116	*Problems and Progress 5,* 137 (OUP for NPHT 1971); *Lancet* (1973) ii, 139; *Health Bulletin* (1973) 33,1
185	Royal College of Obstetricians and Gynaecologists	Postgraduate Training Programme	VII,76.IX,101	
186	Birmingham General Hospital	Central Sterile Supply Service, and study of the introduction of central sterile supply	V,105.VI,72.VII,91	
187	Broadgreen Hospital, Liverpool	Intensive Care Unit	VI,73–4.VII,91–2	*Lancet* (1969) i, 855
	EXPERIMENTS/DEMONSTRATIONS			
	1961			
188	Glenside Hospital, Bristol	Industrial Therapy Workshop	V,53.VI,45–6	
189	Oxford Regional Hospital Board	Operational Research Unit	VI,30–1.VII,19–20	*Problems and Progress I,* 70 (OUP for NPHT 1963). *Operational Research Series* (Oxford Regional Hospital Board, 1964–7)
	1962			
190	Northern Ireland Association for Mental Health	Belfast Mental Health Centre	VI,64.VII,50	
191	Exeter Valexe Products Ltd	Marketing organisation for the Exeter Industrial Therapy Organisation	VI,61	
192	Boy Scouts Association	Facilities for emergency treatment at Buckmore Park Camp Hospital	V,67	

	Principal Authority	Subject	Trust Reports	Other References
193	Radcliffe Infirmary, Oxford	Experiment in automation in the Haematological Lab.	VI,75.VII,91	
194	Swalcliffe Park Trust	School for maladjusted adolescent boys	VI,53–4.VII,49	
195	Queen Alexandra's Hospital, Cosham	Treatment and assessment unit for pre-school mentally handicapped children	VI,62.VII,47–8	
	1963			
196	Nuffield Health & Social Services Fund	Nuffield Health Centre, Witney	VI,66–7.VII,88	*Midwife and Health Visitor* 4, 147
197	Barnstaple Group Practice	Experiment in the attachment of an almoner to a group practice	VI,82.VII,80–1	*Social Casework in General Practice* (OUP for NPHT 1968). *J. Roy. Coll. Gen. Practit.* (1968) 6, 243
198	General Practice Advisory Service Ltd	General Practice advisory services	VI,82.VII,82	*Buildings for General Practice* (Ministry of Health 1968)
199	Birmingham Accident Hospital	Head injuries rehabilitation unit	VII,96–7	*Nursing Times* (1967) 63, 1667. *Brit. Hosp. J. Soc. Serv. Rev.* (1967) 77, 2443
200	Institute of Community Studies	Experiment in improved communications between hospitals and patients under their care	VI,33.VII,23–4	*Problems and Progress III,* 115 (OUP for NPHT 1968)
201	Cranage Hall and Mary Dendy Hospital Management Committee	Nuffield Audiological Asessment Unit	VI,62–3.VII,48–9	
202	Highcroft Hospital, Birmingham	Industrial therapy organization	VI,60–1	
203	Fulbourn Hospital Management Committee	Experiment in the use and integration of voluntary services in a mental hospital	VI,59.VII,63	*Lancet* (1966) i, 1088
204	North-eastern Regional Hospital Board, Scotland	Child psychiatric inpatient unit	VI,50–1.VII,46	

205	Newcastle University, Dept of Psychological Medicine	Nuffield Child Psychiatry Unit	VI,51–2.VII,46–7	*Brit. Hop. J. Soc. Ser. Rev.* (1968) 78, 1132
206	Glasgow Royal Hospital	Children's psychiatric day centre	VI,52–3.VII,47	
207	Smiths Hospital, Henley-on-Thames	Hostel for parents of psychotic children and special accommodation for psychotic children	VII,51	
208	Sussex Postgraduate Medical Centre (part-loan)	Medical Centre at Brighton	VI,93.VII,72	*Brit. Hosp. J. Soc. Ser. Rev.* (1965) 75, 51
	1964			
209	York 'A' & Tadcaster Hospital Management Committee	York Medical Centre	VI,95.VII,72	
210	St Joseph's Hospital, Rosewell	Extension of accommodation for mentally defective children	VII,107	
211	Edinburgh University, dept of Psychiatry	Young people's unit at Tipperlin House	VII,53–4	
212	Oxford Regional Hospital Board	Experiment at Northampton in telephone-linked seminars in psychological medicine for general practitioners	VII,70	
213	Oxford Regional Hospital Board	Planning Unit at the Churchill Hospital, Oxon	VI,74.VII,92	
214	Camphill Village Trust	Community centre for the Bottom Village	VII,107–8	
	1965			
215	Royal Manchester Hospital for Sick Children	Pilot screening service for mental retardation in infants in the community	VII,52–3	*Proc. Roy. Soc. Med.* (1968) 169, 294. *J. Develop.*
216	Guildford & Godalming Group Hospital Management Committee	Experimental holiday relief service in geriatric wards	VII,108	
217	Religious Drama Society	Sesame scheme for drama training courses in the treamtment of mental illness	VII,108	

	Principal Authority	Subject	Trust Reports	Other References
218	United Leeds Hospitals & University of Leeds	Experimental frozen food catering system at the Hospital for Women at Leeds	VII,105–6	*The Hospital* (1967) 63, 321. *Brit. Hosp. J. Soc. Serv. Rev.* (1968) 78, 394. *An Experiment in Hospital Catering Using the Cook/Freeze System* (United Leeds Hospitals, 1970)
219	Gloucestershire Council for Alcoholism	Counselling service for alcoholics and their families	VII,109	
220	Mapperley Hospital, Nottingham	Sheltered workshop for day patients	VII,55	
221	Birmingham University, Institute of Child Health	Centre for child psychiatry and mental subnormality	VII,51–2	
222	Exeter University	Exeter Community Health Research Project	VII,83	*Computers in the Service of Medicine I, No. 12* (OUP for NPHT 1968)
	1966			
223	York University	Unit for research into social and economic aspects of the health service	VII,32.IX,108	*Economica* (1971) 151, 295; *Soc. Sci. & Med. J.* (1972) 6, 35; *Problems and Progress 7*, 33ff. (OUP for NPHT 1972)
224	Newcastle University, Dept of Child Health	Assessment and counselling centre for handicapped children	VII,88–9	
225	St Martin's Hospital, Bath	Unit for measurement of medicine and monitoring equipment in intensive care	VII,95	*Nuffield Intensive Care Unit* at St Martin's Hospital, Bath (St Martin's Hospital 1969)
226	Salvation Army	Cardiff Maternity Home for Unmarried Mothers	VII,109	
	1967			
227	Dundee University	Development of a computer system in clinical chemistry laboratories	VII,39	*J. Clin. Path.* 22, 609
228	Birmingham University, Dept of Medicine	Model of patient care in hospital	VIII,30	*Brit. Med. J.* (1970) 3, 396

229	Exeter University	Computer system for processing community health records At Exeter	VII,38–9	*Computers in the Service of Medicine I,* No. 12 (OUP for NPHT 1968)
230	Glasgow University, Dept of Medical Cardiology	Development of techniques for routine interpretation records at Exeter	VII,37	*Computers in the Service of Medicine I,* No. 7 (OUP for NPHT 1968)
231	Reading University, Dept of Applied Statistics	Nuffield Operational Research (Health Service) Unit	VII,26–7	
232	Aberdeen University, Dept of Public Health and Social Medicine	Research and Intelligence Unit	VIII,36	
233	Edinburgh University, Dept of Psychiatry	Experiment in the prevention by after-care of suicide cases	VIII,29	
234	Kilworthy House Tuition Centre, Tavistock	Rehabilitation centre for adolescents	VIII,30	
235	Manchester University, Dept of Child Health	Comprehensive record system for infant welfare clinics	VIII,29	
	1968			
236	United Birmingham Hospitals	Information system for a divisional structure		
237	Exeter University	Institute of biometry and community medicine		
238	Wessex Regional Hospital Board	Establishment of a divisional structure at Southampton	VIII,35	
239	Manchester University, Dept of Social Administration	Unit for evaluative studies in health service administration	VIII,36–7	
240	Association of Deans of Medical Schools in Scotland	Co-ordination of research in community care	VIII,27	
	1969			
241	Glasgow University, Dept of Epidemiology & Preventive Medicine	Development of a reformed administrative health service structure in Scotland	VIII,35	

	Principal Authority	Subject	Trust Reports	Other References
242	Birmingham Regional Hospital Board	Experiments with a divisional structure	VIII,35	
243	Glasgow University, Dept of Epidemiology & Preventive Medicine	Management appreciation courses for clinicians	VIII,34	
244	Bath Institute of Medical Engineering	Testing developments and setting up an information system	VIII,37	*Brit. Hosp. J. Soc. Serv. Rev.* (1970) 80, 1020
245	Birmingham University, Dept of Social Medicine	Centre for health services research	VIII,37	
246	Queen Mary College London, Dept of Mechanical Engineering	Design and inventions laboratory	VIII,37–8	
247	United Newcastle Hospitals	The lady Ridley Memorial for a mothers and babies unit	VIII,29	
	1970			
248	Royal Manchester Children's Hospital	Assessment unit for physically and mentally handicapped children	IX,88–9	
249	Exeter University, Institute of Biometry & Community Medicine	Development of a prototype mobile surgery for the Bodmin Moor Area	IX,87	
250	Royal Hampshire County Hospital, Dept of Physical Medicine	Experimental Service for the treatment of bedsores	IX,89	
	SEMINARS ETC.			
	1962			
251	Conference of MOHs and General Practitioners (NPHT)	Use of social and ancillary workers in general practice		
	1963			
252	Symposium at the University of Birmingham	The plan for a balanced teaching hospital	VI,23	*A Balanced Teaching Hospital* (OUP for NPHT 1965)

253	Conference at Rhodes House (NPHT)	The selection and training of hospital administrative staff		
254	1964 Symposium of Psychiatric Consultants	Good mental hospital psychiatric practice	VI,14	*Psychiatric Hospital Care* (Bailliere, Tindall and Cassell 1965)
255	1965 Working Group (NPHT)	a. Tactics and strategy of research in maternity care b. Proposals for improvements in the notification of births	VII,39	*Problems and Progress II,* 251 (OUP for NPHT 1966) *In the Beginning No. 2* (OUP for NPHT 1970)
	1966			
256	Seminars (NPHT)	Review of research related to medical records and data processing	VII,15–6	
	1967			
257	Joint Trust Seminar with the Nuffield Foundation	Future trends in general practice		
258	Trust Working Group	Validation of screening procedures	VIII,18	*Screening in Medical Care* (OUP for NPHT 1968)
259	Trust Seminar	Review of the role of operational research units in the health services		
	1968			
260	Joint working party of medical work in hospitals Sub-committee on management, Seminar	Problem solving by medical executive committees	VIII,34	
261	Trust Seminars	Manpower studies		
262	SAMOs Seminar	The geriatric services		
263	Trust Working Group	The evaluation of hospital care as a guide to medical priorities	VIII,18	
264	1968/9 Royal College of Physicians with Regional Hospital Boards	Symposia for chairmen of medical executive committees and divisions	VIII,34	

	Principal Authority	Subject	Trust Reports	Other References
	1969			
265	World Psychiatric Association with the Royal Medico-Psychological Association	Conference on psychiatric epidemiology	VIII,15	*Psychiatric Epidemiology* (OUP for NPHT 1970)
266	Trust Seminars	Management training in the health services	VIII,17–8	
267	1969/71 Trust Working Group	Problems of the 1970s	IX,22–23,85	*Challenges for Change* (OUP for NPHT 1971)
	1970			
268	SAMOs Seminars	Mental subnormality services		
269	Trust Symposium in association with the Josiah Macy Jr Foundation	Medical History and Medical Care	IX,31,76	*Medical History and Medical Care* (OUP for NPHT 1971)

CHAPTER 6

CHALLENGES FOR CHANGE and REFLECTIONS ON REFORM

1970–80

Challenges for Change and Reflections on Reform

1970–80

The Seventies started with the widespread uncertainty invariably concomitant with the gestation period of prospective structural reforms. In the case of the NHS the proposed changes looked to be substantial affecting all three parts of the Service.

The general objective of the changes was to make the NHS as a whole more efficient. It was all too evident however from the Trust's experience that the lack of measures of efficiency and effectiveness in the institutions making up the NHS meant it was not going to be easy to judge the effect of the structural reforms which hardly touched the many problems identified within the infrastructure. These were accentuated by the policy adopted by the Government of financial reallocations following the Report of the Resource Allocation Working Party (RAWP).

To indicate, illuminate and analyse these problems became a major objective of the Trust, its resolve strengthened by the contemporary uneasiness in the health service research field because of the possible limiting effect of the 'Rothschild' proposals which were accepted by the Government for the support of research. This aim involved improving the 'intelligence' arrangements, commissioning position papers, and the convening of expert groups to look at specific issues.

The eventual result was a significant expansion in the seminar and publication programmes over the period.

All these activities were greatly helped by the taking over of No.4 Prince Albert Road which allowed for the installation of a well-equipped seminar centre there, so providing in both buildings, sufficient facilities for private meetings and a Library and Archive specially geared for developing the 'intelligence' arrangements.

By the middle of the decade, despite the reforms embarked upon the general criticisms of the NHS had multiplied and a Royal Commision was appointed. Its Report which followed the passing of the consolidating measures of the NHS Act 1977, did little to still the general criticisms of health policies by the increasing number of special interest groups. Nor did the Commission make any significant recommendations for health service research; and those it did in that important area, were never implemented.

The Trust therefore saw no reason to change its policies of seeking to analyse and discuss the complexity of the problems of health care, including now such key matters as quality assurance and the place of health services research in improvement.

I. REACTIONS TO IMPENDING CHANGE

1. UNCERTAINTY BREEDING INSECURITY

The beginning of the Seventies was one of great uncertainty for health care. By the end of the Sixties there was a widespread belief that the NHS and its organisation required reform. This was kindled by the hope of achieving greater efficiency. Yet over the period from 1968-73 of the issue of the Green and White Papers and eventually the 1973 legislation, it was evident that the proposals for the NHS evoked those feelings of insecurity on the part of the workforce which invariably tend to accompany change and affect morale. The Trust continued on the courses it had embarked in its belief that it had a part to play in the analysis of the elements of the infrastructure. This was based on its experience and perception of the crosswinds in health affairs, in a society more aware of the inter-dependability but becoming less assured of the stability of the welfare institutions which had been established since the end of the War.

It also became more firm in its belief that responsibility for research should include provision for the publication of its results. It accordingly continued the development of its arrangements to publish reports and essays on health service research. It became even more convinced that these, together with the detail in its own periodic Reports would be seen as significant movements in their own right and more substantive indications of achievement in the use of Trust resources than an annual publication of lists of grants made with their attendant objectives expressed as intentions.

Historically it is not unlikely that the first years of the decade may well be marked as a time noted for successive traumatic domestic crises in public institutions in the United Kingdom as a whole, as a direct result of reforming legislation affecting both local government and health care. The National Health Service which has a virtual monopoly of the health services for the people of the UK, the improvement of which as they relate to the major part of the country, may be said to be part of the main purposes of the Trust, mirrored the national problem and did not

escape its share of crisis. During the same time, unfortunately, the chronic, largely financial restrictions facing health service developments were compounded by those inevitably arising from the prospect of and eventually from fundamental changes in the structure of the NHS following the NHS Act 1973. These helped to disturb somewhat the institutional stability of the service gained over the 20 years of its existence, since they involved the virtual submergence into the larger entities of Districts and Areas, of existing institutions including Teaching Hospitals with established traditions, some venerable, some of no greater age than the NHS itself but well established.

2. THE ATTEMPT TO IMPROVE THE STRUCTURE OF THE NHS

The period cannot be seen in perspective without an appreciation of the fact that the more significant of the changes effected were administrative in character and instituted by Acts of Parliament with the principal objective of improving the integration of the health services and to some extent paralleling geographically the changes in local government. In particular, the over-all aim of the first Green Paper in the late Sixties, was to effect a restructuring of the three branches of the NHS in order to rationalise the management arrangements of the NHS, if still on a geographical basis, into comprehensive regional and area authorities.

Yet the impression was inescapable from the onset that what appeared tidy in organisational charts, were in effect largely inadequate blue-prints, albeit designed for the improved working of a social welfare service of great complexity which in the event for effectiveness, depended on personal relationships between the key workers in the vast array of authorities which provide the 'comprehensive' services. Indeed it was to identify the many problems in the infrastructure that directed the Trust to the policy of developing linked seminars on a wide variety of issues touching many institutions for which papers were commissioned and the proceedings of which were later published.

In retrospect the major dislocations which took place in the mechanism of administration and the fact that the running-in of the new machinery coincided with a period of high inflation with its attendant anxieties at all levels, were undoubtedly and

sadly prejudicial to a successful establishment of the high morale which was hoped for as a result of the 1973 NHS Act. It is no exaggeration still to maintain that high morale is a *sine qua non* for an effective therapeutic and care service of whatever form, in any society. Indeed it was a fundamental belief of the Trust which had frequently been stressed before and since the changes which took place, that no government can afford not to have the establishment of other than the highest morale as the first priority in its policies towards the provision and regulation of health services. All considerations and policies concerning change have to be judged against their resultant effect on morale.

A high morale had always been taken for granted in the NHS which was initially launched successfully from a peak of enthusiasm, even though the economic atmosphere in 1948 and immediately after, was bleak. But the period of uncertainty and foreboding in the early Seventies caused by reform and the straitened circumstances of the time, gave cause almost for the first time for doubt about the continuance of the NHS as originally envisaged. The resultant doubts gave yeast to the thought expressed in Trust publications that there was need for a thorough examination of the assumptions on which health services have operated hitherto. In particular, it posed urgent questions about the need for imaginative leadership at all operating levels as well as for tolerance and compromise, as essential elements in good management in the face of differing ideologies, if the high morale necessary to the effectiveness of the complex of health services was to be cultivated and sustained.

3. EFFICIENCY AND THE PROTECTION OF THE INDIVIDUAL

The organisation of the modern state with its bureaucratic machine designed to pinpoint ultimate accountability and responsibility does not lend itself easily to the kind of exercise necessary to question some of the concepts which tend to support the *status quo*. Accountability, too, shapes the operating mechanisms, because their power drives depend almost completely on public finance as virtually 'sole source' funding of health care services. Radical reform to secure the kind of effective devolution for example, which might exploit local administrative genius had never been seriously debated.

Again there was no suggestion of a conspiracy of silence or worse from the centre, but invariably it is ignored that because of

their basis and nature, public policies tend not so much to stifle, as to fail to include provision for the nourishment of the critical atmosphere necessary both to protect the individual and permit publicly financed systems to develop effectively in the face of inevitably narrow political, professional, and even administrative interests.

Nor was it certain that the post-Rothschild arrangements for health service Research and Development which dominated the research scene in the Seventies, was likely to provide this. Indeed it was not long before questions were being posed about the implication of the 'customer/contractor' principle on policy research viz.,

'What hope of support is the customer-critic likely to get by way of funding from any part of the system: and will he/she be allowed or encouraged to publish criticism?'

Such questions were the reason for the Trust with its long established interest in Health Services R and D to explore research management and publish in the Seventies a number of treatises on the findings which had bearings on the effectiveness of the management of research on the management of services.

4. WHAT IS GOOD MANAGEMENT?

Questions about the requirements for efficient and effective management in the NHS began to surface in the 1970s. Indeed the philosophic bases to the art of the possible in good management in the case of health services seemed perhaps to be a little insubstantial. There seemed to be dangerously jagged edges to the ultra-narrowness of sectional views which gave cause for anxiety to those whose interest is in the overall improvement in the quality of health services and their effectiveness in therapy and care. Yet since effective health services which is the test of 'efficiency', must be the objective, the politics, whether party, professional, or sectional have to note the realities. Confrontation of any sort within an organisation tends to obliterate reason and good judgment and is prejudicial even to the best of management. While the 1973 reforms stressed 'consensus management', on many of the sectional and professional sides, in the early Seventies there was the beginning of a show of truculence by the Trade Unions towards Authorities and other interests. This foreboded ill for collaboration and the future working of services dependent on a division of labour but with a

requirement of co-operation between individuals belonging to a variety of bodies and interests of differing social values and of quality, professional and non-professional.

The over-all effect of the rows between unions and management which marked the middle period of the decade with its distasteful incidents arising from the forces of confrontation and of threats of withdrawal of labour, exacerbated an always delicate position. Indeed a strong case was emerging for a complete reappraisal of the realities against which the narrower political and sectional assertions could be judged.

There was some speculation in the Trust publications and Reports whether it was not too soon to try and theorise about the rights and expectations of patients in this day and age, to sketch if not a Bill of Rights, then a schedule which might serve as a guide against which good 'Authority' and 'Professional' practice can be judged such as had been the objective of Dr Stephen Taylor's study of General Practice. In the highly complex area of health services it was for speculation that such a schedule may also be in the event an aid to good management, for it became slowly evident it was perhaps time to examine the effect of the potential regulatory as against the reality of the executive functions of government in relation to the authorities and other statutory bodies having health functions. There was a general feeling gaining ground that the need for this might still be more urgent than at first sight might appear. Thus could we in Britain be far from providing for a system of continuous review of professional standards with all its attendant drawn-out traumas for which even the US Government had seen fit to legislate, in an admittedly different set of circumstances, but primarily with quality of service in view? It was this that lead to the development of the Trust's interest in **questions of quality** including the place of education and training.

5. THE LACK OF AN OVERALL VIEW

As the Seventies began, with the threat of reforms in Local Government and Health Services hanging over the political and administrative scenes it was clear from the Trust viewpoint and experience, that the many interrelated problems of health services were immense and unlikely to be totally cured by structural changes. There was also not much evidence of an over-all view being taken of the implications of the complexities at central government level. It is, however, the ability of the

independent body concerned with improvement to focus on issues which give rise to wide anxieties and effects on institutional as well as on individual morale, and yet to take an over-all view that gives a special point to its role in improving services albeit in an era beset with a series of different and possibly less complex problems. This was the reason for the comment in the *Ninth Report* (1970–75), with particular reference to the exercise denoted as *Challenges for Change* which sought to identify the major problems which would remain after the reforms proposed.

If the importance of such bodies with regard to the direct financing of services has shrunk over the years not only have they discovered an important brokerage role in relation to many of the bodies concerned with health services, but they are still free to probe and inquire. They can also develop in different ways the forums of high quality on which there is some prospect of reason and operational compromise emerging as victors for the public weal, over selfish and short-sighted attachments to narrow ideologies and professional and sectional privileges.

6. A FRESH LOOK AT GRANT-MAKING POLICIES

This was no more than indeed the general line of approach which had been adopted by the Trust from its inception. The record of publications shows it continued during the decade to act as an independent observer of hospitals and associated medical services, commissioning studies etc., which could contribute substantially to the knowledge necessary on a basis for the practical experiments and demonstrations which it was hoped might complement the results of research. A notable feature which reflected the high cost of applied research was the strengthening of the change in emphasis of approaches to the Trust, in that there were even fewer applications for the introduction of experimental and developmental services, but many more for studies and reviews.

It was felt that the continuance of the decline in the volume if not the quality of applications for outright grants for services noted in earlier reports was probably as the result of three developments.

The **first** arose from the nature of the ever-increasing sophistication of grant review accompanied by the rising cost of all research and development, which meant that it had become evident to researchers that if the projects were to stand much

chance of securing approval, they had to be both more imaginative and scientific in conception than ever before.

The **second** lay in the vastly increasing competition behind applications, arising from the increased resources for research which were even greater than remarked on in the *Eighth Report* in 1970. The origin for this was the increased allocations by the Health Departments for Health Services Research and Development, although it seemed from a critical viewpoint, in many cases this was not accompanied by a sharpening of the assessment procedures of the DHSS and therefore made for an easier passage of applications to eventual funding by the Department.

The **third** derived from the vast cost of creating and assessing experimental alternative services within the NHS framework which meant that for optimium effect the Health Departments and Authorities had to be involved virtually from the beginning in all research which was likely to recommend innovative schemes dependent on demonstrations or experiments. The shortage of finance for service needs from Government however greatly militated against experimentation by the Authorities.

7. THE BROKERAGE CONCEPT

The effect of this on Trust policy was to accelerate the trend noted earlier towards the recognition that the best policy would be for the Trust to act more and more as an independent agent for the brokerage and development of ideas and for the encouragement of even sharper critiques of underlying concepts. Such a policy gave greater accent to the Trust's role as an 'Institute' with the primary objective of the improvement of health services.

Its resources were accordingly utilised more and more for 'intelligence' work both internally and through commissions to sharpen the focus on issues not fully covered by the Health Departments' operations in the field. Indeed it was felt that the need for independent action on this front was demonstrably acute, since for the Administration to support research which might end in the publication of criticism of policy would require a degree of liberalism in research policy which had never been too obvious hitherto. This was later to be confirmed by the reaction to the Report of the Royal Commission in 1977 which had little or no discernible impact on Government policy. As far as the complex infrastructure of the NHS is concerned, in the

absence of external pressures, a bureaucracy of such complexity is hardly likely to respond quickly to the needs revealed by speculation and inquiry into certain aspects of health services particularly those concerned with policy. This is not to claim much for the independent observer except perhaps for an optimistic outlook. Some of the results of research supported by the Trust and communicated through its publications and its connections at many levels, may have been noticed but seemed rarely to have been acted upon.

Yet it was also evident that the need for independent thought and judgment on the many and varied aspects of modern health organisations, including policies, would become even more pressing as more critical attention was being given to long-held general concepts of care, cure, and prevention. The very complexity of such issues as the assessment of the effectiveness of medical intervention and its cost in relation to general medical care which is a key element in quality of care studies, and the need for rational choices of the balance to be struck between institutional and community care, and priorities for action related to the cost of modern medicine, were seen as condemning the over-simplification and trivialisation which tend to abound in the discussion of policies in health care from all sides of both the political and professional spectra. The position in health matters pointed to the need for a more balanced view of the realities. Above all, it called for better-based criticisms and judgments about what could be done practically than tended to be the fashion on the all too facile comment and observation from some of the media.

8. THE NHS AS AN 'AUNT SALLY'

It was a matter of note that part of the trouble, of course, was that by the late Seventies it had become universally obvious that the term 'The NHS' is a something of a misnomer in that it is not a service in the sense that it is a single entity. In reality, overall policy for the Health of the public or even the NHS had never been hinged on a General Staff Organisation with a firm 'Intelligence' base. There was possibly, at least it was hoped there was, a general Departmental policy, but that is not the same as arrangements for arriving at policies to ensure the optimum in comprehensive services dealing with all aspects of health and disease, with interrelated short-, medium-, and long-

term considerations developed into comprehensive plans of action for the Public Health.

It is moreover hardly possible nowadays to improve the personal health services unless they can be seen not just as clinical services, but in the full context of the contribution to the society in which they exist. It is significant of the broad view seen as relevant and indeed necessary that it was a distinguished clinician Sir David Smithers who in 1974 summed up the thesis, quoted in the *Ninth Report* because it encapsulated the Trust's overall view:

> advances in science depend a great deal on the way in which we look at problems; they depend on asking better and better questions. Population methods in dealing with health have proved far more effective than individual methods. Improvement in health over the last 200 years or so has been due to limitation of family size, good food supplies, better environment, prevention and curative medicine in about that order - certainly to family planning, nutrition, hygiene and immunisation, long before treatment.

9. A GENERAL STAFF APPROACH - SEMINARS AND PUBLICATIONS

The Trust's efforts since its foundation and increasingly over the years, had indeed been largely devoted in effect, albeit in a modest way, to selecting its interests empirically in a kind of General Staff operational activity in relation to health matters, to the asking of better and more practical questions about improvements and how best to achieve them. Thus, in relation to the observation quoted above, before the view was widely (and now almost fashionably) held, the Trust had over the years pointed to the ultimate importance in using population methods for a wider sweep of purposes, from containing the incidence and prevalence of diseases, to the evaluation of the effectiveness of screening techniques and of therapies. It is undeniable that this approach must still, even in 1990 be a priority in policies regarding health affairs.

Population medicine was given a special accent in 1974 in the new reorganised health service, with the emergence of the community physician specialty. It was maintained by the Government that this was not intended in concept as an old-style Medical Officer of Health , but rather a development in function and education to meet the need of the times and as such would have been so recognised by such as Simon and his illustrious

successors in the field. To the Trust it therefore almost seemed then, that epidemiological methods were likely to be reviewed and applied as never before and this belief had its effect on its policies. Among these was a grant to the fledging **Faculty of Community Medicine (now the Faculty of Public Health Medicine)** to help draw up a constitution in the belief that that body would be a leader in the promotion of the concept that the reorganisation of the NHS, if it was to mean anything, should be providing the distinctive population-selected laboratories for scientific methods to enable scientific advances to be applied at the right place and at the right time.

It was also recognised that the best atmosphere for advances in this direction is an understanding of the vital forces affecting health in our society. It will be seen from the list of activities that the main thrusts of the Trust's inquiries which increasingly used the means of the private seminar programme, were being devoted to a succession of probes into issues fundamental to a better understanding of what determines health and what can be done about it by way of public policies, not just in reviewing the effect of existing institutions, but by seeking a better conceptualisation of the issues embracing health in all its aspects (105-128). To do this involved the mobilisation and analysis of the best available 'intelligence' about health matters and the sharpening of various intelligence techniques to explore concepts, review activities, synthesise conclusions, and to point to further thrusts to future actions.

As a necessary complement to this, as is reflected in the approach to research, a major policy was to continue the development of the publications programme in an effort to help the creation of a literature for the wide dissemination of ideas which deal adequately with the great range of issues raised by the expansion and ever-burgeoning complexities of the health services. This inevitably tends to pose the need for special and differential analyses of a myriad of often separate and sometimes contradictory policies. The establishment of a literature whether as a combination of knowledge and understanding or more specifically in pursuit of specific issues resulting from such analyses, requires no justification at any time, but the publication of essays and books not exclusively on work supported by the Trust, was becoming in itself an important part of the Trust's policy in creating an atmosphere of serious intellectual enquiry in which many disciplines can participate with benefit for all.

That these also lead frequently to the highlighting of gaps in knowledge and to speculation and projections about future developments hardly needs pointing out. Indeed the world-wide reception of such books as *Screening in Medical Care* in 1968 and as a virtual off-shoot, Professor Cochrane's stimulating *Effectiveness and Efficiency* in 1971 led directly to the appointment of a Trust group led by Lord Rosenheim (116) with the aim of reviewing and prompting activities concerned with **the quality and effectiveness of care.** This subject was deemed likely to be soon a major issue, whether as a regulatory matter or as a necessary part of the exploration of the better use of limited resources and as a prerequisite of rational action for improvements in care.

10. HEALTH AND SOCIETY

It will be evident from all its publications that the over-all concern of the Trust was not exclusively with the problems of personal health services. Reviews of the effectiveness of health services can only be a partial contribution to a better understanding of health in the society in which we live. Although the provision of medical and associated health services have come to bulk largely in social policies, one of the features of the early Seventies was the emergence of the realisation that for all their function to cure and care in response to the emotive forces of personal illness, health care has to be placed in a wider perspective in which the influence of all the prime determinants of health, the genes, behaviour, and the environment must be considered and given their relative weightings in a less emotional consideration of public policies related to health generally. Professor Thomas McKeown who had been Chairman of the Screening in Medical Care Group and was also a member of the Quality of Care Group (116) set up in 1972, brought this particular thesis to public and professional attention in his controversial Rock Carling monograph *The Role of Medicine* (1976). This theme has sometimes been characterised by the reflection, and increasingly so in recent years when the debate in such issues has become more popular, that in exploring these issues, new ground is being broken in the philosophy governing health policies; but indeed the observation is old, going back many years, albeit possibly given greater point and perspective recently.

Any individual starting afresh to survey the health field

cannot fail to stumble across the evidence of past prophets apparently crying in the wilderness about the need to pay more attention to the major determinants of health, the effects of which are relatively more important than services. Indeed it is interesting that although the theme had come up again and again in the seminars and publications of the Trust during the period under review, it was not new but fundamental Trust doctrine which is almost as old as the Trust itself.

This theme was taken up in the *Tenth Report* (1975-80) to promote the point by a historical review and the argument bears reproduction at this point in this History of the Trust as it encapsulates an important perspective to the Trust's activities.

Thus, it was noted that in the Canadian Government's important pamphlet *A New Perspective on the Health of Canadians* (1974) acknowledgement was made to the ideas developed by Professor McKeown, himself a Canadian Rhodes Scholar, in an essay in *Medical History and Medical Care* (1971) and while giving credit to the improvements which have been made in health care in recent years, specific reference is made to the

> ominous counterforces which have been at work to undo progress in raising the health status of Canadians. These counterforces constitute the dark side of economic progress. They include environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns which put the pleasing senses above the needs of the human body. For these environmental and behavioural threats to health, the organised health care system can do little more than serve as a catchment net for the victims. Physicians, surgeons, nurses and hospitals together spend much of their time treating ills caused by adverse environmental factors and behavioural risks.

There is a strong historical attachment of the Trust to the essence of this thesis and many of its policies, past as well as current, are rooted in the general concept.

Indeed it will be realised that possibly the first mention of Social Medicine in a modern concept was by Sir Farqhuar Buzzard, the Chairman of the Trust's Medical Advisory Committee, in his Harveian Oration at the Royal College of Physicians in 1941. Professor John Ryle, the Foundation-holder of the first Chair of Social Medicine in the UK, in the University of Oxford, which in 1943 was established through a Trust grant (and the first Director of the Institute of Social Medicine in Oxford, also set up by the Trust in 1943) had to say of Social Medicine:

Social Medicine means what it says, it embodies the idea of medicine applied to the service of man as 'socius' as fellow or comrade with a view to a better understanding and more durable assistance of all his main and contributory troubles which inimitable to the active health and not merely to removing or alleviating a present pathology. It embodies also the idea of medicine applied in the service of 'societas' or the community of men with a view to lowering the incidence of all preventable disease and raising the general level of human fitness.

Again, Sir John Charles in the first Rock Carling Monograph, *The Social Context of Medicine*, published by the Trust in 1962, returned to the theme and in pointing to the development of Jeremy Bentham's invention 'Mesology' the science of the means of obtaining happiness, detailed Lois Adolph Bertillon's concept of the social mesology of man.

He suggested that as a discipline it would be concerned with the effect upon human beings as individuals and in society of temperature, light, humidity, gravity, atmosphere, pressure, meteorological and electrical influences, food and drink, urbanisation, sanitary conditions, occupation, domesticity, religion, institutions, laws and psychological factors. He emphasised the importance of the economic situation of the family, vitality, viability of children, were governed to an astonishing degree by the home conditions and by the presence there of poverty or of comfortable circumstances. According to Bertillon 'there are only two possible ways of modifying man, either individually or in the mass.

(i) By modifying his ancestry which is possible so far as future generations are concerned but extremely difficult to apply.

(ii) By modifying the natural or social environment.

Another early interest of the Trust, the field of Industrial Health, over which many questions still remain, was initiated in 1945 with the establishment of the Chair of Social and Industrial Medicine at the University of Birmingham, the first holder of which was Professor McKeown. It was continued subsequently in the support given to the Slough Industrial Health Service at Farnham Park and to the Harlow Industrial Health Service in recognition of the importance of environment in man's working conditions, and because occupational health services were excluded, as they still are, from the NHS.

In the concept of the then current 'New Look' at health in which increasing attention was being paid to the major

determinants of health, these observations had a familiar ring in the Trust's history.

It will be evident from the record of activities that these ideas continued to surface in different forms and contexts in many of the probes carried out as well as in the seminars organised by the Trust. They influenced the Trust's outlook on policies as they indicated the universal application to current problems of the thesis that health is a concept concerned above all with the individual which in the context of health service provision and organisation can only be ignored at peril.

11. THE COMPLEMENTARY NEED FOR QUALITY ASSESSMENT

Above all they also pointed inexorably to certain trends among which was the increasing realisation of the need for assessment of quality as a precedent to choice, institutional or individual. Because this raised controversial clinical questions it seemed almost certain to be one of the major issues in the future expecially so if, regrettably, the sense of vocation which had been one of the prime elements of attitude of health service staff was overwhelmed by other considerations of a more material nature. It was considered that such a result as had proved to be the case in other Western societies, such as the United States, would almost certainly entail a higher degree of personal (and legal) accountability from those providing services, with all the attendant anxieties involved, than had obtained hitherto.

12. THE SEAMLESS ROBE OF HEALTH CARE

It was against this background that the Trust continued the function of looking at the total health scene, at both philosophical and operational levels, not only because there appeared to be no official machinery at Departmental level or in the NHS for so doing, but because even if such machinery did exist unheralded, there was increasing evidence of the need for independent critical views on health services and on many specific matters of material and philosophical interest to the whole population in general. Indeed it is arguable that independent bodies constantly and critically surveying the particular field of activity might well in the main have to ensure if not constitute the requisite institutional memory, and sometimes perhaps even the institutional conscience of society as we know it today. Such

independence becomes the more quintessential at times when the future is distorted by the anxieties of many individuals and institutions providing personal health services about the possible effect of radical policies on health care.

Yet during the decade this conviction of the need for independent assessment was complemented by the sober reflection noted by the Trust that if the depreciation, due to inflation, of the material resources of independent bodies like the Trust continued, there would have to be substituted in time, some means of the public financing of independent critical views of public policies and their results, to provide necessary checks and balances. Indeed some prominence was given in the *Ninth and Tenth Reports* to the notion that some consideration would in time have to be given to the setting up of a body independent of the Executive financed out of public funds as an assurance, like the Ombudsman concept, against the faults, if not actually the tyrannies which could arise from political, professional, and administrative opportunism and the expediencies which often involve *ad-hoc* action and which may lead to long-term problems. It was recognised that this would require a permanent commitment on the part of Government since it would not be possible to develop and continuously review research policies without heeding the course of events in the ill-defined and vastly complex health care universe .

The Trust, while accepting the prime role of the hospital, saw it in the context of health as a whole and developed their policies according to the tradition which had been established of taking a critical view of major issues in the whole field of Health to include not only diagnosis, treatment and care, but also the active promotion of health and its complement, the prevention and containment of disease. This inevitably posed questions of selection and an empirical approach.

As the Seventies were entered and change was in the air, the real question emerging was whether the real challenges to the effectiveness of the NHS were being met: and if not, how best to explore them.

II. EFFECTS OF THE REFORM

1. HANGOVERS DESPITE THE REFORMS

It had long been evident that the Trust with its limited resources and powers could contribute only marginally to the debate on

structural issues, except by way of analysing the problems and pointing to evidence to remind the authorities that there are underlying universal and reactive questions attaching to modern health services which can only be lost sight of at some peril if effective services are the objective.

The way in which Trust policies were developed and their general direction may probably best be illustrated by the course of and dividends from the *Challenges for Change* operation which began in 1969. The uneasiness about the original Green Paper in the late Sixties which seemed to concentrate only on form and structure and to omit or ignore the assessment of possible after-effects was the reason for the assembly of a small but greatly experienced panel of experts which embarked upon an investigative exercise which culminated eventually in the production in 1971 of the book *Challenges for Change.* This consisted of a collection of specially commissioned review essays by the panel's members, based on the discussions at the seminars.

The collection was launched as (in the light of what has since transpired) a reminder of some of the major issues with which the to-be-reformed Health Service would have to be concerned, no matter the form and structure finally selected. Indeed, passing quickly over the now academic question whether the reforms involving the administrative dislocations that resulted were altogether necessary, the reason for the setting up of the group and the commissions, was that it was clear early on that the reforms were going to produce management problems of their own, as administrative equivalents of the iatrogenic effects now recognised as consequent on certain therapeutic actions.

Once the path of reform, leading on into the undergrowth of likely consequences was taken, the exercise illuminated many problems which could only be dimly sighted in the original debate on the effect of structural change. Thus an immediate follow-up of the 'Challenges' exercise showed that it was doubtful if any work had been done to plan or even to assess the vast amount of detailed work on the information requirements of the several authorities involved, prior to the change, to allow for a smooth handing-over of functions to the new all-purpose authorities. A study was accordingly commissioned from a small group based in the **Nuffield Centre for Health Services Studies at the University of Leeds** (7), and the report of the findings was published in 1973 under the title *Si Vis Pacem . . .* Like *Challenges for Change,* its publication was timed to be a guide

and help to the joint liaison groups set up to smooth over the problems of change. To judge from its reception and sale, it was widely consulted in the run-up to 1st April 1974.

This was a problem relatively easy to distinguish and tackle through a special commission by an *ad hoc* expert group as part of the 'intelligence' mechanisms being fashioned by the Trust. Yet the other questions which emerged from the *Challenges* exercise languished in the wilderness of inaction because of the management dislocations experienced in the NHS as a result of the reforms. This gave further weight to the suspicion that the lack of the means for identifying and adopting a long-term policy for Health was a threat to the effectiveness of the NHS as a whole.

Primarily one of the major questions in *Challenges* was that of morale in a labour-intensive service, and while it is possibly the case fortunately that the administrative reforms had little or no immediate direct effect on the clinical management of patients, it is nevertheless true that one result of the changes was to disturb for some time the fine balance of cohesion necessary in a complex service depending a great deal on the sense of vocation. This being so, the immediate over-all effect of these reforms was judged by many to be somewhat negative, a view borne out by the dissolution of the Area Authorities some eight years later.

The cumulative effect of the subsequent nurses' and doctors' crises in the Seventies, - that is on those individuals concerned with providing services closest to the patients - linked with the fall in the morale of the administrative staff as a result of the administrative disturbance, was disabling if not a little short of disastrous. The fear that was expressed in *Challenges for Change* with regard to morale well in advance of the changes, was thus unfortunately borne out. The question which posed itself was how the ground so lost over these years could be recovered if the NHS was to maintain its position as a highly regarded institution in British society, far less how it could be developed as it ought to be.

Indeed, practically all of the subjects of the essays in *Challenges for Change* could be considered as important items of an agenda of likely problems which those responsible for Government policies should have had before them in both the run-up to the reform and the period immediately following the date of implementation. These included **The Quality of Care, The Organisation of the Consultant Service, General**

Practice, Community Medicine, The uses of Information and Technical Change, The Unification of Services, Decision Making, Staffing the Service and Notes on Administrative Theory.

Altogether this confirmed the lack in the NHS 'system' of General Staff and Operational thinking with regard to policies of a comprehensive character and the effect, a fact originally noted in the *Fifth*, of the Acton Society Trust pamphlets published in 1958. It was felt, to take a contemporary parallel extant in the Seventies, if there was a case for an independent Central Policy Review Staff (CPRS) for general Government policy, was there not equally a case for the establishment of a body capable of acting along the same lines for health policies? Indeed the question was later asked specifically in the publication *By Guess or by What?* (1978), a complementary volume to the earlier *Framework and Design for Planning* (1977) which together highlighted the failure to devise a comprehensive policy for the use of information by health service management.

The *Eighth Report* had noted it was, however, a hopeless stance merely to lament the past or absence of official mechanisms and be so fearful of the future as to do nothing, and fail to face the hard realities of the times. Indeed the exercise of thinking the unthinkable might have a positive effect if it stimulated those who in the end take decisions, to face realities.

A small group of senior administrators of the reformed NHS assembled in 1976 by the Trust (124), while alarmed at the fall in morale, concluded not altogether surprisingly that although times were hard, efforts must be made to make real the thesis that the realities of a shortage of resources required could make this a time for opportunity for a New Look Service.

What was significant, if certain responsibilities were delegated and support was given to the operational levels, the members were confident the reformed authorities could do the job they were being geared to do, if full authority was not denied them. Further explorations in greater depth, to test what may be involved, were planned and are reflected in the subsequent programme of activities.

This line of assessment and exploration was an outcrop of a continuation of the *Challenges for Change* series of seminars. The vehicles for exploration took the form of several probes into questions related to monitoring how health services were coping with their responsibilities and to exploring what the priorities

were likely to be, as well as what could be done administratively in the future to improve the effectiveness of services related to resources.

The conclusion was forming from the seminars and research that moves must urgently be made to distinguish the fundamental requirements to make devolution to Regional and Area Health Authorities the reality it must be. The managements responsible would also require adequate support to be given to enable them to tackle particular local problems. This objective went far beyond propping up the existing services or even reallocating resources but would involve a greater delegation of responsibility and authority downwards than ever before.

2. PREVENTION, SCREENING ETC.

For the long term, it was felt the authorities must urgently consider what could positively be done in the next phase of the development of health services especially by way of services designed specifically for **prevention,** if the best use was to be made of the slender resources available. Once again this was primarily a question which involved a comprehensive review of health policy on the part of Government.

Indeed the question of what prevention really means became worthwhile pondering. The publicity given over the previous few years say to screening for breast cancer, raised technological, conceptual, as well as logistical issues of providing services inasmuch as there are many closely related practical problems, which were likely to arise from the operation of such services and are part of the general issues of screening populations raised by the screening exercise in 1968. Such general questions need total commitment too by a wide range of specialised interests.

Thus, the paper *The Future of Epidemiology* in *The Future and Present Indicatives* (1973) was an illuminating essay by Sir George Godber lately the Chief Medical Officer, on the theme of what might be achieved in the long term on the basis of current knowledge if the right moves are made in planning and instituting appropriate services. Other variations and implications on this theme are included in many of the publications.

The Trust's long-standing interest in screening was continued by the publication of two further essays by Professor Knox of the University of Birmingham, which are major contributions in the history of the literature of community medicine. The first in *The Future and Present Indicatives* (1973)

sketched a simulation system for **cervical cytology screening** programmes. The second in *Probes for Health* (1975) outlined a similar system for **breast cancer.**

All of these essays took considerably further the debate on prevention (and to follow up a theme in *Screening in Medical Care* (1968) the place of prescriptive screening in it[1], as well as the responsibility in planning of community physicians who have to be alive to the possiblities of preventive action. Moreover they were also important reading for all those who have a non-specialised concern for the need to develop truly comprehensive policies for health services since they touched on key matters of **prevention** about which there was considerable scientific knowledge on which good preventive practice could be based. While acknowledging that all the implications had to be weighed against established traditional care in the balance of resource allocation, it was found that action was imperative if the reformed Health Service was to exploit its more positive and sharp management organisation for preventive work and meet the growing consumer expectations.

3. THE COMMUNITY COUNCILS

There was one intriguing part of the reformed service to which special attention was given since it brought in for the first time, the consumer interest. This was a review of the concept of **Community Health Councils.** The official literature issued in advance of their formation was somewhat slender as to guidance: indeed as with so many new initiatives, the desirable complement of the education and training of their members to provide a background as a guide to practice was lacking. It was felt therefore that it would be important to look urgently and closely at what was really likely to be involved in the setting up of Community Health Councils. A group based on the **Nuffield Centre at the University of Leeds** was commissioned to explore the basic needs of the Councils in relation to what was expected of them. An interim report was published as *Mounting the Health Guard* (1974) which was widely greeted as an important primer for Councils. The same group was invited to study the Councils in action in their first year or so (40). It was already clear the concept needed a great deal of attention on the

[1] Greater responsibility with regard to the health of populations have now been placed statutorily on Directors of Public Health (ie. previously community physicians) by the NHS Act 1990.

part of those responsible for central policy if these were not to be breeding grounds of frustration, cynicism, and indeed anger which could well spill over into public consciousness. If the Councils were to mean anything at all it was already evident they would have to concentrate on the things they could do best, and not try to duplicate the functions of the health authorities with which they have to deal. Unbiased comments if soundly based are desirable, if not always welcomed by executive authorities. The resultant publication was *CHCs in Action* (1978) which discussed the positive features of the Councils and indicated a need for special encouragenent.

4. UNCERTAINTY IN RESPONSIBILITIES AND ACCOUNTABILITIES

Indeed it was felt the question of the interrelated functions of all authorities in the health and allied social services could not be left to float. There was **prima facie** evidence of uncertainties about responsibilities between the different executive levels already in the tri-partite Service, and it gave rise to the thought that more fundamental work would have to be initiated essentially by the Department and the Authorities to explore how the various bodies at each level might best function to fulfil the objectives of the reforms. Unless this was done there was likely to be grave misunderstandings with regard to responsibilities and action. This question too could not be divorced from that of how effective the theoretical devolution of power to the Authorities was in practice, and how the relative responsibilities of each level lay with regard to specific policies on services and whether the reforms had indeed provided a more responsive and efficient management mechanism.

This had a special bearing on a question relating to a hangover from the previous organisation: the reorientation and continuing education of the 'top administrators' in the 'old' health service for their functions as managers in the 'new'. It was a subject needing urgent special exploration and considerably more than the *ad hoc* action which seemed likely. The relevance of good continuing education and training arrangements are necessary if decisions on both policy and planning are to be effective. This was specially brought out in the seminars concerned with the **future of epidemiology** (105), the functions of the **medical advisory structure** (108,109), and the **use of information for management** (117,122,123). An

over-all assessment of the training needs of all staff in the reorganised health service and a policy to fit requirements seemed overdue.

5. INFORMATION POLICIES

A long-standing relevant question which was also highlighted was the adequacy as well as the utilisation of the **data system** (24,25,26,31,35) which is the basis of good information for the public as well as for management. Two publications produced by firms of management consultants during the period, *Focus on Medical Computer Development* (1970) and *Foundations for Health Service Management* (1972), gave point to the earlier criticism of DHSS computer policy, especially in its failure to link up with the all-important general policy about the use of data for health services. Any effective development in the sector of information collection, collation and handling presumes above all the building of confidence between the management of the various authorities concerned and the clinicians, based on a full understanding of the accountability and responsibility of each individual concerned in the complex institutions which constitute the health services in modern societies. Aspects of these problems had long been subjects for special studies supported by the Trust. These indicated the need to keep the confusing effect of seemingly separate official policies for the garnering of information for clinical and management purposes and the use of technology, under constant review. It was felt it was time to look at both the quantity and above all the quality of information being generated for different purposes and how it was used for decision-taking.

6. CLINICAL MANAGEMENT

This reflected at the time the needs of the organisational side of clinical medicine where for all the activity of the previous few years which had resulted in the 'Cogwheel Reports', the forward movement towards better co-ordinated organisation had not been sustained at the rate hoped for. *In Low Gear* (1971) was a sobering reminder through an assessment of the 'Cogwheel' system in operation which was disappointing, of the yawning gap between conception and practice relating to organisational as well as professional issues.

7. COMMUNICATION IN HEALTH CARE

The general question of communications in medicine (89,121) both between the profession and patients, and intraprofessionally was taken into the Trust's programme following the monograph *Communication in Medicine* (1973) by the 1972 The Rock Carling Fellow Professor Charles Fletcher, who raised certain problems which proved to be a starting point for some cautious exploration in this important area.

[Later publications dealing with some fundamental issues involving communication were *Communication between Doctors and Patients* (1976) and *Mixed Communications* (1979). Further investigations into the complete range of problems which arise and what can be done about them were taken up by a specially assembled group of doctors which resulted in a subsequent publication at the end of the decade *Talking with Patients* (1980)].[2]

8. MEDICAL EDUCATION

An important area of policy in the previous fifteen years was that concerned with the setting up of **Postgraduate Medical Institutes** throughout the country in the non-teaching district hospitals in accordance with the recommendation from the Trust's Christ Church Conference in 1961. At the same time there had been certain problems in the development of medical education as a whole: undergraduate, postgraduate, and continuing. Problems were being identified in the new medical schools, and the general prospect for postgraduate medical education (that is the point at which service needs are often inextricably mixed up with educational requirements), were studied in specially designed seminars. A distinguished panel convened to review developments since 1961 looked specially at the latter problems and an account of the conclusions of the meeting was published in *The Way Ahead* (1974). This report was acknowledged as of value to the (Merrison) Committee of Inquiry into the Regulation of the Medical Profession. The Trust also published in 1976 the two volume Report of the GMC Survey, *Basic Medical Education in the British Isles*, the first ever of its kind.

[2] Others published later in the 1980s were *Doctor to Doctor* (1984) and *Talking and Listening to Patients* (1988).

9. RECRUITMENT

On an allied yet more specific line and of immense importance to effective service, the question of **recruitment to the shortage specialties in medicine** was probed by a specially convened group in which there were representatives of the Royal College of Pathologists, the Faculty of Anaesthetists, and the Royal College of Radiologists. This was part of the Trust's interest in **manpower and human resources** which dated back some considerable time as a key subject meriting special consideration because of the problems posed for the future of shortages in such specialties. After a series of 'intelligence' seminars on **manpower policy** an attempt was made in the late 1960s to set up a special unit on manpower at the **University of Glasgow** on a shared finance basis with the Health Departments, but it lapsed because of the death of the Professor provisionally designated as its Director. Following a review of the position, finance was made available by the Trust to set up a small research unit at the University of Glasgow on a more modest scale than was originally planned, to undertake basic reseach into the subject.

Because of the importance of the role of the established professional specialist groups, the Trust had for long taken the line of helping professional specialist organisations to bolster their educational and, where appropriate, research activities. Examples of this were the grants made to a number of the **Royal Colleges etc., for education and research** (5,26,38,52,64,69,83,100,129).

10. MENTAL HEALTH

The policy concerned with the exploration of problems relating to the mental health services was continued. Six books on psychiatric matters were published during the period, two of these *Approaches to Action* (1972) and *Policy for Action* (1973) being based on seminars assembled by the DHSS at which current research and action on mental health matters being pursued by the Department were reviewed. These publications identified key problems and possibilities for research in this very difficult and crucial area of service. The use of population methods was also highlighted in *Psychiatric Epidemiology* (1970), *The Mental Hospital in the Psychiatric Service* (1971), *Evaluating a Community Psychiatric Service* (1972) and *Roots of Evaluation* (1973).

11. THE YOUNG PATIENT

The problems of the young had always had sympathetic consideration. It is perhaps worth noting specially that the conclusion in *Stress in Youth* (1971) that for effective therapy one must get to the root of the problem at a very early stage in the first few years of life, and that there are important social and environmental factors involved going well beyond the accepted scope of health services, has echoes elsewhere and has policy implications.

The sobering message of *The Formative Years* (1974) was that the major factor in the handicap of children is the social class of the father. Yet what is to be made of the implication that the health services, however therapeutic their design, seem to be of limited value weighed against the effects deriving from certain social factors, and failures to gear therapy to the time factor?

Developing this particular line of interest, but again as part of the thesis that the influence of responsible professional bodies has to be a recognised fact of life in these days of participatory government, the considered views of the British Paediatric Association on the policies affecting child health which should be pursued in the future were made available for public comment through an 'Occasional Hundred' publication *Paediatrics in the Seventies* (1975).

At the same time, a collection of essays *Bridging in Health* (1975) the reports of studies on health services for children, both from the academic and the health care planning team view, and deriving mainly from projects supported by Trust grants, was also published during this period. These studies showed that success or failure for such services depends on how well health care planning teams do their work, in particular identifying local needs and providing the essential leadership to achieve solutions.

12. MEDICAL ENGINEERING

Frequently there are issues concerned with health services on which little attention is focussed because the subject has so many facets, with many authorities involved, and there is no machinery for reviewing the complete field. For a number of years the Trust had been interested in **medical engineering** (11) of which there are many aspects and indeed many definitions of what the term comprises. A private report was commissioned under the aegis of Professor Douglas Holder who had been

Chairman of a Committee of the Royal Society which had looked at one aspect of this problem. Special grants were made in this field, one of which, mainly as the result of the success of earlier grants to the Bath Institute of Medical Engineering, helped to establish a **Chair in the University of Bath** (96) which it was hoped would stimulate greater academic interest in this sector.

13. HEALTH SERVICE RESEARCH

The subject of research generally and its management has always been among the prime interests of the Trust, and during the period which saw first the publication of the 'Rothschild' report and eventually the acceptance by Government of its general principles, special collaboration with the DHSS resulted in the publications *Portfolio for Health* (1971), *Portfolio for Health 2* (1973), and *Positions, Movements, and Directions* (1974) which together formed a unique compendium of informed criticism of publicly financed research, as well as providing an outline of policies for research and development of the DHSS which was now responsible for the major part, if not quite having a virtual monopoly of the field of health service research. Among the matters studied and reported on were the place of **research units** in the scheme of health affairs, the **basis of their financing, the direction of their thrusts,** and the question of a **career structure** for health care researchers, all still contemporary issues.

On the same tack, the 1977 Rock Carling monograph was an account of the Scottish experience by Sir Andrew Watt Kay in *Research in Medicine* which gave pointers for a more rational policy for England.

A grant was made later to the distinguished political scientist **Professor W J M Mackenzie** to look at the after-effects of the application of the **'Rothschild' recommendations** with regard to health service research. This resulted in *Power and Responsibility in Health Care* (1979), which is a splendid conceptual analysis of the problems of governmentally funded research, which those responsible for policy would do well to study, since such problems are always likely to be with us.

14. THE HISTORICAL AND PHILOSOPHICAL PERSPECTIVE

It was becoming strikingly evident from all the activities that to be effective health policy must be looked at as a whole, a

message which was underlined in the publications *Medical History and Medical Care* (1971) and *Patient, Doctor, Society* (1972). The problems explored in these are universal and the subject of many of the essays remain applicable today if we are to learn the lessons of the past.

Thus the British-American seminar (5,269) of distinguished medical scholars from both countries which resulted in the publication *Medical History and Medical Care* sought to explore and evaluate the history of human experience of disease and the effects of genetic and environmental factors including the social and economic aspects, in order to put contemporary health services problems in a realistic perspective.

It was recognised there were also many current problems in which decisions about priorities were inextricably mixed up with the evaluation of services and certain ethical considerations because of the way in which significant technological advances in medicine and important scientifically determined knowledge are accepted and applied.

It had also become increasingly obvious that on occasion the interest of individual patients, the research community and society as a whole can often be in conflict. This was the general area explored in the seminar on which *Patient, Doctor, Society* (106) was based. In 1990, a study of this collection of essays still gives a sharp spur to speculation about the inadequacy of certain of the bases of current health policies.

15. THE BALANCE OF CARE: INSTITUTIONAL OR COMMUNITY BASED?

Indeed on the general topic of the indivisibility of policy relating to health care organisation and institutions, the question of policies concerning the balance to be struck between institutional and community care continued to be a subject of interest as it still does in 1990, especially because of the different authorities involved. One of the indications from the early operational research supported by the Trust was the urgent need, in order to make the best use of resources, to determine the right **balance between institution-based and community-based services** which would in turn indicate policies required in a variety of different authorities for **capital, manpower,** and **education and training.** It was known that the DHSS for some years had had an **Operational Research** group looking at this subject, but little was known and nothing had been published of

their conclusions or their effect, real or potential on Departmental policies. Yet the balance to be aimed for in the future was one of enormous interest to all concerned about public policies and their direction. The conclusions of such an official group were likely to be far-reaching in effect if they were to be incorporated in official policies: yet there was no indication of their conclusions.

Consequently a seminar (123) consisting of a group of critically but sympathetically minded people interested in the application of techniques of **operational research** was organised in association with the DHSS to review some of the work of the DHSS's OR group relating to strategic policies over the **balance of care** between institutions and the community. As the body almost certainly first in the field of the application of OR techniques to the problem of health services and sympathetic towards their development, the Trust's credentials as brokers between the researchers and their critics was hardly in question. The review ranged over most of the problems of method and application and it is hardly surprising that a policy that was comprehensive to ensure advances on both of these fronts at the same time was recognised as necessary. But perhaps one of the most important observations from this review was that the production of macro-models as a help to central policy formation is limited. It was effectively demonstrated that this is largely because of the difficulties of including in any worthwhile model, such measurable factors relating to influences as the behaviour of both institutions and individuals.

The fact that the overall problems were not fully explored then, has meant for example the carry-over to the 1990s of the major problem arising from the failure to ensure there is adequate provision for those mentally ill and handicapped patients, discharged as a result of the policy of running down the institutions for chronic patients.

16. LOOKING ABROAD

It was a long term policy of the Trust to look beyond the UK to see what is happening in health affairs elsewhere. There had been for some considerable time an exchange of information between the Trust and groups concerned with research in the USA where many of the Trust's publications were well known. During this period too there had also been close collaboration with the **Institute for European Health Services Research**

at Leuven University which carried out for the Trust a survey for health services research in five of the then six EEC countries, using the *Porfolios for Health* as a model guide to their relevance to the British interest (13), This resulted in *Community Health Investment* (1976) which had been preceded by an English version of a definitive review *Prelude to Harmony on a Community Theme* (1975) from the University of Leuven on the harmonisation of health service policies in the original six member countries of the EEC. The essays were introduced by a Chapter by Professor Gordon Forsyth relating these policies to the British scene. During this period too, the Trust collaborated with *The Lancet* in publishing on the occasion of their 150th anniversary *Health Service Prospects* (1973) which consisted of essays commissioned from indigenous experts on the problems and strengths of health services in some twelve countries.

17. A COMPREHENSIVE HEALTH POLICY?

If the health services have any hope of being truly comprehensive they should be concerned with issues not exclusive to the personal health services with which the NHS is primarily concerned. The related questions of **environmental health** (119), **health education** (80,86), and the provision of health care for people at work ie. **industrial medicine**, were all subjects for special exploration. The latter was a long-existing interest of the Trust, and the Harlow experience was a demonstration of how industrial medicine should be linked with the general medical and the hospital services especially in relation to the clinical requirement of having complete information about the health of individuals in a particular community. The fact that industrial health and the effect of environment on health was excluded from the reform of the NHS in 1973 (yet another instance especially commented upon at the time in Trust publications of the lack of co-ordination in health policy) underlined the criticism that there was currently inadequate consideration of the total health picture.

The history of the links between **environment and health** (125) were reviewed in a special seminar. The implications for medicine and the personal health services as well as the personal social services, especially in view of the reorganisation of local government were great and it seemed clear there was a need for an exploration in some detail, preferably by Government, of all the implications.

A subject for another seminar was that of **health education** (86) which for too long has popularly been more associated with warnings and exhortations *via* the communications media, than as a matter of major policy. It was evident that the broad concept that there should be greater concentration on modification of behaviour as a major element in the prevention of ill-health needed differential analysis, and that the implications of behaviour must be integrated into consideration of general health policies. A special study (80) was commissioned to try and bring all the relevant concepts concerning health education together.

18. EFFECTIVENESS AND QUALITY

The move which began in the commissioning of the review by Professor Knox of Birmingham of the scientific evidence extant about screening of cervical cytology in *Problems and Progress 2* (1966), and developed in *Screening in Medical Care* (1968) had been taken further in Professor A L Cochrane's Rock Carling Monograph *Effectiveness and Efficiency* (1972). The world-wide demand for copies of the book which was reprinted twice and which has also since been translated into Italian, Polish, French, German and Spanish, was an indication of the widespread interest in examining the effectiveness of screening, and what were becoming extremely expensive therapies based on technologies which themselves are scientific, but the effects of the application of which to service are often less scientifically assessed than is generally assumed. The entry into public debate of the thesis by critics such as Illich, that therapeutic performance had hardly matched the expectations raised and that there had to be a more sensible view of what can be done by way of intervention to check the development and eradication of disease, posed the question of how to raise the level of necessary inquiry into the issues involved, as well as the complementary public education about personal responsibility for self-care and health maintenance.

The Trust's policies over the years had been designed to attempt this. It took as a hypothesis (and used it as a text in the *Ninth Report*) the kind of approach distinguished by Sir David Smithers in the article in 1974 already referred to, who while writing specifically in connnection with cancer, pinpointed this particular problem relevant to health services as a whole.

The way in which cancer problems are usually presented to the public does little to make them any easier to solve. The idea that this is a disease the causes of which can be discovered and the cure from which will one day be provided is encouraged while its true nature is a very mixture of disorganised reactions to many inciting agents and the successful prevention or control of many of its forms are neglected. A false expectation of miracles is thus combined with an under-estimate of the present high level of achievement. Some fresh thinking, replanning and plain speaking are needed and might do a great deal of good.

Probes into questions of the **assessment of quality** do not imply the denial of the need for putting the best possible effort into therapy and improving the organisation of services. But assuming that there never will be enough resources to meet all demands, it was concluded by the Trust that one of the problems of the future might be more stringent requirements than hitherto to assess what the quality of any therapy, new or existent, is likely to be.

Hence the Trust's taking up the exploration of the range of problems involved in assessing the quality of care (116), which has at its heart the management requirement to ensure a more effective allocation of resources. There seemed to be an acute need to analyse the issues involved.

This entails a range of multi-varied appraisals, and the lists of studies initiated during the period indicate the complexity of the subject of quality assessment. The requirements in terms of the requisite information to establish public confidence in policies relating to private, professional, and institutional accountability are many, and involve a great array of bodies. Above all they overlap decisions about making the best use of all-too-slender resources, and add to the complex management problems which have to be resolved in any system providing health care. *A Question of Quality* (1976) was a collection of illuminating essays summarising the conclusions of the distinguished panel of doctors steering the enquiry and pointed to the complexity of the issues and the work in progress to illuminate this.

III. BITTER LEMONS

1. A GLOOMY PROSPECT

In general by 1975, the more publicly debated current issues were the residual problems following the 1973 reform of the

NHS, compounded with the administrative difficulties arising from the tight financial position of the Service and unrest about pay, particularly about the differentials between the multitudes of professionals and para-professionals involved in the NHS. It has to be appreciated that these problems, mainly arising from a political decision about the reform of the NHS to a large extent paralleling local government reform, were not of the stuff which offered opportunities for Trust action on structure, other than recognisably as transient elements which have to be taken account of in the continuous appraisal of the major problems of health services. There were and will always be, however, a number of issues in the infrastructure of both intermediate and long-term character, most of which are universally non-political and non-structural and which will always attract the research-minded.

The later years of the decade, however, presented a more sobering picture of health affairs in the UK. They included the disappointment caused by the failure of expectations roused by the reforms provided for under the 1973 Act to make appreciable differences in terms of service, and the unease at every level engendered by the assumption that further reforms were likely to follow.

Other major influences were:

1. the onward march of inflation which affected the health economy no less than the economy as a whole;

2. the increase in conflict and confrontation which were stoked by a new militancy in industrial relations at every level in the NHS - possibly a reflection of the uneasiness in the country generally, fuelled by inflation, and inflamed perhaps more than it need have been by the controversy over the place of private medicine and the reduction in the original provision made in the 1946 Act for pay-beds (section 5) in the NHS. The effect of the latter cut more deeply into medical morale than the situation warranted and because of the medical profession's leading position tended to have repercussions in the health care work force as a whole;

3. the traumatic effect of the policy initiated by the Labour Government (and carried on by their Conservative successors in 1979) in restricting finance for the rational development of the NHS to allow for little more than the maintenance of existing levels of service and

4. not least the perplexities introduced in a period of restricted finance by the Government discussion paper *The Way Forward* which forecasted switches in resource emphases according to certain priorities. The general uncertainty was made worse as a result of the quite separate report of the *Resource Allocation Working Party* (RAWP) which forecasted and indeed preceded switches in central funding to adjust the major differences in resources allocated to the several Regional Health Authorities.

It seemed to be conventional wisdom that the gross expenditure in the public sector had reached such a critical proportion of the gross domestic product that it had to be severely restricted to avoid jeopardising the economic health of the country as a whole. This hypothesis deepened uncertainties and anxieties about the future of the NHS, since there was no sign of either alternative or supplementary strategies designed to ensure increased funding for desirable Health Care developments reflecting technological and demographic change. Like so many aspects of the national economy, it was evident that the major problem of the future would be to determine priorities for action and to decide policies to reallocate roughly the same amount of resources without undue dislocation of a system geared to expectations unlikely to be fulfilled across the board to the satisfaction of all interests. The failure to convert the principles embodied in the White Paper on Government-financed research to help in these and other problems of the NHS was yet another sobering feature which confirmed the sensibility of the Trust's policies to keep identifying the issues which were likely to bulk large in the the foreseeable future and to use its resources to place them in realistic perspective.

2. THE ROYAL COMMISSION

The appointment of the **Royal Commission on the NHS** bred no little cynicism, since it appeared to be a temporary palliative to a series of crises across the social spectrum, some political in nature, which gave rise eventually to a widespread demand that something ought to be done about health services in the UK. In the event the Commission proceeded staidly from 1976 to 1978, some optimists seeing the Commission as a promising supply ship of state, while others regarded the appointment of such bodies as Royal Commissions as a political ploy designed for less

complex institutions and times. Nevertheless the Commission existed, and the Trust helped the Commission by organising special seminars, in one of which it arranged for experts from abroad to attend to sketch what was happening in health care in a number of countries.

In the event the Commission did nothing during its life to change much in the NHS, nor did its Report lead to the solution of any of the obvious problems of the NHS or influence greatly other health matters. Moreover, it is doubtful if the recommendations together with the general reception of the Report, materially relieved or even promised relief for any of the major pressures affecting the performance of health services in the UK: rather did the reception of the Report confirm the earlier doubts about its worth and deepen the gloom which surrounded the NHS as it approached the 80s.

3. THE INVESTIGATION OF IDENTIFIABLE PROBLEMS

It had always been the practice of the Trust in addition to reacting to the immediate problems as perceived by its Trustees and staff, as well as by the wide circle of associates and friends it had drawn to it over the years, to look ahead and and seek gaps in services and in knowledge. This is characterised by identifying problem issues, re-examining existing assumptions and concepts etc., and with its publications to give greater depth to debates.

This role was greatly helped when in 1972 the Crown Commissioners offered a lease on No.4 Prince Albert Road to the Trust. The building was remodelled as a modest seminar centre, also allowing for the development of the existing Library and Archive in No.3 Prince Albert Road as a more suitable base for the 'intelligence' exercises.

The priorities which emerged from the differential of the ongoing reviews of the health scene depended greatly on a sense of what was pragmatically possible by way of research, timing and opportunity. Above all, it had become apparent that to have independent bodies studying and analysing the problems of health outside government circles is a definite requirement in our complex society, even if apparently little notice is immediately taken of the result of such enquiries by those in authority.

The general economy in Britain may be a mixture of private and public action, with a bias towards the former, but there is little reflection of this in health care, nor in the research

arrangements for investigations. Yet the sheer preponderance of public resources devoted to health care in the UK makes it imperative for there to be to hand independent means to monitor the often seemingly random processes and directions of policy by the Health Departments as well as by those other Departments of State concerned with health issues.

The supplements to publicly financed research are those provided by Foundations. Such bodies above all provide opportunities for independent thinkers to offer the results of research involving the numerical sciences or more philosophically based observations on the concepts and policies which rule the current scene. It is not an exaggeration to suggest that the bureaucracy inseparable from public monopoly and applying vigorously the consumer/contractor principle of the Rothschild character might well be reluctant to fund studies in sensitive areas of policy which might result in criticism of quality likely to spark off demands for intensive investigation or more resources. The existence of independent sources therefore for the funding of research is an important insurance against political expediency.

Again, while there may be rocky hazards in the health scene, there have to be islands of hope on the road to improvement. The notion on which the Trust was founded is a form of utilitarianism which implies that society in all its manifestations can be better ordered and improvements ensured by action based on as much scientific knowledge as can be gained and applied. In the case of health it is rooted in the belief that the advancement of scientific knowledge, whether basic or applied, furthers the wellbeing of individuals and of society. The issue is more complex than is often accepted in simple political terms, because the many influences that bear on personal health are too often ignored in many of the simplified solutions put forward. Occasionally these are virtually the compromises accepted by the bureaucracies involved, to meet the expediencies of the times.

It was now accepted that the major difference in the Trust's operations since its foundation in 1940 was that the cost of experimentation and demonstration put these desirable complements to studies largely out of its reach. Nevertheless the belief was fundamental that the results of good health care research will ultimately prevail and management will inevitably have to react if effectiveness in both quality and economy is to be achieved. There was a strengthening of the underlying hypothesis that in the absence of an active role in research by the Health

Authorities themselves, the Trust had an important function in focussing attention on the major issues through its 'intelligence' programme identifying faults in the infrastructure and what could reasonably be done about correcting them.

4. OPTIMISM AND SELECTIVITY

By the mid 1970s the optimism which was generated in the first half of this century about the contribution of advances in science to the improvement of health and which was a powerful spur to the idealism on which the NHS was founded, had been somewhat tempered. The uncertainty about the roads to improvement had been modified by some of the work sponsored and published by the Trust and the critical reaction to it. In the early days there was little doubt about the success of the information which had flowed from such research as the Hospital Surveys and 10 years later from the Investigation into the Function and Design of Hospitals as well as from the Postgraduate Medical Education initiative. Now, 20 years after the increasing sophistication of observations about health and the NHS in particular was showing the complexity of the issues concerned with improving the quality of the care services.

During the previous few years the observations made in *Screening in Medical Care* and by **Cochrane, McKeown,** and **Dollery** in their *Rock Carling Monographs* about the effectiveness of screening, of therapies and of preventive measures, had made the Trust known on the world stage. Particularly the need to question the results from apparently spectacular scientific advances is of universal validity, even although the commissions on such matters which resulted in Trust publications were made in the context of the UK problems and Trust purposes.

Yet one conclusion to be drawn from Dollery's Rock Carling Monograph *The End of an Age of Optimism* (1978) was that we ought to be more cautious in our hopes and so more selective in our choices how resources ought to be applied. The day of ever-expanding finance for services whatever their value, seemed to be drawing to a close; and accordingly there was need for a more intensive analysis of cost and benefit than the bland acceptance that any service (or for that matter research subject) related to the person is good, and that increasing all services (and research activity) is very good. But equally, and particularly in hard times

the great challenge is the more fruitful selection of priorities for improvement and ensuring that scientific knowledge is applied to the optimum in cost and benefit for society and the health and wellbeing of individuals.

Some of the paths chosen will inevitably involve political choices, but the intellectual objective of observation and research transcends political ideology, for it depends on the belief that eventually truth will prevail. Part of the thesis is that it is not too optimistic to hope that scientific knowledge will inevitably be applied rationally for the relief of suffering, which is a prime purpose of health care: but while it seemed inconceivable that health care would ever become a political/ideological battleground it has to be accepted that the decisions taken on priorities for the common good at a particular point in time might themselves be politically inspired. It has been fundamental doctrine that it is inappropriate for a body such as the Trust to take a prominent part in debates of a political character. In the long run, however, it is the belief that the **effectiveness** of any policy can be assessed independently and scientifically to judge whether improvements even in attitudes have indeed taken place. In any event it was becoming clear that there are activities which transcend politics and which must figure in any programme for improvement.

Thus the Trust felt and it is reflected in the record of its activities that it was unlikely there would be a loss of faith in the need for improvements in **research** objectives and methods to increase the sum of human knowledge, or to help decide what has to be done to promote positive health and the prevention of disease. It was also becoming clear that an important element in this is **education and training.**

As far as service needs are concerned it was also believed there would always be a wish on the part of society to improve the arrangements which have to be made, not only by way of therapy to redress illness, but to provide the **care** necessary for the too **easily neglected groups in society, the handicapped, the elderly** and in certain respects **the young.** Yet these activities and many more which contribute to better services were likely to involve greater public expenditure. The question (which will always continue to be posed) is how in a period of limited resources, can the question of priorities be pursued and the objective of improvement be achieved?

5. A RE-EXAMINATION OF CONCEPTS ...

It is for these reasons that the Trustees felt that the Trust should continue to develop the 'Institute' role albeit modestly, particularly on conceptual thinking and analysis, in demonstrating the need for better arrangements to achieve **improved quality of care, better education** and **training,** and a more rational approach to **support research, both basic and applied.** Much of the future depends on the outcome of the settlement of these issues, as well as on various major aspects of management which could be tackled scientifically, such as **information** and the deployment of **manpower.**

It was becoming ever more evident with the bewilderment caused by the public expression of views from every direction and level of society, that there must be continuous re-examination of certain of the concepts concerned with health under which we in the UK have laboured for years. There was certainly not much evidence that such a continuous review was taking place and developing, as part of public policy.

It is of course not altogether surprising that bureaucracies at central or at dispersed local levels fail to tackle problems of policy in fundamental terms. Because of well-established interests and immediate pressing problems they naturally tend to look inwards at their own domain rather than to seek to formulate policies which involve the crossing of administrative and sometimes professional boundaries. It was this kind of consideration which had stimulated the abortive Central Policy Review Staff (CPRS) paper *Joint Framework for Social Policies* (JASP) and which was very much of the character of the thrust of Trust policy. The suspicion that the failure in application lay at the doors of special interests was confirmed recently[3], when it has come to light that the reason for this lay in the bureaucratic system itself, since its implementation would have cut across existing well-established interests in a number of Departments of State. Yet the need for a system in which cross-the-board considerations can be applied, is important.

Independent bodies with wide terms of reference can concentrate on and draw attention to the effect the lack of joint policy has on the problems of special groups served by many interests. They can also seek to put in general perspective the power of sectional vested interests which can and occasionally do set up unnatural constraints, some of them exemplary enough in

[3] See Hennessy P in *Whitehall* Secker & Warburg (1989)

professional terms and rational enough to the principals concerned. An independent body can if it wills, examine the results of any action, however inspired, unhindered by fear, or other constraints. Yet another aspect of unbiassed independence is that it is unprejudiced in approach, by considerations explicitly or implicitly political. Such restraints may well apply in the case of the direction of research to be commissioned if it appears that the likely results might point to unacceptable (in purely bureaucratic or financial or ideological and so political terms) lines of action.

6. ... AND THE MEANS

There is no simple choice between leaving such questions either to God or Caesar. The previous thirty years or so had indicated that the idea that many matters could be left to intellectual exercises by the academic world was recognised as false in itself, for even in the best of times the academic community is not well geared to such a role, and their now chronic financial problems are not likely to make for any closer gearing.

Equally, there are severe drawbacks at the other end of the spectrum in government, and it is all too clear it would be just as unwise altogether to leave the funding of research and all conceptual thinking to those invariably concerned with immediate practical (or political) problems, who can more easily attach research only to the directions in which their chariot-wheels are already moving. Indeed it had become apparent that the role of the independent private body, in which a Foundation can more easily have the role of honest broker, is even more important in that the public version. The Quasi-Autonomous Non-Governmental Organisation (QUANGO) had become by the late Seventies much maligned in a society where independent sources of ideas etc. are of great importance, because increasingly the amount of public money for research had put government in a near-monopoly position. Indeed by the late 1970s there was some evidence that the 'customer' principle for initiating research which was a feature of the Rothschild proposals seemed to have been virtually elevated by the bureaucracy to a principle of inaction, which had its effect on those seeking research funds. This made it more and more likely that the use of such funds would be governed and evaluated on what results are likely to be achieved. This was not it must be said as a result of a sinister policy, but probably rather more for administrative convenience. This gave yet more point to the role of the independent

Foundation deploying its resources on research and to build up a network of 'intelligence' sources which enable it to draw on so much knowledge and experience for its studies and commissions.

By the mid-point of the decade it was seen that the increase in knowledge gained in the previous fifty years or so in many disciplines and having a bearing on health, was so great that there seemed to be a requirement for a capability for the assessment of the implications of a wide variety of research. This is equally applicable to all institutions concerned with health services including the Health Departments since any kind of body with pretensions to policy analysis and policy formulation should have such a capacity to sort out the valid and important from the humdrum. There were doubts whether the Commons Select Committee on Social Services which had recently been appointed was likely to be so general and powerful enough, not only to address itself to the general question of 'intelligence', given its construction, scope, financial backing and staffing.[4]

Another requirement of such an 'intelligence' capacity is to have some knowledge of what activates current public policies and what is likely to influence future policies, both at central or operating authority level. This was seen as particularly important in the case of the UK where there is an enormous volume of public funds being pumped into a hideously complex system in which public policies are inextricably mixed and modified by a variety of ideological and professional policies and ethical considerations affecting practitioners, all of them reacting on the quality of the services available to patients. It is hardly surprising therefore that the often obscure workings of and varied influences in such a system are frequently misunderstood, even by participants concerned with local considerations.

The major problem still to be recognised is how the results of the vast amount of good research can be fed into and be used for the improvement of the system of Health Care.

IV MORE CHANGE IN PROSPECT?

1. TOWARDS THE THIRTY YEARS MARK

The Trust has always had the firm belief in the indivisibility of health care as a concept, which has constantly been reflected in its policies and programmes. Many of the parts of these have

[4] These are still there in 1990, and indeed it may be significant that a quite separate Health Select Committee has now been appointed.

been inter-related, some of them interwoven and the whole intended to advance the policy first conceived in the late 1940s, namely 'the study and solution of some of the questions that need to be answered before the National Health Service can provide the best possible service to the patient, medically, socially and economically that the community can afford'. Its attitude to policy analyses and the studies to make these possible, had been shaped into a commitment to research throughout the years, without losing sight of the personal nature of health services in cure and care, the quality of which depends in the essence on human skills and personal attitudes of those engaged in health care. As consciousness of the 30th Anniversary of the Appointed Day for the beginning of the NHS loomed, issues affecting those parts of the spectrum of health for which Departments of State other than the DHSS are responsible, began to be identified.

2. THE GENERAL APPROACH

In summarising its position at this time, the Trust accepted that no Foundation operating in the public service sector is likely to be for long in a position financially to compete with Government in developing services, but it could have a unique role in its independent stance in research and intelligence, and in the communication of perceptions arising from well-conceived studies. Indeed, the policy of the Trust had evolved that if it was to avoid a standard practice of responding merely to haphazard applications for support, it had to develop as a continuity an 'intelligence' base and network as a foundation for selecting issues for investigation. At the same time there had to be a complementary policy of ensuring the communication of the results fom such work. Experience had led the Trust to choose to do this latter by a combination of publishing books and essays by individuals of a wide variety of disciplines, on health service matters, and of organising seminars and forums which because they are private, allow for frank discussion on fundamental issues, when sometimes opinion is still in the formative stage.

The importance of the accumulation, selection, publication and judicious use of 'intelligence' as a means of avoiding wasteful effort in both research and development and of achieving the maximum output from limited resources, hardly needs stressing. It is a truth equally applicable to both public and

private sectors and especially so in these chronically straitened times.

Yet in the public sector the concept of a specific mechanism for 'intelligence' gathering and use by the authorities at all levels as part of the operational system, was conspicuous by its absence, essential as this might seem as a preliminary to the identification of priorities. In the Rothschild principles concerning research, it seemed to be assumed as a matter of course that there was a governmental process for this which applied across the board and produced an ordered queue of 'customers' for research which could be applied. This may be so in Defence for example, but it is small consolation that its absence from the health scene leaves bodies such as the Trust with more opportunities to fulfil their purposes than otherwise.

3. THE EVOLUTION OF PROGRAMMES

A glance at the lists of the Grants made since the Trust's birth, the Seminar issues, and the Publications, the major of which appear in the Supplements at the end of each Chapter, will indicate the wide, if selective yet empirical range of the programme; and a reading of the literature which has resulted, and the reviews (sparingly referred to in this history which indeed form a literature of their own) confirms their relativity to the issues endemic to health care.

These constituted analyses of some of the major problems standing in the way of improvements in the personal services, and by the same token posed the need for a better use of resources. What distinguished the Trust efforts in the late Seventies from those in the past was they showed perhaps a greater appreciation of the range and depth of the investigations deemed necessary to provide a more solid foundation to the generally more sophisticated debates which were expected in the next decade to be even more intense than formerly. It seemed all too likely that the rising tide of public expenditure would come under increasing scrutiny with particular effects on the NHS from which there were ever-greater public expectations.

At the same time from the public debates on health services, and in reviewing the literature including what had been written for publication for the Trust in the commissioned books, papers and reports, it was clear that the major recurrent theme was the search for opportunities to **improve** the quality of services to individuals requiring cure and care. Indeed it was interesting that

an obligation to achieve 'improvement' had been specifically laid on the Secretary of State in Section 1-3 of the consolidating NHS Act 1977.

Leaving aside the question of more resources for the NHS which consistently ever since 1948 many have felt are necessary, some of the elements in **quality** clearly have to do with **professional standards,** others with **better professional education and training.** A special emphasis was being placed on greater efficiency through more **skilful deployment by management** of what many see as limited resources. This calls for improved **educational and training arrangements** for **all** staff employed in health related fields.

It has always been a beguiling thought to seek to solve the range of problems by structural reform of the NHS itself and eventually the advent of the Conservative Government in 1979 seemed to many of its supporters to provide an opportunity for changes in this direction. Nevertheless the incoming Government seemed determined to hold to the existing structure and financial arrangements and stoutly maintained 'the NHS is safe with us'. There was a growing feeling, however, that the structural problems had not been solved by the 1973 reforms and an appreciation that fundamental challenges for management at local level were likely to remain.

The 'intelligence' approach to many of the questions current towards the end of the Seventies did reveal a basic need for **better information** than was then available. The studies supported in this period by the Trust on **planning, resource allocation** and above all **information policies** were in effect new phases in the rational development of a number of previous ventures drawing attention to the need for the production of better information for management. These dating back virtually to the earliest days of the Trust were continued in the second part of the decade by such publications as *Measuring for Management* (1975), *Framework and Design for Planning: Uses of information in the NHS,* (1978) and *By Guess or By What? Information without design in the NHS* (1978) and *Patterns for Uncertainty* (1979).

Management in this context included not only the arrangements dealing with the organisation of services, but above all the requirement to assist the health professions to improve the **quality** of care afforded to patients. Some of the basic efforts in this direction obviously come within the category of **profes-**

sional practice and thus mainly require practical encouragement from management. This looked promising when the 'Cogwheel' Reports were accepted but in the event as had been indicated in *In Low Gear* (1971) the results in practice were disappointing.

As a private body the Trust in its continued interest in improving services directly concerned with patients, continued its policy of supporting ventures concerned with putting this problem in the context of the management of patient care and thus with improvement of communication between doctors and patients. During the period it published a collection *Communications between Doctors and Patients* (1975), and later it assembled a group[5] to follow up Professor Charles Fletcher's Rock Carling Monograph (1972). This culminated in the publication in 1980 of a specially commissioned booklet *Talking with Patients* designed for the medical profession.

The more recent Trust-associated literature on the subject of quality, viz, *A Question of Quality: Roads to quality assurance in medical care.* (1976): *Intimations of Quality; Ante-mortem and post-mortem diagnosis* (1977), with subsequent initiatives[6], made the case for better **information** as a fundamental requirement to the improvement in quality assurance.

All of these publications confirmed a long held view that an important element in assessing the effectiveness of services and developments in medical care lies in the application of epidemiological techniques. This had been a recurrent theme in Trust publications viz. *The Future and Present Indicatives* (1975), *Probes for Health* (1975), *Measures for Management* (1975), *Questionnaires in Medicine* (1976), and indeed in many essays in all the *Problems and Progress in Medical Care series* (1–12). It is indeed, incontrovertible that for effective economical advances in health care practice there have to be improvements in the production of fundamental data as the basis of epidemiological practice in clinical and public health medicine. This is not only necessary for the effective practice of population and community medicine but for improved scientific management especially in a publicly

[5] This group continued in being and later produced other booklets.

[6] There were also specially commissioned studies resulting in such as *Reviewing Practice in Medical Care* (1981), and **Professor A S Duncan's** *Review* of activities in this field which, specially commissioned and published in the *B M J* in 1981, is an important position paper.

financed system where personal and institutional accountability is specially called for.

Nor could the fact be long concealed that improvement in data inevitably require more resources directed towards that aim, which inevitably adds to the immediate cost of management but with a long-term pay-off. In the climate of the late Seventies, NHS managers seemed somewhat diffident to make the case that information is an essential tool of management and that research has an important part in service development. It was saddening to observe that the NHS with all its potential for the application of management science as well as the improvement and addition to knowledge through population and co-operative clinical studies, had not developed a better information system. The case for more investment in it seems self-evident and had continuously been made in a number of Trust publications.

This also particularly applied to the looseness of policies related to **manpower,** the most costly single item of expenditure in a labour-intensive service. The frailties of current policies were discussed in *Framework and Design for Planning* (1977) and in *Patterns for Uncertainty: Planning for the greater medical profession* (1979).

The grants and seminar series on **Information and Planning** (12,20,31,35,44,48,49,61,66,111,114,115,123) continued to present revelations about the lack of information policies related to the British health economy as a whole and of a somewhat haphazard approach to health planning and consequent policies. These confirmed that strategic planning, and credible resource reallocation at both regional and area levels in a publicly-financed service, must be based on satisfactory information if the measures stand any chance of success in establishing confidence in the approach to making the best use of resources. It has to be an essential element in policy that both the key professions involved in health care and the public must have confidence in the effectiveness of the management system.

Once again it was evident that this cannot be established merely by changing the structural form, the search for the ideal of which will be never-ending and never fulfilled since the success of which depends on many elements in the infrastructure including the human factors. The mechanics of collecting, processing, handling and using information, critiques of which had been set out in many of the Trust publications, and evaluated

for example in the SCRIPS (48) exercise in Scotland a report of which is in *By Guess or by What?* (1978), are all part of management policy, the constituent parts of which for improvement have to be identified and the effectiveness of which should be kept under frequent review.

Closely related to this also was the question of the effectiveness of **computer policy in the NHS** which had come under criticism from the Public Accounts Committee but had already been questioned in a Trust publication as part of the need to apply **Information Technology** (IT) (21) to the major problem of information for management. IT has always to be seen in relation to the many facets of information requirements as well as technological advances.

Thus in this respect it was questionable whether recent developments in microelectronics were being assessed at sufficient depth to judge how they could be applied effectively in a service which would increasingly have to gather and retain a great deal of confidential information about individuals at a number of points. The younger generation schooled in pocket calculators and the like from an early age, is quicker to grasp how it can benefit directly and effectively from the advances in technology than is widely assumed, and this would be bound to have its influence in time. Again, the large mainframe computer system as the principal base for information with all the inherent drawbacks of centralised staffing and confidentiality requirements seemed to have a limited future when power seemed likely to shift to the peripheral authorities and micro-computers of immense capability were being developed.

Indeed, it was concluded that the whole question of the critical evaluation and assessment of innovation, development and application of technology of any sort related to medicine, needed looking at as a major research task of its own, as was demonstrated in the case-study of the impacts of medical technology reported in *The Image and the Reality* (1978). Computer use and technology assessments are indeed part of the whole question of information collection and retrieval and their analysis for policies requires direction through the kind of general staff thinking which was certainly not available in the NHS then. This was specially noted in *By Guess or by What?* (1978). It was appreciated that a DHSS enquiry on information based on a Departmental Committee was under way, but its

terms of reference revealed its limitations.[7] In the absence of a mechanism for surveying the whole question of information and its use and developing an integrated policy for the NHS including the training of all personnel in the use of IT, a much more comprehensive Governmental enquiry based on a suitably composed and specially directed 'task force' seemed to be required.

A particularly sad example of the lack of a general staff operation was the clear failure of **effective co-ordination of health and local government services** in appropriate cases. This was a subject in which the Trust had long had an interest, even before the 1974 reorganisation of the NHS. The **Inlogov Study** (45) set up in 1979 and reported in *Matters of Moment* (1981), emphasised the special problems involved and commented on the disappointing performance of the joint financing mechanism set up to encourage co-operation between Hospitals and Local Authorities which had promised more than it had achieved; but the real indivisibility of care for special client groups was all too evident in the sectors of social welfare concerned with the 'disadvantaged'. The fact that some of the serious Press had taken the matter up, (*The Times*, 28–9 May 1980) seemed to have had little effect on Government policy.

The importance of **joint action in social policy** was demonstrated forcefully in 1979 with the initiation of a **study of the elderly** by a special group whose Chairman was Professor (later Sir) Donald Acheson, later CMO of the Department of Health. The conclusion of *The Impending Crisis of Old Age* published in 1981 was that there was a necessity to develop a joint partnership agreement between all the bodies, public and voluntary, concerned at local level, and positively including the family too, to make the best use of available resources to counter the problems posed then, but especially in the future when the problems were likely to be more acute. Certainly this exercise showed above all, how necessary it is to have a credible joint policy embracing the several Departments of State and the Health and Local Authorities.

The seemingly chronic problems of ineffective **health services research management,** its failure to build up and

[7] This was confirmed with the subsequent Report which was later analysed by a group assembled by the Trust some of whose members had been members of the Departmental Committee. A critical review was published later in *A Time for Decision* (1982).

develop research potential in the peripheral Health Authorities and in the Universities as a prime issue of policy, continued to be reviewed in a series of seminars (122). The need for the present arrangements to be urgently reviewed and weaknesses diagnosed had been indicated in the *Portfolio for Health volumes I & II* (1971 and 1973), and *Positions, Movements and Directions in Health Services Research* (1974). To these were added further reviews viz. the 1976 Rock Carling monograph by Sir Andrew Watt Kay which set out the more far-seeing and productive Scottish position on the subject in *Research in Medicine* (1976), and *Five Years After: A review of health care research management after Rothschild* (1978). The message was that if there was to be more than a token obeisance to the need for some effective research the general question of the place of research in the scheme and management of health affairs and how it should be organised, had to be taken much more seriously than hitherto. It was difficult to believe that the application of a comprehensive scientific policy to aid management could be effectively developed without one. It was sobering to note that there was no longer even a token 'Council' for overseeing DHSS funded research since the dissolution of the Chief Scientist's Research Committee.

The Trust's special group consisting of distinguished members of the Research community operating in the field, continued to analyse and comment on this aspect of government activity because it was felt there ought to be some external monitoring of the near-monopoly held by the DHSS as agents for 'customers' and the effects of their decisions, on researchers as 'contractors'. Failure to establish confidence among potential researchers is always likely to threaten the future of this important sector; and more specifically the confidence of the University Departments involved, which need to operate in an atmosphere of encouragement and positive consistent policies.

The fundamental belief of the Trust stretching back to its foundation, was that health services research is of a utilitarian character and at its best should lead to improvements in service. It is relevant that the Trust had sought for many years before the event, to make the case for substantial research funds to be deployed by the Health Departments and at the time of the publication of *Portfolio for Health* (1971), the future of an expanding official programme appeared to be secure. By 1980 it seemed evident, however, that the unsatisfactory state of

research management on the part of the major funding agent could only lead to the fear in the research community that the right amount and quality of stimulation would not be forthcoming to ensure successful activities at the research centres in the already hard-pressed Universities.

The order of **finance** available, its management and deployment, are probably the critical areas in which most of the problems of health services are rooted, which puts a premium on good research to ensure 'value for money' excercises. It is in monetary terms that shortages and imbalances can be expressed and frequently are, publicly and forcefully. Sometimes there appeared to be an over-simplification of solutions, to the effect that there seems to be a constant belief that most problems can be solved by the allocation of more money. Because the future seemed to hold out a prospect of dilemmas in the selection of priorities as a consequence of pruning expenditure rather than of options of allocating greater resources, the question of efficiency and effectiveness needed to be probed at a number of points, often where relevant information is lacking. It may be (as it is still maintained in many quarters) that the resources made available for the NHS were not enough. Reason demands, however, that what is allocated should be used at optimum efficiency; which raises questions of **independence, accountability, public responsibility** and above all how to measure **efficiency and effectiveness,** all of which will always be major challenges to management. In exploring the use of resources in the NHS, the underlying **assumptions and concepts** which give the NHS its particular shape and character have also to be taken into consideration and kept under continuous review since they tend to change subtly in detail. Again national and local organisational problems too often become entangled with professional dilemmas. Finally, policies involving financial expediency are often adopted in reaction to immediate crises which only tangentially have to do with long-term health service considerations, but that establish precedents difficult to disturb.

The way in which finances were utilised was seen as fundamental to the practice of **planning,** which in the modern state will always be a tool of management in one form or another and will need to have the means to fashion public policy rationally. Financial logistics including costing systems will always therefore have a significant place in financial policy; and

ultimately planning to be effective has to operate through the financial system. It became evident that the concept of resource re-allocation applied on RAWP principles on a Regional basis, with apparently a minimum of consideration of the relationship to service priorities at local level, or an appreciation of what is likely to be the result of the general formula designed for reforms being applied sub-regionally to Areas and Districts, was a recipe for confusion, and sometimes a disaster to confidence. Indeed, it was bewildering that there seemed to be little recognition in practice that priorities, planning and financial policies were inextricably linked, and appropriate studies of the effects of separate policies appeared necessary.

Promotion of health and the **prevention of disease** had long been recognised as major issues, but both have always been acknowledged as extremely difficult subjects to tackle. Lip Service is perpetually paid to the concept that prevention is better - and possibly cheaper - than cure, but very little had been done to realise the aim of having effective preventive services. Indeed, by the end of the decade, with the demise in 1974 of the MOH as an officer of the local health authority with statutory responsibilities for preventive policies in relation to the Public Health, there seemed to be no individual with responsibility for the concept at any level of authority. It was clear that an initial step would be to make an overall study of the subject and draw up a reasonable programme of action. As a start to a long-term 'intelligence' exercise likely to involve both seminars and special commissions, the Trust brought together a small nucleus of experts (119,125) to map out the approaches to the subject. This included developing a conceptual framework, examining the public health role in the machinery of Government and thus taking in the important issue of the liberty of the individual against what is believed to be the public weal.

4. TOWARDS A BETTER UNDERSTANDING OF THE COMPLEXITIES

In pursuing its purposes the Trust continued to concentrate on studying the policies behind health services operations. The invitational seminars which are probably best categorised as tactical/operational exercises aimed at assessing the options in policy for services, or as contributions to studies, sought to explore, to conceive (and to subject to critical review), hypothe-

ses or speculations based on commissioned work and publications.

Some of these in the past had led directly to important developments which were still in train. Thus the Christ Church Conference in 1961 established what was to become the Trust's special interest in the field of **education and training,** particularly the arrangements for both postgraduate and continuing education because of their importance to quality of service. The necessary close association between medical education and medical care services, had been the special subject of the international seminar mentioned earlier and the publication *Medical Education and Medical Care* (1971).[8]

There is also a broad educational spin-off from the kind of **seminars** concerned. All the participants in these were part of the great and influential army who contribute so much in addition to their professional roles, by way of voluntary work in society, and who stimulate and inspire serious thought about how to improve matters. The seminars were also seen as an informal and private means albeit modest of filling gaps in the continuing education through the exchange of knowledge and ideas of leading individuals concerned influentially in one way or another with the NHS, and in the means of communication between people in separate disciplines and in different operational roles, in various tiers of management. It was believed that this particular educational function needs to be continually developed because of the complex nature of health services, and the possiblities of its extension were being continually explored, since the lack of understanding of the subtleties of the complexity of health service provision is considerable at all levels. The importance of better communication between legislators, health professionals, members of authorities and those who have parts to play in forming public opinion and policies cannot be underestimated.

It is notable that the need for such **educational exercises** is possibly better appreciated, and was to some extent being met in the USA, where the formal separation between the legislature and the administration perhaps makes the need more obvious. It is, however, equally applicable in the UK, where perhaps a

[8] This question was pursued in a commission in the Rock Carling series and the absolute necessity for this association was specially stressed by the 1981 Rock Carling Fellow, Sir Frederick (now Lord) Dainton in *Reflections on the Universities and the NHS.*

model in a specifically distinctive field, that of international affairs, exists in Chatham House. In addition to the specialised seminars based on the Trust it was hoped that the **Royal Institute of Public Affairs (RIPA)** venture in this general area, financed and sponsored by the Trust would be productive, and lead to further development by the Institute (133).

Indeed, a better understanding of how people in the different operating authorities see and appreciate each other's roles is fundamental as a constituent element in the maintenance and eventual building up of service co-operation and consequently of improved morale which in the case of the NHS was widely believed to have deteriorated seriously in recent years. The signs of this had been noted in the *Ninth Report* (1970-5) with special reference to the fears expressed in *Challenges for Change* (1971), which had identified a number of important issues in the prospective NHS reforms which later, in 1974, came into being.

The sometimes undue attention given to structural reform politically and in the media tends to overlook such important issues. The theme of **morale** in the NHS and what can be done about it, raised originally in the Sixties by Professor R.W. Revans, is still in 1990 a challenge which will only be ignored at peril by those concerned with instituting policies for the NHS - Ministers, MPs, Civil Servants, and the Professions. The implications of failure are dangerous to the quality of personal services, the effectiveness of which depend on individuals of all disciplines and persuasions operating at the various administrative and professional levels, in the effective functioning of which hitherto, a sense of vocation has played an important part. This was the reason for monitoring the experience of **Community Health Councils (CHCs)** (40) as representatives of 'consumers', the result of which appeared in *CHCs in Action* (1976).

The subjects of **industrial disputes** generally and the failure to reconcile structural changes with **professional ethics** as factors affecting the caring services which make up the NHS, have also strong bearings on the theme of **morale.**

These effects were studied by the **Edinburgh Medical Group** (55) whose findings in two studies were published by means of a subsidy from the Trust viz., *Dilemmas of Dying* (1979); and *The Ethics of Resource Allocation in Health Care* (1979).

All of these activities pointed to the special need in various parts of the infrastructure of the NHS to bring together those concerned with operational activities and researchers. An imme-

diate requirement was to explore the important question of bureaucratic remoteness in a caring service. As far back as 1974, over-centralisation of control and the bureaucracies which had grown up to implement it, was diagnosed as a major part of the problem and devolution to Districts was seen as one likely condition for the raising of morale. By 1980 it appeared that this hypothesis was close to being accepted; but there was evident hesitation about the devolution of responsibilities, on the plea that the Service really needed time to settle down after the 1973 Reforms and the 1977 consolidating legislation.

Yet it is evident from the Trust publications that the feeling of helplessness and frustration suffered by those intimately bound up with the care of special 'client' groups such as **the elderly** arises from the spread of responsibilities over different bureaucracies, the effective operations of some of which are prejudiced by the not infrequent inflexibility of separate authorities.

On the evidence of a number of Trust studies - for instance, those on **'Research', 'Manpower', 'Collaboration', 'Care of the Elderly', and 'Prevention'** the apparent rejection of the proposals for joint action for social policies (JASP) proposal which if they had been implemented would almost certainly have influenced local policies, seemed short-sighted on the part of those responsible for the machinery of government, The lack of mechanisms for good communication and adequate comprehension policy formulation (and action) at local level was traced as arising from a fault in the machinery of central government which often seems incapable of overriding the sometimes narrow and jealous independence of individual Departments of State.

There has also always been in the NHS not a little frustration felt at all operational levels at the lack of information about how and why decisions are taken at the higher levels of authority in health affairs. It was felt that **better communication, even role clarification and identification** of where and how policies are made in the Health Departments as well as at the various operating levels, would make for an atmosphere more conducive to the co-ordination which all desire, observers as well as participants, but that is at best only a palliative. Some of the existing machinery designed for such a purpose such as those of the 'Cogwheel' Committees seemed to have deteriorated, even fallen into desuetude. Time and time again this had been

evident from the 'intelligence' exercises based on the research and planning studies, covered in *Measuring for Management* (1975), *Probes for Health* (1975), *Framework on Design for Planning* (1977), *By Guess or by What?* (1978), *Patterns for Uncertainty* (1979) *and Matters of Moment* (1981).

The analysis of public policy issues on which the evidence is incomplete is no simple matter, yet the subjects are often in the forefront of public consciousness and so give rise to pressures for leads. It is still, (even in 1990), an open issue how to present effectively some of the results of research on many of the problems to a wider audience for debate and better understanding, particularly to those few responsible for policy decisions. Consensus may if abused be a suspect concept but it has long been accepted that it is important in a service such as the NHS - not in the narrower management sense, but in the context of service development to achieve good practice, expecially since on many issues there are no simple answers leading to greater effectiveness of services. It seemed to follow that some special attention had to be given to the opening of debates on how to effect the establishment of means for the steady development of consensus, particularly at local levels about aims and their achievement.

It is not always appreciated that such a means too could play an important part in the improvement of the **health education** of the public on matters of public policy. This had been recognised in the United States where the responsibility for holding Consensus Development Seminars to include representatives from special interests was placed on the National Institutes of Health. There have been understandable doubts about the effectiveness of these, but the idea of suitably organised forums as a means of **continuing education** on the implications of policies, is sound and it seems worthy of extension in time. It was notable that one such conference widely reported (cf. the *BMJ*, September 1979) in the USA hailed as raising the standard of public debate there on a controversial subject, was on **amniocentesis** (and its implications for service) the subject of the *1974 Rock Carling Monograph, Pre-natal Diagnosis and Selective Abortion* which on publication had raised little stir in the UK.

Many bodies, of course, stage seminars with various objectives in mind, but their use as a comprehensive deliberate part of (if preliminary to) **policy formulation, consensus develop-**

ment and general education of those closely concerned with **policy development** has not been tested or exploited as widely as it might have been. It was too evident that the Health Departments efforts in this direction such as that reported in such Trust publications *Policy for Action* (1973), in mental health and in research in *Positions, Movements and Directions in Health Service Research* (1974), had unfortunately not been followed up.

The private seminar **The Next Thirty Years** (130) convened by the Trust with specially commissioned position papers for the DHSS in 1978 seemed to promise much , and showed what could be done in a neutral atmosphere as were the seminars held for the Royal Commission on *Trends in Medicine* (127) **Assumptions behind the NHS** (128) and on **The Foreign Experience** (129).[9]

V THE PROSPECT IN 1980

(a) FILLING A GAP

The striking conclusion from an 'intelligence' appreciation at the end of the decade, of the management of the NHS was that it was unfortunate that there was no obvious central policy for the reconciliation of the regional and district redistribution embodied in the principles of the *RAWP Report*, with priorities sketched in *The Way Forward*, (a discussion document of the previous government, introducing a policy which had not been superseded). Neither was there a clear programme of action and a strategy to take account of the resultant problems.

Thus it was an over-simplification and confusing to authorities to frame such intentions as indeed they were, on national averages of data which which were said to be for 'illustrative purposes only' and gave no inkling of the course of evolution and very wide variations in the levels and quality of most services which invariably have local features. It was understood that the newly formed Conservative Government would shortly be publishing its own priorities document later in 1980 to correct any doubt, but in the event this did not occur.[10]

[9] This particularly applied to the opening up of the question of **biomedical prospects in the context of the NHS** by a commission to Professor (now Sir) David Weatherall which resulted in the authoratative review *The New Genetics and Clinical Practice:* the 1982 Queen Elizabeth the Queen Mother monograph.

[10] It was almost another 10 years before the 1990 reforms effectively killed the RAWP policy.

It was disappointing from the Trust viewpoint that there seemed to have been no effort to sketch from the results of health services research already published, a programme and policy designed for experiments which could be readily grasped and understood at the various levels of authority as well as by those individuals providing services professionally.

Meantime the Trust continued its policy of presenting analyses drawing attention to what it regarded as important issues and how confusion arises by tracing causes and effects which may not be all that obvious to the casual observer, but to the skilled can be identified as arising from a variety of official policies.

The kind of anomaly particularly pinpointed was one which had emerged from a number of seminars viz. the strategic planning authorities in the NHS. The Regions for which the RAWP formulae were drawn up, were being required to apply the formulae to Districts and in doing so had the problem of reconciling their view on priorities for local services, with somewhat different policies already laid down nationally!

There were clearly structural faults in the system of administration of the NHS by the Department since there seemed to be an endemic failure to grasp the inconsistencies of a variety of policies. A lesson from the experience of the 1974 reforms seemed to be that reformed structures and operating mechanisms to be fully effective for the NHS need purposeful direction and power drives from a central position recognisably geared to service requirements. Hence the posing in Trust publications of the fundamental question why there was a lack of such direction. Particular attention was drawn to the fact there were two quite different types of body, a Department of State whose first loyalty is to Central Government, and the NHS consisting of several authorities. Both are concerned with operational issues yet there was no effective operational headquarters for the NHS at the apex. The NHS is in effect thus deprived of the means of central operational 'intelligence' and active leadership in solely health matters.

The ill-fated reforms proposed by the Chairmen of Regional Health Authorities and virtually endorsed by the Royal Commission, which sought to define where accountability could reasonably rest at points below the DHSS, could be interpreted as a definite practical move in the direction of effective

devolution to Regions with the likelihood ultimately of the co-ordination of operational policies for the NHS. The recommendation was probably not as well-founded in constitutional terms as it might have been and the Public Accounts Committee was to give it short shrift in 1981 on the basis it seems that they wished only a single Accounting Officer not fourteen Regional Chairmen. There seemed to be a reluctance to provide the NHS with a mechanism for such an operational leadership. Yet the NHS needed more of a dedicated operating entity than it had, with maximum delegation from the Government to Health Authorities to allow for the setting of well-defined practical objectives. Certainly the dangers of the weakness of the existing linkage ought to have been examined more closely by the Royal Commission.

To achieve the desired objectives it was evident that any change would have to be made consistent with effective control, responsibility, and accountability. If a well-integrated service structure was to be developed, comprehensive inter-related health policies with realistic priorities might be secured. The Royal Commission report ignored, or failed to concentrate on how the obvious ineffectiveness of the existing link could most practically be repaired. As a consequence the detractors of the proposed reforms had a field day on constitutional questions. The lack at any executive level of a 'general staff' mechanism for 'intelligence' gathering and for strategic thinking for the NHS in order to draw together all the major strands and relate them to what was happening or what was not happening outside the DHSS but affecting concerns of health, and above all what should happen in specific areas of desirable action, seemed bound to continue to be a major point of issue.

The suggestion aired in the *Tenth Report* based on a review of the literature, a large part of which consisted of Trust publications, was not to take away a function of the DHSS, but rather to add an essential piece of machinery to the system. It seemed that as long as there was no such mechanism, the best use was unlikely to be made of current resources, and planning would become virtually a useless exercise.

At the same time as far as the Trust was concerned the absence of such a mechanism probably left even more openings for private initiatives than if research was better integrated with management.

(b) INDICATIONS FOR THE FUTURE

In the absence of any move by the Department in this direction the Trust continued its own 'general staff' activity, to recognise important issues in the infrastructure. It had in the past initiated and published commentaries on fundamental policies and philosophies, about health services. Among these were *certain monographs* in the *Rock Carling series,* as well as *Challenges for Change, A Question of Quality, Five Years After, Power and Responsibility in Health Care, Prelude to Harmony* and *Community Health Investment* among the publications; and **the seminars for the Royal Commission** and **the DHSS.,** including **'Assumptions Behind the NHS'**, and **'The Next Thirty Years',** as well as **'The Foreign Experience'.**

Optimism as always was the spur and it was agreed that these exercises, entailing among other things the examination of fundamental concepts by leading health professionals of all disciplines, and surveying what seemed analogous on the international scene, should continue; even if the resultant conclusions seemed to be a long time in limbo before making any observable impact on the Government machine.

The complexity of the health scene meant there were many questions being posed, some of the major of which had long been in the Trust's programme. Others were explored initially in 1978 in **The Next Thirty Years** seminar which having been suggested by the Department with a Minister participating, was an interesting experiment in itself. It suggested the immense possibilities from the use of forums not only as the preliminaries to 'Think Tanks' to explore the likely major issues of the foreseeable future, a method which had been used successfully by the Trust in Christ Church in 1957, and also as a means for further and continuing education. This idea could probably be applied more widely with advantage to all with substantial interests in health services in respect of issues requiring initially, informal **private forums** for frank discussions.

Indeed the decision to look at the specific problem of **the elderly** (131) was a direct result of the **'Next Thirty Years'** forum. Ultimately the conclusions of that exercise pointed to a set of principles concerning a specific group of 'clients' which might be applied more widely to examine policies and services for other 'unfashionable' groups labelled generally and accurately in more senses than one, as the 'disadvantaged' but which is little more than a euphemism for the 'handicapped', an

increasingly larger group in society. Principal among these are the **mentally handicapped** and the **mentally ill** where demographic changes and their effects can be forecasted fairly accurately. An indication of the range of issues concerning this group is given in the publications on the subject.

In some of the other subjects which were coming to the fore towards the end of the decade, such as **quality of care, industrial action in the health services,** and changes in **professional ethics,** it was apparent that the initial task was to raise the level of debate by carefully prepared explorations, some by commissions from individuals, some by carefully selected groups, of what was wrong and what could practically be done about them.

There were, however, other important issues, by no means exclusively confined to those already discussed in this history but the effects of which go deep, which would have to be probed and debated before long, in any consideration of how services could be improved and made more comprehensive.

Thus, if there were policy decisions which seemed bound to peg health service provision roughly at existing levels, should there not be a cool realistic debate on the implications of fixing priorities for the future, both for the NHS and for individuals? It was inconceivable there should ever be sanctions placed on the development of services outside the NHS, and thus some limitation imposed on private enterprises or on options open to individuals of choosing to purchase services other than those available in the NHS. A major question was whether that should be encouraged by a specific public strategy to assure some supplementary resources for developments in health care. Above all how would such a policy accord with certain long-held concepts of the character of a national service based on the principle of equality of access, and that two levels of quality of service were not in the public interest. In the NHS itself, if as seemed likely, there were to be policies involving changes in priorities without additional resources to support them, what kind of preparations were in hand in the Health Departments and the Health Authorities to make harsh decisions concerning the limitation or even the closure of services not accorded the highest of priorities?

Such questions can never be ignored: but there was little of this kind of speculation in the *Royal Commission Report* in 1978 and nothing in the Discussion Document *Patients First* published

in 1979; nor any sign of it in immediately subsequent indications of health policies. Indeed, the climate at the end of the decade with the possibility of renewed militancy on the part of the unions strongly suggested that since the development of health services was likely to be greatly restricted by the resources available, the pressures for more diversity in options for individuals to seek the level of care and treatment they wish, would become great. This was not to forecast the abandonment of the major assumptions on which the NHS was founded, but it was felt nothing would be gained by ignoring the reality of mounting demand and public expenditure. Much was to be said for the opening of a sensible debate as early as possible, as part of the democratic process, on what are the implications of financial limitations and whether reasonable alternative strategies involving options open to individuals were possible and practicable.

There were other considerations affecting some of the assumptions behind the organisation and manpower policies of the NHS, which had taken on the characteristics of an expanding universe in which the **lack of integrated educational and service (including pay) policies** had hardly been discussed. Yet, based on the observation of the difficulties in providing personal services for certain categories of the population it seemed likely that soon some attention would have to be paid to the random interactions of policies of markedly different genus and origins, viz. the settling and reconciliation of **priorities at national and local levels, the reallocation of resources to encompass these objectives; the provision of incentives perhaps through pay (including differentials) and fiscal means, to ensure effective services for the elderly and the mentally ill and handicapped.**

This gave even more substance to the proposition which was being explored in the exercise concerned with the **elderly**, that there was an urgent need to try to quantify and relate to current and potential resources, the kind of services deemed to be desirable and indeed reasonably expected for all the identifiable 'unfashionable' client groups in a caring society. The theory was that the results of such an exercise, when related to the priorities decided by the policy processes could then be compared with what human and financial resources are available, in order for any Government of whatever complexion, to move towards policies designed to achieve the highest degree of effectiveness and efficiency. It was hoped optimistically that the reality might

lead to the need for a reconsideration of the relationship of policies of direct and fundamental concern to the range of professions working in the NHS with effects on the way in which decisions on **educational, and fiscal (including pay) policies** were reached. Thus, if, for example traditional caring measures designed for certain client groups fall short of the quality desired because of the inability to recruit and train staff, alternative incentive policies would be required. It might be appropriate above all, to seek to provide the individual personal services needed in a civilised society through cash or other special inducements.

This also posed the complementary question of what investment was needed in the next 10-20 years for deploying to the full, **voluntary effort** for personal services, a subject which it seemed important to explore in an important but neglected sector. This indeed might be necessary in the future in the case of both **the elderly and the handicapped of all sorts.**

What seemed to be urgently necessary was the opening of a well-founded debate on the professional, sub-professional and voluntary composition of the comprehensive services we would all like, as well as on the steps to be taken to develop well-integrated policies to achieve satisfactory levels of service. Such a reconstruction of policies would have to involve arrangements for an organisational flexibility greater than then existed.

(c) THE PROSPECT

The Trust had never deviated from the principle that the formulation of effective public policies is properly a task for Government and the best it could do was to use its resources to illuminate the problems and possible solutions. Looking ahead to the Eighties it seemed clear from the Trust's activities, particularly in the previous ten years, that no capability yet existed within Government for the effective co-ordination and planning of health policies and practices according to the needs of health as a whole. This was particularly obvious in such key matters for management as **quality of care, information development and use through up-to-date information technology and the place of health services research.**

The need was evidently compelling in relation to setting and applying priorities for the use of scarce resources of people and finance. It was felt that The Royal Commission on the National Health Service might have made a larger contribution to the

scope and depth of debate necessary but that had proved a forlorn hope and its Report appeared now to be in limbo. Indeed it was not difficult to conclude that the constitution and temporary existence of such official but transient bodies are hardly an advantage when completely independent, long-term analyses are necessary. For whatever reason the Commission was neither able to make such analyses nor to examine the philosophical and structural issues in any depth. There seemed to be a ray of hope in the emergence of the Commons Select Committee on Social Services but it was doubtful whether with its limited scope and resources in finance and manpower, too much could be expected of it.

The *Tenth Report* of the Trust published in 1980 expressed the opinion that the real need was for an organisation separate from the Executive, properly staffed and fully articulated, as part of the NHS and concerned with health in all aspects including taking account in its policies of the the resources deployed in private health care. This was accepted as beyond the Trust's own resources and purposes, but it was decided to continue with the attempt to fill some of the gaps by the development of its own programme of research, information and discussion drawing on and extending the emerging themes.

SUPPLEMENT TO CHAPTER 6
1971–80

CLASSIFICATION OF MAJOR RESEARCH and DEVELOPMENTS etc., SUPPORTED BY THE TRUST

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HEADINGS

1. STUDIES etc.
2. EDUCATION (Medical, Nursing, other)
3. EXPERIMENTS and DEMONSTRATIONS
4. SEMINARS etc.
5. MISCELLANEOUS

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENT ETC., SUPPORTED BY THE TRUST 1971–80

	Principal Authority	Subject	Trust Reports	Other References
	STUDIES ETC.			
	1971			
1	Council for Postgraduate Medical Education in England and Wales	Survey of Postgraduate Medical Centres	IX,97	*Annual Directories of Postgraduate Medical Centres* (Council for Postgraduate Medical Education in England and Wales 1973, 1974)
2	Glasgow University, Dept of Medicine	Investigation of self-poisoning as a cause of admission to hospital	IX,91	*Lancet* (1972) ii, 1009. *Br. Med. J.* (1975) 2, 426
3	Aberdeen University, Dept of Mental Health & General Practice	Comparative study of psychiatric treatment between General Practice and the Mental Health Services	IX,92	*DHSS Statistical and Research Reports* Series 7 (1974) 50
4	Newcastle University, Dept of Child Health	Consultant Community Paediatrician	IX,91	*The Formative Years* (OUP for NPHT 1974); *Bridging in Health* (OUP for NPHT 1975)
5	Royal College of Physicians & Surgeons of Glasgow	Survey of emergency cases in the West of Scotland	IX,89	
	1972			
6	Manchester University, Dept of Social Administration	Study of collaboration between hospital and community	IX,103–4	
7	Leeds University, Nuffield Centre for Health Service Studies	Study of local management problems in the reorganised NHS	IX,23,104	*Si Vis Pacem . . . Preparations for Change in the NHS* (OUP for NPHT 1973)
8	Exeter University, Dept of Mathematics and St Lawrence's Hospital, Bodmin	Study of care for the mentally ill in Cornwall	IX,92	*Measuring for Management* (OUP for NPHT 1975)

	Principal Authority	Subject	Trust Reports	Other References
9	Hull University, Dept of Social Administration	Case study of the Humberside Area Health Authority	IX,103	*New Society* (1973) 25, 570; *Hosp. and Hlth Serv. Rev.* (1973) 9, 326; ibid. (1974) 4, 119; *Preparations for Change* (University of Hull 1973); *Waiting for Guidance* (University of Hull 1973); *The Shadow and the Substance* (University of Hull 1974)
	1973			
10	Oxford University, Dept of Engineering Science	Reconnaissance of the field of medical engineering	IX,32,111	
11	Loughborough University, Institute for Consumer Ergonomics	Study of the performance, selection and use of powered wheelchairs	IX,111	
12	York University, Dept of Economics	Development in the planning of Health Care Systems	IX,110	
13	Leuven University, Belgium, Institute for European Health Services Research	Intelligence survey of Health Services Research Centre in the Common Market	IX,32–3,114	*Prelude to Harmony on a Community Theme* (OUP for NPHT 1975). *Community Health Investment* (OUP for NPHT 1976)
14	Glasgow University, Dept of Medicine	Hospital Health Service Research Unit	IX,108	
15	Royal Postgraduate Medical School	Study of the management of malignant hypertension	IX,108	
16	Birmingham University, Dept of Social Medicine	Investigation into the decline in autopsy rates	IX,108–9	*Br. Med. J.* (1975) 2, 326
17	Nottingham University, Dept of Applied Social Science	Survey of recruitment to some shortage specialties	IX,29,86,99–100	
18	The Queen's University of Belfast, Dept of Business Studies	Operational research studies of the newly integrated Health and Social Services in Northern Ireland	IX,105	

19	Sheffield University, MRC Social and Applied Psychology Unit	Study of team effectiveness and the Salmon Report	IX,105	
20	Leeds University, Nuffield Centre for Health Services Studies	Study of comprehensive health care planning in the USA	IX,106	
21	Exeter University, Dept of Mathematics	Information system for the management of a Health District	IX,96	*Measuring for Management* (OUP for NPHT 1975)
22	Edinburgh University, Dept of Psychiatry in association with the MRC Unit for Epidemiological Studies in Psychiatry	Study of suicide in Scotland in comparison with England and Wales	IX,92–3	
	1974			
23	Birmingham University, Dept of Social Medicine	Study of the medical role in environmental health	IX,112	
24	INBUCON/AIC Management Consultants Ltd	Study of health information in environmental planning	IX,112	
25	Scientific Control Systems Ltd	Study of the structural aspect of the quality of care	IX,109	
26	Royal College of Pathologists	Assessment of the performance of Clinical Chemistry Laboratories	IX,109	
27	Newcastle University, Medical Care Research Unit	Study of Nursing in the organisation of primary care	IX,107	
28	Glasgow University, Dept of Social & Economic Research	Research Unit on health service manpower problems	IX,29,106–7	
29	Leeds University, Nuffield Centre for Health Service Studies	Information and guidance for Community Health Councils	IX,26,106	*Mounting the Health Guard* (NPHT 1974)
30	Manchester University, Dept of Anaesthetics	Study for the monitoring of postgraduate training in the specialties	IX,100–1	
31	Exeter University, Dept of Mathematical Statistics and Operational Research	Application of quantitative methods to health services management	IX,96–7	*Framework & Design for Planning* (OUP for NPHT 1976)

Principal Authority	Subject	Trust Reports	Other References
32 Southampton University, Europe Dept of Rehabilitation	Study of rehabilitation services	IX,90	
33 Leeds University, Nuffield Centre for Health Services Studies, Mr Jack Hallas	Ten years of Community Health Councils. Representatives of the Public in an NHS Context		
34 Manchester University, Dept of Social Administration	Study of collaboration between hospital and community	IX,108	
35 Hull University, Institute of Health Studies	Research on information systems in the NHS	X,110	*Reorganizing the NHS; A Study of Administrative Change* (R G S Brown, B Black, M Robertson 1979)
36 Royal Postgraduate Medical School	Study of the management of malignant hypertension	IX,108	*A Question of Quality? Roads to Quality Assurance in Medical Care* (OUP/NPHT)
1975			
37 Glasgow University, Dept of Politics	A study of health care research	IX,30,110–11	*Power & Responsibility in Health Care* (OUP for NPHT 1979)
38 Royal College of Pathologists	Assessment of the performance of clinical chemistry laboratories	X,117	Factors Affecting Analytical Performances in Clinical Chemistry Laboratories. Royal Coll. of Path. (1980, N. C. MacLagan)
39 Manchester University, Ad Hominem Chair of Social Administration, Professor Gordon Forsyth, BA	Organisation in Transition	X,118	
1976			
40 Leeds University, Nuffield Centre for Health Services Studies	Information and guidance for Community Health Councils	X,121	*CHCs in Action* (NPHT 1976); Progress and Problems in Participation; Hallas, chpt 4 of *Mixed Communications* OUP/NPHT 1979)

41	Newcastle Community Health Council, Mrs V Bolter, JP, BA	Survey of patient satisfaction with health services	X,119	
42	The Volunteer Centre, Ian Bruce	Study of voluntary support for discharged psychiatric patients		*Volunteers & Psychiatric Aftercare;* T Dartington, The Volunteer Service
43	Newcastle University, Medical Care Research Unit	Study of nursing in the organisation of primary care	X,115	*Brit. Med. J.* (1976) 2; Substitution and the Medical Dilemma (B L E C Reedy); *The Patterns for Uncertainty* (OUP/NPHT 1979)
44	Manchester University, Dept of Social Administration, Professor G. Forsyth, BA	Study of resource allocation in the NHS	XI,95	*Matters of Moment* (OUP for NPHT 1981)
45	Birmingham University, 1st of Local Government Studies, Professor J D Stewart, MA, DPhil	Research into collaboration between Local Government and Health Authorities	X,112	
46	Manchester University, Dept of Anaesthetics	Study in support of the review of manpower policies	X,113–5	
47	Professor James Parkhouse, MA, MD, MSc, FFARCS	Factors affecting deployment of manpower in health services	IX,100	*Medical Education* (1979) 12, 40, 54, 133, 230. *Patterns for Uncertainty, Chpt. 1* (OUP/NPHT 1979)
48	Scottish Health Service, Common Services Agency, Dr M A Heasman, MRCP, DPH, FSS	Development of the Scottish consultant review of inpatient statistics	X,114	*Health Bulletin* (1978) 36, Chpt 1, 5
49	Manchester University, Dept of Social Administration	Resource allocation in the North-west Regional Health Authority	X,112	Health and the Inner Cities Partnerships; An Experiment in Collaboration in Matters of Moment; G Forsyth/R M Varl

	Principal Authority	Subject	Trust Reports	Other References
	1977			
50	Sussex Univeristy, Professor Stuart Morrison, FRCP, FFCM	Manpower studies in the health services	X,123	*The Image and the Reality;* A Study of the Impacts of Medical Technology (OUP/NPHT). *Confusion or Control?* Manpower in the Complementary Health Professions. Chpt 5 in *Patterns for Uncertainty* (OUP/NPHT 1979)
51	Professor A. S. Duncan, DSC, FRCOG	A review of progress in quality assurance	X,114	*Brit. Med. J.* (1980) I, 300
52	Association of Anaesthetists of Gt Britain & Ireland, Dr M Rosen, FFARCS	Enquiry into anaesthetic deaths	X,116	
53	Royal Victoria Infirmary, Newcastle-upon-Tyne, Dr J C Stoddart, MD, FFARCS	Study of the use and outcome of intensive care	X,116	
54	Birmingham University, Dept of Social Medicine, Professor T. McKeown, PhD, DPhil, MD, FRCP	A follow-up to the 'Role of Medicine'	X,121	
55	Edinburgh Medical Group Dr Kenneth Boyd and Dr Ian Thompson	Research in ethics and professional education	X,122	*J. of Medical Ethics,* 197. *Dilemmas of Dying* (Edinburgh University Press 1979). *The Ethics of Resource Allocation in Health Care* (Edinburgh University Press 1979)
56	Leeds Women's Health Group, Ms G S Haden	Research into the health needs of women	X,120	
57	Exeter University, Dept of Mathematical Statistics & Operational Research	Research into the costs of hospital care in England and Wales	X,111	The Structure of Hospital In-Patient Costs; J R Ashford & M S Butts, Chpt 2 in *Mixed Communications* (OUP/NPHT 1979)

58	Edinburgh University, Dept of Sociology, Professor T. Burns, BA	Study of Area Health Boards in Scotland	X,109	
59	Cheshire Area Health Authority, Brian Edwards, AHA	A study of staff problems during organisational change in the NHS	X,109	
	1978			
60	Association of Community Health Councils in England & Wales, Michael Gerrard	Study of the provision of dental services	X,119	
	1979			
61	Exeter University, Dept of Mathematical Statistics & Operational Research, Professor J R Ashford, MA, PhD, FBCS	Information management in health services	X,124	
62	Newcastle-upon-Tyne University, Medical Care Research Unit, Professor D J Newell, MA, PhD	Study of dependency and care of long-stay elderly patients	X,117	
63	Exeter University, Dept of Mathematical Statistics & Operational Research, Prof J R Ashford, MA, PhD, FBCS	Study and demonstration of Micro-processing for medical care	X,110,124	
64	1979/82 Association of Anaesthetists of Gt Britain & Ireland, Dr John Lunn	Mortality associated with anaesthesia	X,116	Anaesthesia, 38, 1090 *Mortality Associated with Anaesthesia* (NPHT 1981)
65	Bath University, School of Humanities & Social Sciences	Socio-economic factors in the use of health services	XI,93	*Brit. Med. J.* (1980), Equity and the NHS, Self-reported Mobility, Economic Factors & General Practitioner Consultants; E Collins & (Bath Social Policy Papers)

	Principal Authority	Subject	Trust Reports	Other References
66	1980/85 Exeter University, Dept of Mathematical Statistics & Operational Research, Professor J R Ashford, MA, PhD FBCS	Database and information		
67	Sussex University, Professor Morrison & Ms Barbara Stocking	Innovations in the Health Service	X,123	*The Image & the Reality* (OUP for NPHT 1978 *Essay in Patterns for Uncertainty* (OUP for NPHT 1979). *Initiative & Inertia* (NPHT 1985)
	EDUCATION (Medical, Nursing, other)			
	1971			
68	Bristol University, Medical Postgraduate Department	Adviser in vocational training for general practice	IX,99	
69	Royal College of Physicians of London	Joint Committee on Higher Medical Training	IX,99	
70	Tunbridge Wells Postgraduate Centre	Tunbridge Wells Postgraduate Centre (Interest-free loan)	IX,97	
71	Trust Working Group	Planning of a survey of postgraduate medical centres	IX,77	
	1972			
72	London Graduate School of Business Studies, Organisational Behaviour Group	Survey of management training schemes	IX,103	
73	Leeds University, Nuffield Centre for Health Services Studies	Bursaries for the Diploma Course in Health Services Administration	IX,102	
74	Kettering & District Postgraduate Medical Foundation	Kettering Postgraduate Medical Centre (interest-free loan)	IX,97	

75	St Helen's & District Hospital Management Committee	St Helen's & District Postgraduate Medical Centre at Whiston Hospital (interest-free loan)	IX,97	
76	West Kent Postgraduate Medical Centre	West Kent Postgraduate Medical Centre at Farnborough Hospital (interest-free loan)	IX,97	
77	British Postgraduate Medical Federation	Experiment in the co-ordination of Medical Library Services	IX,98	
78	Trust Seminar	Management training for the reorganised National Health Service	IX,27,80	
79	Oxford University	Chair of Social Medicine	1,25.IX,99	
	1973			
80	London School of Hygiene & Tropical Medicine, Institute of Occupational Health	Review of health education	IX,28,113	
81	Trust Conference at Pembroke College, Oxford	Postgraduate Medical education: The prospect	IX,28–9j,81	*The Way Ahead in Postgraduate Medical Education* (OUP for NPHT 1974)
	1974			
82	Edinburgh Medical Group	Research in ethics and professional education	IX,110	
83	Royal College of Physicians of London	Self-assessment programmes in the medical specialities	IX,109	
84	Walton Postgraduate Medical Centre	Walton Postgraduate Medical Centre (interest-free loan)	IX,97	
85	West Cheshire Medical Centre	West Cheshire Postgraduate Medical Centre at Chester (interest-free loan)	IX,97	
86	Trust Seminar	Health education	IX,28,83	
87	Trust Commissioned Study	An appraisal of medical education within the National Health Service	IX,100	*Basic Medical Education in the British Isles* (NPHT 1976)
	1975			
88	Mid-Sussex Postgraduate Medical Centre	Postgraduate Medical Centre at Cuckfield (interest-free loan)	IX,97	

	Principal Authority	Subject	Trust Reports	Other References
	1976			
89	Professor C M Fletcher, CBE, MD, FRCP	Review of the teaching of communication in medicine	X,107	Towards Better Practice & Teaching of Communication between Doctors and Patients C M Fletcher, Chpt 1; *Mixed Communications* (OUP/NPHT 1979); *Talking with Patients* (NPHT 1980)
	1978			
90	Leeds University, Nuffield Centre for Health Services Studies	Continuation of support for training in health affairs	X,107	
	EXPERIMENTS/DEMONSTRATIONS			
	1971			
91	North-west Kent Postgraduate Medical Association	Dartford Medical Centre (interest-free loan)	IX,97	
92	South Essex Medical Education & Research Trust	South Essex Medical Centre at Basildon Hospital (interest-free loan)	IX,97	
93	Exeter & District Society for Mentally Handicapped Children	Annexe for the Special Day Care Unit for Severely Handicapped Adolescents (interest-free loan)	IX,93	
94	Derbyshire County Council	A computer-assisted preventive medical service in Paediatrics	IX,90	*Bridging in Health* (OUP for NPHT 1975)
	1972			
95	Odstock Hospital, Salisbury, Dept of Physical Medicine	Assessment and treatment service of hemiplegics by electronic stimulation	IX,90	
	1973			
96	Bath University	University Department of Medical Engineering	IX,111–12	

97	Colwyn Bay General Practice	Equipment for a Personal Health Education Service	IX,113	
98	South-east Thames Regional Health Authority	Experiment for a working model of geriatric services	IX,104	
99	Hull (A) Group Hospital Management Committee	Child Health Planning Team for the Humberside Area	IX,105	*Bridging in Health* (OUP for NPHT 1975)
100	Royal College of General Practitioners	Expansion of resources for vocational training in general practice	IX,100	
101	Sheffield University, Dept of Community Medicine	Experiments in the improvements of standards in general practice	IX,88	
	1974			
102	Lancaster University, Dept of Linguistics & Modern English Language	Development of English Language skills for overseas doctors	IX,101	
103	Edinburgh University, Dept of General Practice	Experiment in the community care of diabetic patients	IX,88	
	1975			
104	Norwich Health District, Dr A Allibone, MROGP	Attachment of a voluntary services co-ordinator to a primary health care team	X,118	
	SEMINARS ETC			
	1971			
105	Trust Seminar	Epidemiology and the future	IX,25,79	*The Future and Present Indicatives, Problems and Progress* 9, 3 (OUP for NPHT 1973)
106	Trust Symposium	Doctor and patient versus society	IX,31,77	*Patient, Doctor, Society* (OUP for NPHT 1972)
107	Trust Seminar	Research in health economics at the University of York	IX,78	
108	Trust Seminar	The executive role of the medical administrator	IX,79	

	Principal Authority	Subject	Trust Reports	Other References
109	Trust Seminar	The divisional structure	IX,27,76	*In Low Gear?* (OUP for NPHT 1971)
110	Trust Seminar	Problems and progress in the new medical schools	IX,28,78	
111	Joint Seminar with the DHSS	Present studies and future research needs in mental health	IX,78–9	*Approaches to Action* (OUP for NPHT 1972)
	1972			
112	Trust Seminar	Research at the Department of Social Administration, University of York	IX,80	
113	Trust Conference at Edinburgh	On the Rock Carling Monograph, 'Effectiveness and Efficiency'	IX,79–80	
114	Joint Seminar with the DHSS & Royal College of Psychiatrists	The planning of a comprehensive district psychiatric service for the adult mentally ill	IX,55–6	*Policy for Action* (OUP for NPHT 1973)
115	Trust Working Group	Planning for the survey of recruitment to some shortage specialities	IX,29,86	*Intimations of Quality* (NPHT 1976) *A Question of Quality* (OUP for NPHT 1976)
116	Trust Working Group	Evaluation of the quality of patient care	IX,33–4,85–6	
117	Trust Working Group	Follow-up of 'Challenges for Change'	IX,22–4,85	*The Future—and Present Indivatives. Problems and Progress* 9, 59 (OUP for NPHT 1973)
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118	Trust Seminar	Medical engineering	IX,83–4	*The Medical Role in Environmental Health* (OUP for NPHT 1978)
119	Trust Seminar	Environmental Health	IX,28,81–2	*Practical Guide for Medical Officers for* (NPHT 1979)
120	Trust Seminar	Research concerning manpower and human resources at the University of Glasgow	IX,29,82	

121	1973/4 Trust Seminars	Communication in medicine	IX,32,82–3	*Talking with Patients* (NPHT 1980) *Communications between Doctors & Patients* (OUP for NPHT 1976)
122	1973/5 Trust Working Group	Policies for research and development	IX,30,86	*Positions, Movements & Directions in Health Services Research* (NPHT 1974) *Five Years After* (OUP for NPHT 1978)
	1974			
123	Trust Seminar	Operational research in the National Health Service	IX,31–2,84	
124	Trust Seminar	Administrators and the new National Health Service	IX,84	
	1975			
125	Birmingham University	Symposium on 'Man and His Environment'	IX,30,110–11	
	1976			
126	Oxford University, Medical School	Student conference on delivery of health care	X,106	*Oxford Med Schl Gaz* (1976) xxviii, 3, 119
127	Trust Seminars (for Royal Commission) (a)	Trends in Medicine	X,91,4	
128	Trust Seminars (for Royal Commission) (b)	Assumptions behind the NHS	X,91–4	
129	Scottish/American Conference on Medical Education	Foreign Experience/Medical Education History		*Medical Education & Medical Care*
	1978			
130	Trust Seminar (for DHSS)	The Next Thirty Years	X,190	
	1979			
131	Trust Seminars	Study of the problems of the Elderly	X,99–100	*The Impending Crisis of Old Age* (1981)
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132	Seminar-Conference of Royal Colleges & Faculties in Scotland	The Importance and role of quality assurance in medical practice	X,94	*Scottish Med. Journal* (1981) 26, 271–7

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133 Royal Institute of Public Administration, William Plowden	Development of interest of the RIPA in health affairs	X,113	
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1978			
134 Sir George Pickering	Reflections on Medical Education	X,73	*Quest for Excellence in Medical Education* (OUP for NPHT 1978)

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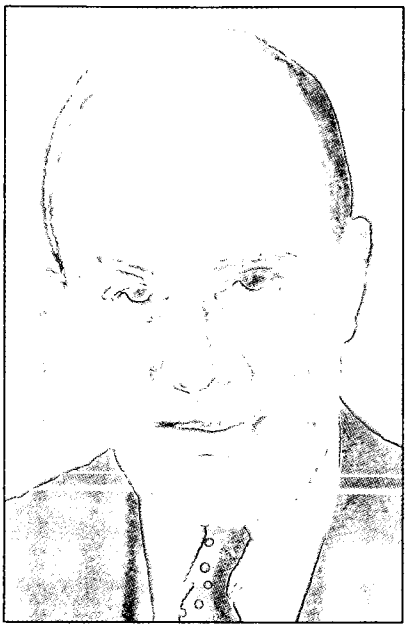

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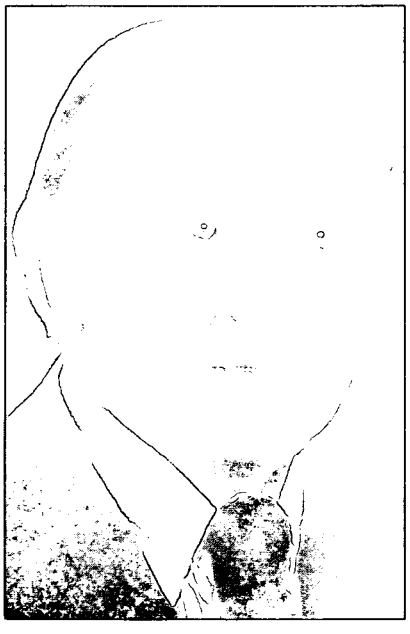

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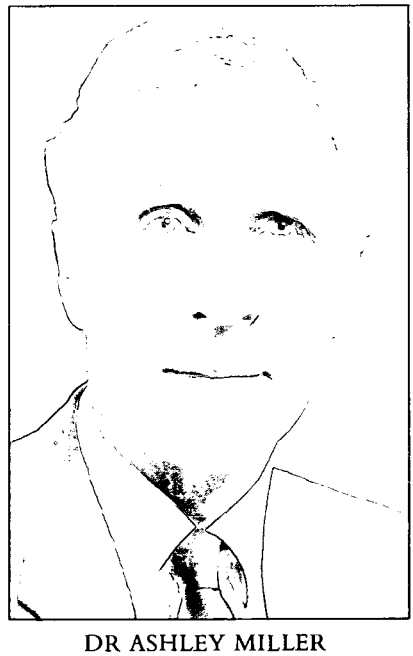

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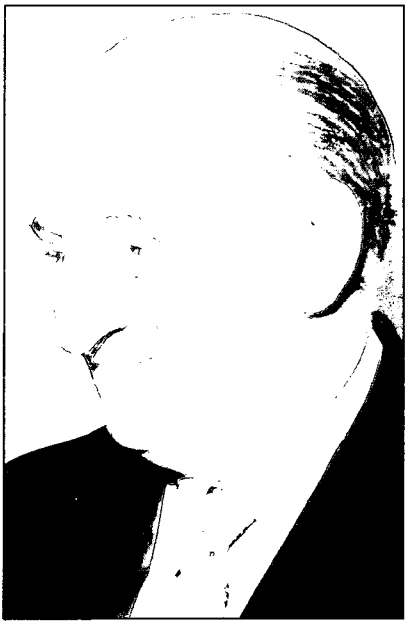

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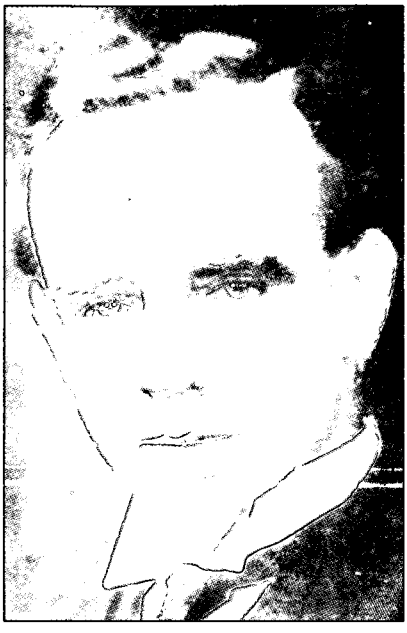

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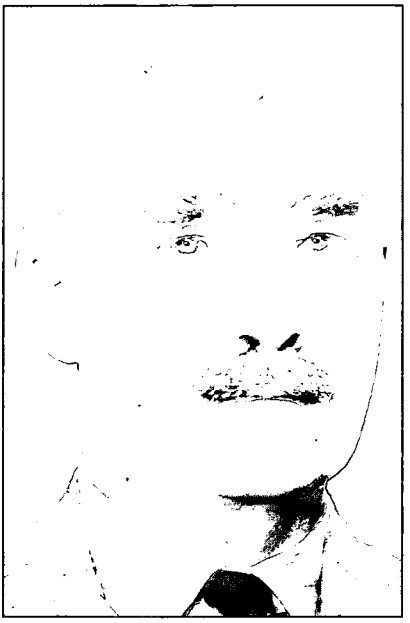

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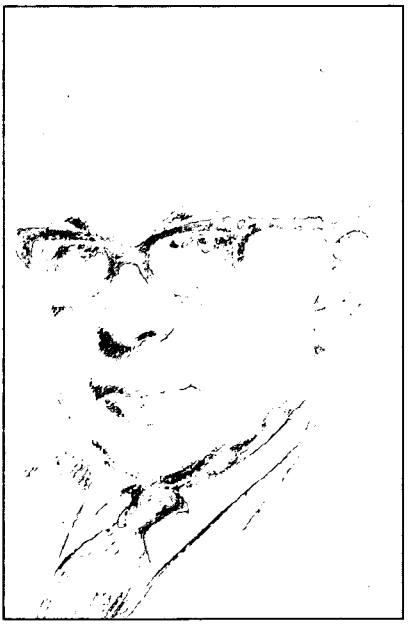

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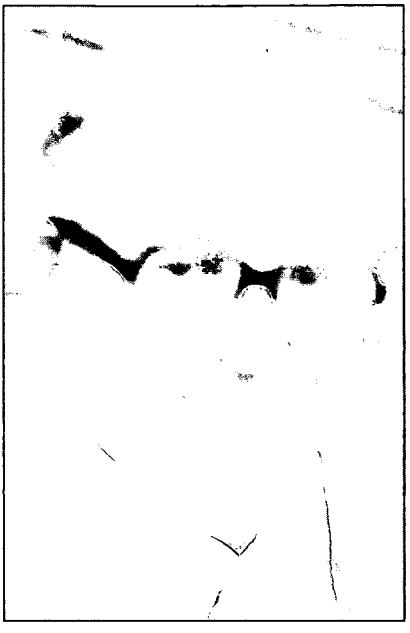

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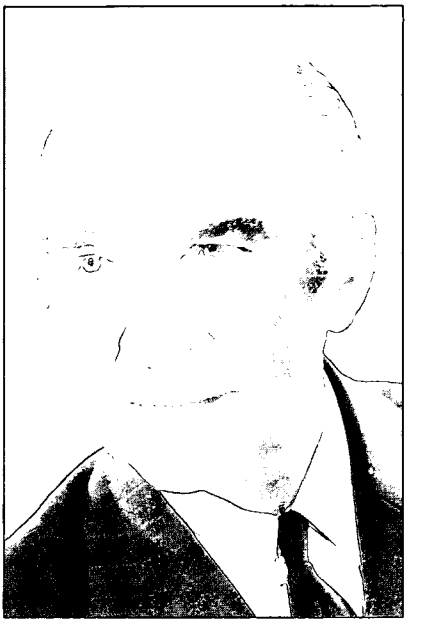

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CHAPTER 7
A DECADE OF CRISIS?
1980–90

A Decade of Crisis?

1980–1990

1980 saw the start of a period of sustained debate on policies concerning Health Services.

The advent of the Conservative Government in 1979 with its avowed objective of confining public expenditure, encouraged criticism of the alleged inefficiency of the NHS. The projections of expenditure to be met from the Treasury were disturbing and there seemed to be a section of the Conservative Party thinking which raised questions about whether the method of financing the National Health Service was a suitable one to meet the increased expectations of the population.

This sparked off a feeling generally that the 70s reforms were not enough and that further changes were likely. The Trust seized the opportunity to identify and analyse what the major challenges seemed to be.

On the structure of the NHS the Government decided in 1982 to abandon the Area principle and move back to the organisation in which the Districts were the operational bodies responsible directly to the Regions.

It was felt by the Trust that because of the general uncertainty the important thing was through its private seminar programme to try and get as many different kinds of health professionals together to discuss and analyse some of the major policy issues which had to do with the effectiveness of resources and the movement towards reform. This was to a large extent a development of the 'intelligence' part of the Trust's activity to help the grant-making and commissions policies.

A major initiative in this policy was that which produced the collection of internationally based position papers The ***Public/Private Mix for Health*** *which received a great deal of commendation for the depth of its policy analysis.*

In addition to ***The Public/Private Mix*** *and Professor Alain Enthoven's* ***Reflections etc*** *on the application of the 'market' to the NHS which seemed to have influenced the reforms of the 1990 NHS Act the principal initiatives were concerned with* **quality of care,** *the* **care of the elderly, general practice, nursing, communications in medicine, relationship of medicine to social work,** *as well as the constant monitoring of* **health service research policy.** *At the same time it was realised that there was need for a greater attention to be paid to the application of* **information technology** *to provide good* **information** *to help the solution of the many problems of health.*

In 1986 Dr Ashley-Miller succeeded the author as Secretary of the Trust and the major thrust of the last three years of the decade was directed towards the problem of physically disabled persons, by means of the continuance and the development of the historic means of grants, seminars and working groups and commissions.

In the health field generally the end of the decade saw some uneasiness about the prospect of the reforms later incorporated in the NHS Act 1990 which seemed to promise a period of crisis.

The Supplement setting out the main activities broadly reflects the continuance of the range of issues with which the Trust has always been concerned.

I. POISED FOR FURTHER CHANGE?

1. THE TRUST IN THE CHANGING WORLD OF HEALTH

The programme of the Trust in the first years of the decade was largely concerned with highlighting the challenges for any major change contemplated in the Health Care arrangements in the UK. This had reflected the views of many leading figures in the health field that there was no simple solution to the problems of improvement in health services. By 1980 the original view of the Trust of the proposals in the Green Papers which eventuated in the 1973 legislation was confirmed that the changes envisaged therein were rather more cosmetic than fundamental. This can be seen in the provisions of the consolidating measure, the NHS Act 1977, which showed the reforms were largely in the nature of reactive expedients to criticisms reflecting the reigning political climate. They did however carry with them all the threats of disturbance that changes of such character cause, and so gave rise to an erosion of confidence in the stability of the NHS because of the risk to its basic premises. This was given an added jolt because the ever-increasing expenditure of the NHS was alarming to the Conservative Government which when elected in 1979 pledged to contain public expenditure. By 1980 the Service was coming under close scrutiny, particularly its management arrangements.

In reviewing the Trust's policy for the future, the Trustees confirmed the rejection of the notion of their being merely a grant-making body responding to applications for support; and the *Eleventh Report* of the Trust covering the first five years of the Eighties served to underline the development of the fundamen-

tal approach of the Trust as an independent 'Institute' surveying the field and shaping its programme accordingly. This to a large extent was no more than the recognition of an evolution in the mode of practice and reaction to the changing scene in health since its inception in 1940.

The subjects of the **seminars** and **publications** during the period indicate that the Trust was particularly concerned with the long-established aim of the application or extension of knowledge and the need for better information which would lead to the better co-ordination and improvement of the infrastructure of health services. This was rooted in its experience of the previous 40 years. Social and economic history suggests that the promotion of a greater understanding of the complexity and the essential elements of effective health services for the population, is a *sine qua non* of improvement. It also suggests the way is through an evolutionary approach.

In looking back over the history of the Trust in its reactions to the changing health scene, it is rare when it has not been operating in an atmosphere clouded by the complaint of hard times and constrained resources for health care services. This was true even before the establishment in 1948 of the NHS as the major system of health care in the UK. Such general complaints concerning health care institutions are not confined to Britain but are indeed a worldwide feature. In an ideal democracy this would place an onus on complainants from all interests, a duty to analyse the problems closely to find the reasons. The Trust's hypothesis is that it would be wise and beneficial for the morale of those working in the health services, for commentators really dedicated to improvement, to be realistic about the perspective of the health scene. Because there had been a substantial positive advancement made in health care services for the British people during the previous 40 years, it had become a tenet of Trust belief that there was a need for all of us to be constantly reminded not just of its shortcomings, but of its ideals, achievements and positive virtues in order to put in perspective its major position in health affairs and in British society.

In retrospect, to judge from the welter of criticism and comments from the vast number of pressure groups and professional critics around the fringes of the NHS it had to be accepted that the general standard of debate had never been high. This perhaps poses a special obligation on the part of uncommitted independent bodies to seek to analyse and present

as many facts as can be established, if only to put into perspective the kind of comment and opinion which tend to obscure the significant issues, and perhaps as a result, retard the development of public policies desirable for the improvement of health care. There is indeed a strong case in the interests of good government, for the greater encouragement and use of independent bodies uncommitted to narrow interests as a public policy, perhaps even through subsidising the activities of such organisations. This is the case in international affairs, as exemplified by Chatham House, on the theory of their being as much a part of the machinery of democratic government as the Ombudsman is now seen to be, in a not so different context.

To play its part in such a design, the Trustees continued to interpret the policies of the Trust as broadly and flexibly as the Trust Deed allows, since it was believed the improvement of hospital and health services might have challenging implications for a whole range of public policies and social behaviour. This did not mean in the event, seeking to deduce from generalisations the analysis or exploration of the subjects and projects chosen but it does imply that it is important to develop means for the improved presentation through analysis and weighing up the evidence of information which illuminates separate as well as the sum of health policies.

A specially important question recognised by the Trust at the beginning of the decade was whether the existing priorities declared by Government contributed to the improvement of those fundamental services which a caring society must be prepared to offer to the obviously needy such as the handicapped of all kinds, as well as the mentally ill and the elderly if it wishes to regard itself as civilised.

Indeed a clear example of this was the failure of Government to co-ordinate the policies of the NHS and Local Authorities for the elderly and the mentally ill, the need for which an 'intelligence' of the situation (cf. *The Impending Crisis of Old Age* (1981) and *Between the Acts* (1984)) would have established. Indeed it was specially highlighted later in the *Griffiths Report* of *1986* on community mental health etc but has yet to be followed with strong action.

The complexity of the several political issues of power and financial responsibility which apply in matters of health makes such co-ordination difficult to achieve except as an objective at the conclusion of a theoretical exercise in political science. Yet

that does not excuse the paralysis of politicians seeking to assess what is best for the people they are elected to serve. It has to be concluded that those who take decisions are not always well served by applied research in the health field by those responsible for tending the machinery of Government. This gives a special spur to external agencies to find the means for their conversion to seeking more rational considerations in periods when reform of institutions is in the air.

2. THE MAJOR CHALLENGES

It is a stimulating challenge therefore to the independent institution, albeit with limited resources, to commission research and publicise all that may stem from the results: which leaves the problem of how best non-politically to point to those conclusions which are firmly based, and occasionaly almost irrefutable. Official policies when based on political considerations may occasionally ignore some of the crucial facts, or perhaps suggest properties for this or that theory of practice or development, which are more expedient or opportunistically optimistic than they are real: but that is in the nature of things politically inspired.

By the mid-eighties this was particularly relevant to two of the major recent themes of recent years, that is, the emphasis which tended to be placed on the likely dividends from **improved management,** and from the hopes of greater coverage of the population by a rapid **expansion of private medicine.** Both these as policies require greater analysis and assessments of the effects of optional policies on the population as a whole and their limitations as well as their strengths than governments are wont to consider. The effectiveness of all Health Services depends on the care and dedication of people concerned with patients; and for rational decision-making it is desirable to put aside the polemics which, because these tend to extreme polarisation, distort what can effectively be done by improved management and by combinations of both public and private enterprise in the services on which patient care depends.

Indeed to strive towards improved management, and to search for the effective 'mix' of public and private endeavours, are activities in pursuit of the Founder's original hope in setting up the Trust to be enterprising and that

in the course of time a truly national health service might be evolved which would enhance all that is best of both public and voluntary

effort with the maximum of economy to the State and the private purse.

3. A PERIOD OF CHANGE AND UNCERTAINTY

Part of the approach to policies for improvement has been the recognition that it has been too easy since the inception of the NHS for anyone to play the role of Cassandra about health matters and the future of health care at anytime, and to make cynical or pessimistic projections based on criticisms of shortfalls in current arrangements, conjuring up a depressing picture in aggregate. Yet this does not necessarily mean that certain policies adopted by one Government or another threaten the whole fabric and morale of the NHS and it is important that this should be kept in mind by health professionals as well as the public. Health care services are essentially conservative in nature and rapid change is unlikely, but it is certainly true that however relatively mild some of the policies by Government adopted in the early Eighties, their influence on the behaviour of management affected particular areas of health activity and in certain instances, upset the balance and rhythm of particular institutions and services. The more significant of these, some perhaps more real than others, can readily be identified as influencing the Trust's outlook and activities.

The advent of a Conservative administration in 1979 had fired widespread discussions about alternatives to the long-standing principles of central public financing of the NHS, portending possibly the introduction of alternative methods such as an insurance base, and ultimately the ideology of the 'market'. It seemed important therefore for the Trust in the spirit of Lord Nuffield's hope, to look carefully at questions affecting the **public and private mix of health services** available to the population since the Trust's interest has always been concerned with health services as a whole. Some previous publications had given views of other systems elsewhere and of the principle of 'market'.

The idea behind the collection of papers specially commissioned and published in 1982 *The Public/Private Mix for Health: The Relevance and Effects of Change* was more ambitious. It was an attempt to analyse the contemporary facts available and views concerning health services here and abroad, so that public policies on change could be judged objectively. A basic knowledge of the facts would, it was hoped, be important in the adoption of policies by Government of whatever complexion.

It was clear from this study that the wilder estimates of what is possible by way of **expanding the private sector** to fill gaps and improve services as a whole had been exaggerated. Again, **alternative methods of financing health services** did not seem to have worked to solve similar basic problems of provision and improvement being experienced by other countries in the West.

A notable point was made in relation to the Trust's policy of seeking to bring a more realistic perspective to the problems of health care and its financing, in the *Economist Intelligence Unit Report, Private Health Care in the UK.* In commending *Public/Private Mix for Health*, it commented that

> among its excellent qualities... it raised the standard of debate on policy analysis in health care far above the 'emotional' superficial and naive outpourings of the competing ideologists.

Indeed raising the standard of debate had always been a major objective of the Trust's programmes; and in this case the objective seemed to have been achieved since some of the more radical proposals being made at that time disappeared.

4. REFORMING STRUCTURE

Nor, to risk an immediate judgement, did the widely canvassed structural reforms which involved legislative action on the part of the Government in 1982 and resulted in the abolition of Areas which had been hailed as an important development 10 years before, seem to do much, except cause yet another upheaval in administrative arrangements and changes in personnel at the top of the reformed structures. Indeed it was obvious the 1973 reforms had done little to meet the real challenges posed in the Trust's *Challenges for Change* exercise, which still remained.

The 1982 reforms, however, immediately preceded changes which, while requiring no legislation, were probably more fundamental, namely those following the Government's acceptance of the recommendations of the Griffiths Committee on management. These were to appoint General Managers for each Health Authority (as well as for Units) with an NHS Management Board at the centre, apparently to provide for the first time an identifiable body at the apex of the NHS, even if embedded in the Department of Health (although neither *de jure* nor *de facto* separated from the Civil Service structure). Indeed, a glance back now suggests that the 1982 re-organisation and the concurrent

implementation of the recommendations of the Griffiths Inquiry, again represented processes of tinkering with structures, to attempt over-simplified solutions to problems which have more fundamental origins in the various elements constituting health care practice.

It was not, however, difficult to surmise that the uncertainty about the future of the NHS, nourished by the changes was having a deleterious effect on morale and outlook, breeding anxiety and resentment which militate against efficacy.

Nor was it easy to analyse the process of change following the appointment of general managers with added powers. It was evident that inevitably, for judgment as to effect, this would have to be looked upon as a long-term process. Whether it would have a real effect on patient care other than a formal realignment of professional management practices, could be judged only when it got fully underway, and any change in efficiency and effectiveness of the health service as a whole or in its several parts could be measured.

The Trust saw its most useful role in making a positive contribution to the general debate through continuing to concentrate on the various private **seminars** and the **publications** which sought to explore through discussion based on commissioned papers the many complex problems which remained and were relatively unaffected by the structural changes.

One of the most significant of these, in pursuit of the philosophy behind Health Care practice was the series of seminars (128 etc) and the commission to Professor Alain Enthoven which produced *Reflections on the Management of the National Health Service* (1985). The belief is widely held that it was Professor Enthoven's exposition of options which led to the application (albeit in a markedly different way) of a 'market' philosophy which underlies the strategy of the White Paper in 1989 and the subsequent NHS Act 1990.

5. THE FINANCIAL CLIMATE

Yet it was probably the major source of aggravation, the chronic financial restraints, which continued to affect the Service and led to a particular anxiety on the part of individuals, institutions and authorities, inevitable preliminaries to the lowering of morale generally.

It is not exactly an original observation since it is borne out

by much of the literature on health in recent years that Government policies are occasionally at cross-purposes. Never more so are they in the complexities which bedevil the way in which health care is made available to the population at large.

It is almost to state the obvious that a major political objective must always be to avoid the charge of failing to provide resources adequate to sustain the rising demands created by demographic change, new techniques, and types of care, including pressures for various broad-brush priorities much in vogue politically eg. **community care, prevention** etc. Failure to do this adequately and the combination of constrained resources together with reallocation (RAWP) policies which affected 'losing' Regions (and consequently Districts) made for loud protestations about the crisis looming in London. Such difficulties are immediately highlighted in the media and tend to distort the national picture, thus leading to a lowering of morale not only in London but with a knock-on effect in the Provinces too.

There were also longer term effects of the financial constraints to an ever-hungry NHS which were not immediately obvious, such as those inherent in policies which affect the academic world of medicine in both the teaching and research areas which are of crucial importance in health care.

6. THE DETERMINATION OF PRIORITIES

A major question for the Trust was how best to analyse and illuminate the motivations behind the determination of priorities in a period of financial restraint; and specially to highlight the lack of crucial **information** on which effective management policies could be built.

It is quite clear that in periods of acute financial restriction, radical policies involving increased expenditure can only be implemented by a system of 'robbing Peter to pay Paul', which is likely to antagonise the 'losing' Peters of this world. This can be dangerous in political and social terms both when the 'losers' contain a substantial portion of the articulate middle classes who are well equipped to exert political influence, and when the chronically poor can also be shown to be victims. Indeed the social costs can be great. The apparent benefits of a particular policy which is adopted might sometimes be thus dissipated by the need to provide for the **social** as well as economic costs.

In the health field the overall effects of the official policy on

priorities for services cannot easily be judged if in a period of financial reallocation the 'losing' Authorities lose out in real terms, and have to retrench by suspending particular services. If a strategy for redistribution or 'efficiency' involves radical treatment to relieve 'unfashionable' services and bites deeply into an existing preserve of some special interest particularly if it is one or more of the acute services, the political obstacles will be formidable. The multitude of special health interests in matters seem to ensure no ultra-radical policies and so tend to obscure a clear pathway to improvements designed for overall effectiveness.

Britain is hardly a revolutionary society and, taking into account the conservative nature of medical care, all the Trust experience suggests it seems likely policies decided upon will invariably involve creative compromises between relatively minor radical change and continuous incremental change. It seemed important to bring out through the private seminars etc., that these measures had to be seen against movement in the social, economic, and political structure of Britain as well as in socio-political values and the seeming weakening consensus on behaviour by pressure groups. The emergence of specific pressure groups, each with its own policies when added to what many identify as (and thereby help to create) an increasing fragmentation of the consensus between broad interests within society, tends to accentuate the already complex problems of health services. The growth of such a variety of disparate strata is perhaps a symptom of partisan militancy and to some extent a volatility in support of political parties. The results are a weakness in overall consensus and inevitably distracting attempts to change the rules of the games. By the mid-Eighties there seemed to be a society-wide fragmentation into interest and pressure group politics whether ideologically motivated or not, away from the previously fragile yet identifiable consensus politics. Consensus politics are unlikely to flower during the decline of stable party politics, unless the political centre comes to dominate. By this time, however, the political centre could be identified as but another clamouring voice among the many.

7. SOCIAL AND POLITICAL INFLUENCES ON THE HEALTH FIELD

The effects of changes to the social and political scene upon the NHS and health services in general are difficult enough to

quantify in 1990, but were even more so at the beginning of the decade. Yet it is always important to try and gauge their effect on health services policies especially for bodies whose interests lie along non-political lines.

It has been possible in recent years to detect a tendency towards the bureaucratisation of professional etc., associations, the bulk of whose members work in the NHS, especially those whose work is complementary to medical and nursing practice, such as those in management, and in other areas not directly concerned with care. Thus a search for improved professional status - justified perhaps in comparisons of the rewards of labour - may variously produce as unwelcome by-products a lack of flexibility and concordance with other professionals, a diminished appreciation of the patient's general needs, and hostility to the style of management, which to be effective should ideally take account of all and not merely the exclusively fashionable issues. When fiscal constraints meet such sociological pressures in the case of ancillary support workers determined to improve their economic position, the results may be of lasting damage. This is particularly apt when one considers the legacy of strikes as in 1982 or the general climate of increased, if often latent, hostility, between workers (medical and nursing included), and management which perhaps reached its zenith later after the 1989 White Paper. All of these are bound to affect patient care. Again, when political and professional rhetoric consisting of the denigration of management is allied to the increasing constraints on resources which govern the elements necessary for flexibility of management, then low morale is almost bound to result - and a lowering of morale may come to be seen as the greatest problem in improving services which are essentially personal.

Although the differentials in rewards of labour give the medical profession special status, the same problems arise when priorities are set which have a bearing on the several clinical specialist services. The clinicians are expected to pay more attention to Government priorities, yet often without the backup of resources which would make the task of adjustment easier. Increasingly, it was being expected of them to be managers of their own resources, sometimes even over the whole field of clinical services if tacitly within their 'workplace'; or often as part-time managers. If as happened with the 'Cogwheel' recommendations they are given neither adequate goals nor tools, nor stability of career structure in administration

to accommodate a management role, it will hardly be surprising to find a resulting confusion of attitudes. Indeed managerial change which tends to the superficial, along with inadequate support services, provides a good excuse for clinicians to adopt what may seem to be ultra-critical attitudes, and artificial polemics between 'care' and the 'management' of resources is a not infrequent result. As was noted specially in the Fennell Report of the Kings Cross Underground fire, the manager has to reconcile efficiency and economy with overriding safety; and in a Health Service particularly, it was constantly remarked in seminars that safety cannot be short-circuited by economies alone. Nor in the absence of good data is it possible to measure **effectiveness** which is a necessary factor of **efficiency**.[1]

8. EFFECTIVENESS OF RESOURCES

The objectives of the 1982 reforms with the accent on monitoring the effectiveness of the use of resources were in themselves praiseworthy. Suggestions for reforms can however all the more easily be denigrated as impractical or disruptive, if full support is not made available, as was the case following the 'Cogwheel' proposals some fifteen years before. Sometimes the mythical golden age of consensus management and good lay administrators was invoked, yet it was only recently that many clinicians were criticising the old system. Nostalgia for times past, which probably never were, is rarely a morale-booster.

9. AT THE APEX – THE DHSS

It is evident that any analysis of the NHS cannot be divorced from the influences of the Department of State responsible for its funding and general direction. In recent years, Civil Servants had been diagnosed as suffering from low morale engendered by the increasing number of enquiries into their efficiency which eventually produced *The Next Steps* which marked a radical departure from previous policies on the machinery of Government. On top of the more general criticisms to which the Civil Service is universally subject, the DHSS did not seem to be exempt. Particularly it did not escape the managerial innovations being pressed on NHS Authorities. Undoubtedly, there had been a change in style and it was clear that the attention being paid to the efficiency of the public sector as a whole, was leading to the

[1] This is specially discussed in the author's 1990 Rock Carling monograph *What Price Quality?*

requirement for different attitudes on the part of Civil Servants. This does not necessarily imply that there was in process a radical change in the high idealism and political neutrality required of public servants, but there was perhaps the hint of a policy of interventionism by the Department in the case of the NHS sharper than hitherto. Again, this seemed no more than was occuring marginally within the NHS as well, by managers being encouraged to concern themselves with matters formerly almost exclusively in the province of doctors.

In this context, the Trust's objective on convening private informal exploratory seminars on key issues was designed to play a variety of roles which did not obtrude into internal matters which are the business of the Departments of State and of Ministers.

It had long been evident that on a number of issues, the alternative options ranging from 'centrist' to local, which in turn involved both the 'superficially radical' and the 'radical' being discussed on both sides of the political spectrum. As in society as a whole, the health bureaucracy possibly reflected a fragmentation into different camps which was starker than before. As a result, the tasks of both developing and co-ordinating policy required an examination of issues from the perspective of different Divisions, Branches or informal coalitions in the health bureaucracies.

To take some examples then current, which are reflected in the seminar titles listed, in the absence of clarification and co-ordination of policy, the implementation of **budgeting reforms** did not seem altogether compatible with the implementation of other management reforms; **information policy** did not seem to be altogether consistent with the distinctly separate policies for computers, and so with the availability of finance for investment in **information technology** support systems; and - most importantly of all – **priorities** decisions for the NHS, in the light of **financial constraints,** were occasionally difficult to reconcile adequately with stated policies for devolution, to the operating authorities. This was particularly evident in the case of **long-term planning and finance** which have effects on other Departments of State which have different perceptions of their roles with regard to 'Health' policy, eg., **Environment and Employment.**

Yet it was the Trust's belief underlined in 1985 in the *Eleventh Report* that it is possible for differences and differing assumptions which may not even have been overtly perceived, to

be highlighted by patient 'intelligence' analysis: and that the Trust as independent observer could contribute positively to the provision of a better perspective by stimulating research and discussion on some of the major formidable issues which are bound to emerge in the long term. It is perhaps particularly apt if significant that it was a former Permanent Secretary of the DHSS, Sir Kenneth Stowe, in the 1988 Rock Carling monograph asked, of the result of research activities, 'Does Anybody Listen?'.

10. IN THE WAKE OF CHANGE

A major danger to morale and efficiency was seen as the possibility of pessimism about the future of the NHS being allowed to develop into a self-fulfilling prophecy, leaving general criticism of the 'structure' of health services as apparently the only worthwhile activity leading to reform. Eventually attention would have to turn to the relevant issues in the infrastructure. Even within the constraints then current, it was believed there was scope for innovative ideas and policies - by Government, within the NHS, and from independent groups and individuals, to explore and draw attention to seeming inconsistencies if not follies of policy-making, and to tackle a number of key areas in the complex infrastructure likely to be affected by the problems being identified.

This is especially so where problems are not wholly endemic due to political and structural factors, but are substantive as to professions, specialities or functions or even methodological, in the way objectives are identified and pursued. It was part of the belief of the Trust, exemplified by its activities that such problems are likely to be addressed successfully by the development of more sophisticated and subtle policies, through the development of strategic concepts, based on studies of cause and effect.

11. EVALUATION OF REFORM

During the decade it was not difficult to believe that the reforms in structure and in management which bulked large in the forefront of contemporary thinking about the NHS and reached their peak in the White Paper of 1989 and the NHS Act 1990 would be judged successful only if they could deal with and improve such basic matters as **equity in access; the quality of**

care to patients; the services to the more vulnerable groups in society such as the elderly, the mentally ill and handicapped; maternal and child care; the disabled; and the efficiency in use and application of developing technology; and above all **morale.**

Any changes made would take on real meaning if they could bring not only effective teamwork between the professions within the Health Authorities: but also in improvements in the interface between the health and specialist services and the separately managed family practitioner services, together with the whole range of social services whose effectiveness has a bearing on the health of individuals and populations.

The record of the activities of the Trust in the decade shows its approach to many of the elements of these problems. The question still, however, continued to be 'How could the decision-makers be persuaded to listen?'.

12. A CHANGE IN MAJOR THRUST

In 1986 there was an administration change when the author retired and Dr Ashley-Miller was appointed to the Secretaryship of the Trust.

The *Twelfth Report* (1985–90) indicated 'the main thrust of the Trust for the next few years should be concerned with the care of physically disabled persons' and that 'this new major thrust' should be supported by a continuing and developing interest in a number of closely related areas as follows:

General Practice/Primary Care; Nursing Practice, training and manpower; Assessment of morbidity in relation to the allocation of resources to Health Authorities; Local hospital/community/non-NHS agency relationship and co-ordination; Assistance to General Management for the improvement and development of services (concerned with both qualitative and quantitative aspects); Waiting lists and 'blocked beds'; Development of the private sector into caring.

Historically the Trust has conducted its work by means of informal Seminars, Working Groups set up to examine particular issues, commissions for individuals to carry out a wide-ranging policy study; there have also been specific research commissions to individuals and agencies (eg., Grant Thornton management studies). Finally there have been the award of Fellowships (eg., the Rock Carling; The HM Queen Elizabeth the Queen Mother; or for travel) and the support of research studies through grants. It is proposed to retain this range but

to alter the mix. A marked increase in research expenditure is proposed to assist Health Authorities to examine and experiment in order to improve the effectiveness and efficiency of their services, with the emphasis on such studies being widely applicable. In order to increase the Trust's intelligence role selected individuals will be commissioned to prepare brief status reports on particular issues. Such 'snapshot' studies would not necessarily be for publication.

This increased research programme will be developed mainly on a commissioned basis; but it is hoped that the Trust will receive an increasing number of good unsolicited applications which of course can be 'shaped' in discussion towards Trust interests and policy.

II. 'INTELLIGENCE' INTO ACTION

1. ON THE ROAD TO THE WHITE PAPER

In the case of health services the immediate effect of change is often more cosmetic than real. It was evident by 1980 that the position in health care in the UK was one of flux and confusion about the likely results of the recent changes of structure principally those from the 1974 reforms as they affected management. The questions raised were not just on practical issues such as the degree of central direction likely to be involved as opposed to more devolved responsibility for which there was a clamour, but for their effect on patient services and professional practices. The debate was actually one in which like so many issues concerned with health care it could be surmised that slogans and rhetoric might sour dispassionate analysis. Trust policies had long been concerned in the main with seeking to raise the standard of debate on many inter-connected issues of the infrastructure, continuing to probe current emphases in policies, and examining what these actually mean in terms of patient care. In practice this meant trying to put into perspective the various developments, managerial and otherwise, and consequential structural changes which are judged to be a result of central policy initiatives; and not forgetting the problems of those areas of service relatively untouched by such developments which too often are forgotten in the heat of debate on structures.

Against the background of dominant priorities seen at any one time and in the selection of ever-moving targets the Trust's three-pronged inter-dependent attack through **grants, commissions, commercial contracts,** a comprehensive and flexible private **seminar programme,** and a wide-ranging commit-

ment to **publications,** was honed as its operational practice. The record of the decade shows the range and scope of commissions etc, many of which in the most recent period will take time to show results.

It had long become accepted that the cost of action research, and even more the implementation of results which involve substantial outlays, militates against practically all but publicly financed bodies to engage in radical experiments or demonstrations. The optimistic assumption behind the Trust activities therefore is that the results of the **grants and commissions** programme would be noted by the various Authorities from the Department downwards and be applied in the drive for 'improvement'. They would thus lead to **experimentation, pilot studies, trials, and implementation** of results in a wider setting.

For research bodies this policy means placing a greater stress on support for **research** which would help policy formulation and decision-making, and including **communication** with the aim to persuade and help the service authorities themselves to experiment and innovate, albeit restricted within a framework of settled priorities and limited budgets.

Seminars were therefore **exploratory**, geared to 'intelligence' on the results of research and current pressures, for the further development of issues; **continual,** as when a special Working Group tackled a series of issues in the same vein; and also, almost above all, **educational** in the broader sense.

Publications too had always been designed in their presentation to be **stimulating and educational,** aimed at airing ideas as contributions to a health service literature with bearings on policy formulation and to explore the way to potential developments.

All these can, especially in combination, be both formidable means and lead to positive ends if the authorities at which they were aimed had an 'intelligence' capacity, retained resources for development and were not too wedded to expediency as a prime policy. Yet while such suppositions are perhaps rather more optimistic than immediately realistic, they befit a Foundation determined to take a long view.

Thus, while the Trust's programme might appear selective in discrete sets and types of activity, it will be seen on inspection that many are inexorably linked and the main thrust has the common purpose of looking to a future in which resources could

be used rationally and deployed to maximum effect. While all were related directly to the formulation and implementation of contemporary health policies, they also stemmed from evolving concepts developed from series of critical examinations which formed an institutional memory concerned with the objective of improvement established in the earliest days of the Trust. The broad aim was to illuminate how effectively health services in general and in particular the NHS operate, how they function and how their quality can be improved.

From the beginning of the decade it was evident that the search for better public management had become the main approach to health policy by the Conservative Government. This initiative was reflected both in the 1982 reforms and later in the implementation of the Griffiths proposals on management. Yet the principles behind the NHS seemed unlikely to be breached and such changes as were made seemed to mark steps in the pragmatic evolution of the system of health care and to run counter to prospective radical reform of the NHS, for which there had been at certain times some groundswell in the Conservative Party.

In seeking in a non-partisan manner to make a vital contribution in this area, the Trust continued in effect to encourage the exploration of different channels in commissioning research: in particular, using **management consultants** as well as more traditional research units and individuals in the Universities. Such an approach is not inexpensive and can have its pitfalls as well as its advantages, but the Trust's (albeit limited), experience compared with its experience of academic research suggested that a judicious and sparing, yet broad and imaginative approach to commissioning studies from such sources was likely to reap benefit. This proved to be true even in areas formerly the preserve of academic research units which regrettably, because of Departmental research policy, seemed to be in relative decline (125) compared to the promise of the time of the *Portfolios for Health* (1971-3). Given the current emphasis on efficiency, it was hoped that studies of key aspects of the health world by management consultants would add to the knowledge on which public policy particularly concerned with technical questions might be based. It was felt this was particularly true for such projects concerned with contracts **for non-medical services** (13,39), **cost accounting** (29), **and budgeting** (30), as well as those directed towards **management**

development, training and education (28), and the **development of structures and skills** (126,129) at all management levels of the NHS.

The contemporary stress on good management was hardly new to the Trust. Indeed the lack of an identifiable apex for the NHS had been a matter for comment in Trust publications. If, as a result of resource constraints in the face of ever increasing demands, the emphasis on the need for choices to be made, now made for greater attention to be paid by management to the comparative evaluation of developments, then this also was a challenge to which the Trust had long drawn attention and which was reflected in its programmes. Study, Experiment, and Demonstration were key words in the early reports of the Trust and if the Trust had had to modify its policies because of the cost of action research involved in experiments, the sequence is no less true for orderly evolution. Because Health Authorities had become more sophisticated entities than they were, and were therefore as capable of carrying out fundamental 'intelligence' operations as external research bodies, and with greater resources to boot, it seems obvious that the pressure for Authorities to seek the formulation of methodologies to help more rational choice becomes a priority in itself along with the training for the skills necessary. It was evident that to be effective however, evaluative studies require a commitment on the part of Health Authorities to develop successful means, the better to reach rational decisions on resource allocation and planning (and now constraints) which reflect acceptable priorities and needs. An excellent example of this to which the Trust drew attention by financing the publication of the series of papers *Medicine and Management* was Trent RHA's initiative in its forums at which clinicians set out for management the latest developments in certain specialties.

While the external 'Institute' has an important place in the selection and exploration of topics and can embrace many factors, research which does not lead to implementation is incomplete and can be frustrating. The stress which in the Eighties was being laid on evaluation (eg. of **effectiveness and efficiency** and given a special place in the 1985 White Paper) - was a concept raised in Cochrane's *Effectiveness and Efficiency* Rock Carling monograph in 1972. It was thus more than just a product of hard times, even if these always make such themes more urgent to Health Authorities. Such a stress had in fact been

central to the Trust's priorities certainly for the previous 20 years, as reflected in many of its activities, and in the specific observations made in previous Reports. The theme of effectiveness is also central to the ways to achieve the purposes of the Trust, the improvement and better organisation of hospital, medical and associated services, which have continued to be explored by the Trust since its foundation.

Indeed the periodic Reports of the Trust together with its list of publications over the years, showed it had spanned a wide range of topics. Some of these inevitably had roots in the past, others have been garnered along the way as a result of a consistent policy of review of issues, events and gaps of knowledge.

The major topics addressed by seminars and meetings at the beginning of the decade involved ten Working Groups and a number of symposia (116-138). These were added to later. As always, the objective was the elucidation of selected issues which not infrequently were the subject of commissions or grants. Some of these resulted in publications to provide bases for further discussion.

In the general area of official priorities, such topics as **management, planning, resource allocation,** and related needs such as **training,** information, and research were prominent in the programme, and had been developed from earlier projects of the Trust. Some of the initiatives were however slightly different, aimed at more specific targets than before. Thus, because of the creation of new bodies concerned with the NHS, such as the NHS Management Board, and the NHS Training Authority it was felt that attempts should be made to help illuminate what seemed to be their major tasks.

Altogether this part of the programme added up to a series of informal educational initiatives by way of such forums, to fit the requirements and character of the times.

2. CONCEPTUAL ANALYSIS OF CONTEMPORARY ISSUES

The question of health services in modern societies has become exceedingly complex. It seemed evident early in the decade that there was an overwhelming need for analysis of policy issues to place in perspective the 'emotional, superficial and naive' outpourings of the competing ideologists.

The Public/Private Mix and the Concept of the 'Market'

Some of the larger issues, not necessarily new had become burning, and required not only immediate review but also conceptual analysis in the light of ruling circumstances. Thus the role of 'the market' or of 'competition', and its compatibility with the principles of the NHS, had become an important and recurring topic of discussion and investigation. Even within the assumptions and principles of public finance for a National Health Service, it is possible to conceive of various patterns of provision operating within the 'market' concept which could be tested. This was seen to apply to a a variety of services: not just in contracting for **'domestic' support** services, but also for **patient services.** In theory, indeed it had become a matter for debate that there was no reason why in the NHS most if not all services could be contracted for, without surrendering the **principle** of universal access enshrined in the NHS Acts: but any arrangements for these would require close monitoring for their effect on the **quality** of services. Indeed it could be demonstrated that the concept of the 'market' and the principle of 'competition' might not in certain instances necessarily involve the private sector at all.[2] It had been already evident that contracting between District Health Authorities for services (or between Units) was possible with the objective of securing more effective services. It was noted in the *Eleventh Report (1985)* that the 'market' may thus be rooted in private or public enterprise as regards both ownership and control, and its contribution or otherwise to efficient use of public resources, allocation and choice, could well become the main point at issue for the NHS, rather than flights into the realm of utopian theory where in the last resort uncontrolled market forces clear every surplus and every shortage!

A number of studies were put in hand by the Trust to explore the possiblities (and pitfalls) of 'market' ideas; also to examine objectively such fashionable concepts as 'cost centres' in Health Authorities (ie. the use of internal costing for support services to improve financial management); 'contracting out' for services; and what is involved in close relations between public and private sectors.

The relative amounts devoted to the **Public and the Private sectors** are essentially questions for politics and for

[2] See Enthoven's *Reflections etc.* (1985)

management. The Government's moves to more effective management of the NHS - the acceptance of the recommendations of the Griffiths' Inquiries in **Management and Community Mental Health etc. and various costing, monitoring, and management** initiatives spurred on by the Government and by the search for 'value for money'- suggested that, despite the pressures from certain quarters, no health service radically different from the NHS structure or financing seemed likely within the forseeable future - a conclusion eventually borne out by the 1990 NHS Act. This was not to deny that the present system should be examined for **efficiency, effectiveness, and geographical equity:** and similarly for the efficiency of management in the public sector.

While the relative proportions of the public/private mix seemed unlikely to be significantly altered quickly, there is always likely to be a question of how health services might be improved by altering the proportions of such a mix, and also whether the NHS could improve certain of its services through co-operation with the private sector. A number of initiatives were developed in this area which is important not least for the great attention the subject of privatisation (the meaning and inflections of which are not always clear) gets in the media, and in politics generally.

The book published by the Trust with the title *The Public Private Mix for Health* (1982), was an international collection of essays written by acknowledged indigenous experts each of which reviewed the major elements of systems which obtained in their countries and sought to analyse whether these had a bearing on those problems of health care systems which seem universal. It is evident that most of the major problems facing health services throughout the world are not dissimilar. Indeed there is much to be said for the concepts and structure of the NHS, especially during a period of cost containment to ensure social equity, if accompanied by an examination of modes of fruitful co-operation between the public and private sectors. This book's eternal message that theoretical absolutes (whether the utopianism of the private market or of flawless social planning) were unlikely to be adequate, was perhaps timely as a steadying force in the realms of policy-making in a period of great uncertainty. Its reception reinforced the Trustees' view that 'intelligence' on this issue is likely to be important, and as a

contribution to the debate, the book itself might have a practical effect.

Subsequently, a Trust Working Group, **the Managerial Group** (136), was set up to review a number of topics in the public/private area. Certain studies were commissionsed, including a detailed review of tendering for **domestic services** (13) by Thornton Baker Management Consultants which resulted in an impressive and widely welcomed publication not least for its use as a practical guide and handbook in the management process with the title *Health Services Management, Competitive Tendering in the Provision of Domestic, Catering and Laundry Services* (1984).

In the same area of interest the practicality of setting up a **Register** of **competitive tenders** was explored at the Centre for Health Economics at the University of York by means of a grant (27).

Other initiatives were what might be expected from closer co-operation between the public and private sectors. An investigation of **clinical contracting** was carried out also by Thornton Baker (33), to complement the earlier work.

The particular objective of all these initiatives was how to use both public and private sectors to improve efficiency and achieve a better use of resources.

To improve the perspective it was hoped that the 'remarkable' report (to quote The Economist 22 June 1985) by the Trust's visiting consultant Professor Alain Enthoven of Stanford University *Reflections on the Management of the NHS* (1985), published in the Trust's *Occasional Papers Series*, would provide an acceleration and direction to experiments as well as a significant contribution to the general debate on the practicality and use of an 'internal market' within the NHS, and whether generally it would be worthwhile to experiment with the stimulation of competition within the public services, albeit managed to secure optimum effectiveness.

It is widely believed that this Report was influential in the ideas in the application of 'the market' in the reforms of the Government published in the 1989 White Paper. Paradoxically, Enthoven is, however, an apostle of incremental change since, like that of the Trust his experience has given him an appreciation not only of the innate conservatism of health care practices but of the complexity of quality in medical care.

Management: The Current Confusions

In the *Eleventh Report* (1985), which sketched the background to the Trust's policies, it was noted that the issue of better management of the NHS had become perhaps the most central issue of the time. This was largely based on the thesis that resources were likely to be relatively constrained under any government of whatever complexion, and that managerial efficiency in the use of resources was likely to be the keynote of prospective reform. The general issue, however, raises certain fundamental questions of practice, particularly in the style of management it is likely to inspire.

Corporatism in the NHS context had hitherto been a product of consensus, and by 1985 with the promotion of the idea of the importance of the 'market' it seemed at first glance to be in decline, with some danger to the morale of those who felt their places in the scheme of health care was threatened if not depreciated in the new style of management seemingly promised in the post-Griffiths' era. This was not to assume that the supposed withering away of consensus management meant in the event, that managers could totally ignore the process of consultation with key health professionals to achieve broad consensus prior to action: but there was some pessimism, even some mourning, about its apparent demise.

The publications and the seminars sponsored by the Trust during the decade listed in the Supplement and referred to later in this Chapter were designed to spotlight some of the material issues in the current debates and against the perspective of a public service founded on certain basic ideals which still remained central to its operation.

It was believed that the concepts which surround decision-making in a 'free' market, amended where appropriate by doses of interventionism on pragmatic, opportunist, or cultural grounds, had already forced the bureaucracy which had to provide for it, into more flexible stances without prejudicing the application of these ideas Thus, in the NHS, 'the market' had become no longer a foreign concept but domesticated in a variety of senses and contexts of that term. The 'market' is of course part of management theory about the efficient use of resources, not an end to itself and the moves towards changes in management arrangements and style in the NHS made it likely that the concept would have to be explored further, when applied.

It was felt there was no need for an excessive polarisation into two camps, pro- and anti-market; for the use of market principles does not necessarily imply the importing of the practice of the private sector with its own peculiar system of distribution and rewards so much as the use of incentives. It seemed to be not a question either of whether the efficiency of services in the NHS was to be improved by selective market practices, or by more systematic corporate management and planning. Each had a role. Certainly, corporatism in its 1970s sense is not the term to describe either the former or the latter.

It seemed that if free market principles and scientific management, being means not ends in the NHS context, are to be part of the evolutionary process they should best be applied selectively. They need not therefore obliterate the good already established by the best 'administrative' practice which had come out of the experience of consensus in the NHS. It was accepted that consensus purely for the sake of keeping peace between warring factions was of doubtful worth. The 1974 reforms placed the accent on the Area at the expense of the District, neither of which was ever actually the operational centre of the specialist services. The individuality of hospitals themselves, the therapeutic centres, was under attack in another phase of the war between centralism and local interests. The trite phrase 'consensus management' had been singled out as a root cause of inefficiencies, although the real state of affairs was confused by the effect of the plethora of relatively minor initiatives and directives from the centre as well as from more localised but still relatively remote Regional, Area, District and Institutional policies. The addition of these to the professional jealousies and suspicions, inevitably lead to the fragmentation and inconsistencies of command which are the death of consensus.

Yet in the Health Sector it is unlikely that a successful manager at whatever level could ever ignore persuasion or the need for consensus in certain professional matters which touch on the overall effectiveness of services. Nor did it seem that any new system of structure and management would be likely to alter the nature of the more fundamental problems endemic to the development of health services in most Western countries to avoid the more general challenges facing governments about the complex problems of the infrastructure of individual services. One of the more difficult questions was the reconciliation of

central control with the increasing pressures for devolution of operational services.

The Immediate Tasks

At the mid-decade the Trust considered the prospect before it.

The setting up of the NHS Management Board was seen as possibly a great catalyst to change, but many of the basic challenges which must be taken seriously if there was to be a significant advance towards general improvement, were still there, as they had been prior to 1974, and discussed 10 years before in the Trust publication *Challenges for Change* (1972). In addition to services for priority clients such as the **elderly** (117,132) **and the handicapped,** these still remained intrinsically related to policies for **education and training** (126,127), **information** (134), **quality assessment** (130), **efficiency and effectiveness** (128), **research priorities** (129) **and implementation of results** (133): and even these questions were often obscured in the complex infrastructure. The Trust initiatives had been designed to probe and analyse the relevant issues as necessary preliminaries to the improvement of health care: and the problems remained

One aspect of the apparent decline of centralism and corporatism raised as a result of the seminars and singled out as requiring close attention in such a social welfare service is health care. If the replacement of consensus involved confrontation and is any way regarded as an attempt to exclude a variety of professional groups and strata from influence, decision-making, and power, it seemed likely inevitably to have in it the seeds of ultimate failure. It was seen that at its best the concept of consensus was an attempt to co-opt the leaders of a variety of professional and social groups: not just for the sake of elite self-preservation but also for constructive social purposes. The lack of participatory democracy which has often been regarded as a weakness of the NHS was often mitigated by attempts at balance and social stability through the adherence of professional groups in one way or another to the decision-making process. The criticism of inconvenience in reaching decisions was often softened by the ability to impart some cohesion and manageability to the procedure of making policy which has a part in the effectiveness of the results.

By late 1989 with the reactions to the White Paper of the year, it was widely feared that the decline of consensus might

also bring in train a decline in the stability of institutions with traditions which provide not inconsiderable positive factors in a service designed to alleviate personal suffering. The fragmentation of society into clamouring interests and the different objectives of professions breeds suspicion between groups and is an important cause in the decline in corporatism's viability.

In the NHS as elsewhere, the philosophy that 'small is beautiful' often omits the corollary that 'small' is also often powerless. The proliferation of self-preoccupied professions in the NHS - each usually activated by the wish to increase its relative status perhaps reduces the overall effectiveness of all to do good. This was universally seen as a major challenge for **general management** which has to capture the non-partisan benefits of clear authority without sacrificing the democratic ideal of consultation. Poor relations between professions is also likely to affect the basic stability of institutions previously imparted by the kind of corporatism which was a special feature of British life in the three previous decades.

Building effective general management in the NHS (which is never likely to mean the complete dissolution of a broadly-constituted consensus) was being offered as a major step in the development of the NHS. The main hope was that the still-powerful perception of the NHS as Britain's most 'un-sordid' institution, and its overwhelming popularity despite growing perception of problems and shortages and constraints, would help to discourage some disruptive social trends. There was certainly evidence that dedication to duty, and the weighing of power or strategic position in the service with the balancing ethic of responsibility and obligation, were still strong and should not be discouraged in either public or independent sectors.

There was some optimism reflected in the programme planned for the future that the Trust's frequent advocacy in the past of continuous central review of service needs based on **good data** and other **relevant information**, might well become standard procedure. The direction of the reforms and the advent of the NHS Management Board[3] could conceivably now provide the kind of focus and apex for the NHS as a distinct entity. This was recommended in *By Guess or by What?* (1978) even if the Board was hardly separate from the Department of

[3] The predecessor of the Management Executive

Health. Experience seemed to suggest that it was doubtful whether, without some major internal reform, a Department of State could ever do this adequately for the complex welter of services that make up the NHS. It had long been evident that a comprehensive evaluation of the effect of both central and local policies and their compatibility had been neglected. A hope was expressed in the *Eleventh Report* that continuous reviews would be made on the progress of the Board as an effective focussing agent to see what degree of success would be achieved; although it was accepted that the answers to the most urgent health service problems are by no means always to be found through the centralisation of comprehensive planning.

There was however some optimism that the means to co-ordinate productive policies for health care in order to get the maximum value for both money and general satisfaction was an important step in providing a greater concentration of effort on settling and achieving objectives. There would however still be a need for a concentrated effort through **research and a comprehensive educational effort** to instil a real understanding of the elements of **improved quality** in health services, probably best through specially organised forums and seminars (116–138 etc).

This was based on the strong belief that there are no substitutes in the management of a public enterprise for the deliberate development of credible policies which can be set out for public view and appreciated at all levels by the professions concerned in health services, as well as by the public. It was felt that only then could a sensible debate on the future of health services and on further policies for their improvement, be carried forward.

Once again this pointed inevitably to the extreme importance of **education and training** for the professions and groups working in the health services, to bring out through probing and discussion, their relative functions and responsibilities in the health system.

Management Training

In the realm of **management training and development** which was seen as an important element in management, the Trust's consideration of the importance of comparative studies, led to the invitation to **PA Management Consultants** (PA) to review good management practice in other large organisations

(128). This exercise was in effect commissioned for the National Health Service Training Authority NHSTA, and the report was published in 1984 as *The Development of the General Manager.* This followed a seminar on Management Training in the NHS which sought to explore the opportunities.

A further investigation by PA was commissioned by the Trust for its own 'intelligence' purposes as well as for the NHS Training Authority, of the more specific needs in management development and training, especially at Unit level. The report *An Outline Management Development Programme for the NHS,* made suggestions for a management development strategy for the NHS.

A seminar on the future of the National Management Training Scheme was also held in association with the National Health Service Training Authority (NHSTA), as a pilot for a series of meetings geared to **management recruitment, training and development, and appraisal.**

The acceptance of the recommendations of the Griffiths' Inquiry on Management promised that there would eventually be a much firmer chain of command within the NHS than had existed heretofore. It was assumed that the new line of management accountability from the NHS Management Board to Regions, Districts and Units would in time achieve compatability and efficient functioning.

Some changes have already been made since, with the replacement of the Board with the Management Executive. As a consequence of the 1990 Act it will be interesting to observe how well this new hierarchy will sit with the political hierarchy from the Secretary of State and Ministers 'downwards' to the Authorities and to the Trusts being established, as well as with the various bureaucratic and professional hierarchies within the Health Departments.

Health Economics and Health Policies

Better management is considerably more than a matter of techniques in the business sense. It intrinsically involves a grasp of the key substantive issues and priorities of the day. In this connection the Trust continued to identify issues in a number of such areas. One of these is economics and health. A series of pamphlets in the Nuffield/York Portfolio (1985) (11) dealing with economic questions affecting the NHS, were commissioned to examine the economic and financial problems concern-

ing the quality of services, which frequently arise because of the lack of a co-ordination of seemingly disparate policies. The aim was to use a collection of economic concepts to assess the problems of different services in the NHS - such as child care; care of the elderly; community care in general, - and also different goals - such as value for money; careful assessment of capital projects; the reduction of inequality. The general objective was to subject to academic discipline, the current priorities and problems in the NHS with a view to recommending more coherent and consistent policies. The Trust also supported a number of other initiatives relevant to the economic issues through grants principally to the University of York (27,63).

An examination in Oxfordshire of problems of health care services for the elderly etc., as a result of the perverse incentives of the social security system (22), was also supported.

3. PERTINENT POLICY ISSUES

The Trust's translation of 'intelligence' into action designed for the improvement of health services over the years has invariably taken the form of searches for pertinent issues as well as the examination of gaps and shortcomings which had not yet become immediate problems. Many of the problems had been identified many years before but still persisted in the Eighties, and were thus included in contemporary programmes. The approaches to those occupying the forefront of attention, clearly reflect a greater sophistication towards many of the unsolved problems of the infrastructure.

Quality of Care

A major interest continued from past programmes was the key matter of **quality of services,** which continued to emerge as a major underlying theme in many aspects of health care rather than a topic isolated somewhat artificially on its own. In the generally accepted analysis of quality the concepts of 'structure' and 'process', which are largely concerned with organisational methods are relatively simple to grasp.

The concept of the 'outcome' of health care however, raises questions of the policies to be pursued in the measurement of **effectiveness or efficacy,** and indeed in the political search for **value for money.** Given the clinical background, any direct consideration of improvement in quality requires a measurement

of recovery or relief, and the difficulties in assessing those are enormous. The important questions were first raised in *A Question of Quality* (1976) and confirmed in the volume *Reviewing Practice in Medical Care: Steps to Quality Assurance* (1981). Both of these reflect the work of the exploratory work of the seminars on quality. Issues of **quality** of services, not necessarily confined to the clinical, are bound to remain active and to bulk large in all moves in the NHS towards better measurement of 'outcome' and 'output' and better value for money.

At the centre of quality of medical services lies the relationship between the teaching of medicine and its practice. In *Reflections on the Universities and the National Health Service,* the 1981 Rock Carling monograph, Sir Frederick (now Lord) Dainton, outlined the historical determinants of the current relationship between these complementary institutions. Its message is that both adequate finance and co-operation between the Universities and their funding through the then UGC on the one hand, and Health Authorities on the other, are essential for the successful continuation of the Teaching Hospitals' traditions at times when overall resource constraints and reallocation of resources cause severe difficulties.

It seemed unlikely that any aspect of this many faceted subject could be ignored in the long run by those responsible at the top for managing the NHS, since quality of product is central to good management even if the problems of measurement are undeniably daunting. The distribution of training costs between the NHS and Universities was the subject of a special study (29).

A private meeting of the principal officers of both the Departments of State involved, the UGC, and representatives of Universities and the Royal Colleges, was convened by the Trust (127), and was an indication of one of the means of achieving the right perspectives.

Care of the Elderly, Handicapped etc

A sector of the services which was seen as likely always to be critical is the **care of the elderly** which already had been the concern of a Working Group, as well as a series of seminars, resulting in the publication of *The Impending Crisis of Old Age* (1981). The principal issues broadly identified were the fragmentation in the financing of care for the elderly between

Departments of State and between both public and private sources; inappropriate placements of the elderly due to separate and autonomous institutions and structures; and overall a lack of flexibility in policies; all of which problems are still with us.

The general issue was pursued on a number of fronts through various seminars etc. (117,132). One of the important publications was the first of the *Nuffield/York Folio series* (*The Elderly. Who Cares? Who Pays?*) concerning the key issue of financial barriers to integrated care. It had seemed from public announcements (and it was amply confirmed by its subsequent omission from the Green Paper on Social Security) that certain obstacles to efficiency and co-ordinated care were being left out of the review of welfare benefits because of the separation of approach, along with changes in the rules for reimbursement of the costs of the elderly in private nursing homes. The Social Security Reviews made this a pertinent topic. The 1983 regulation allowing Social Security to pay for the nursing home costs of the elderly with low incomes and savings to be a charge on Social Security funds, led to a boom in private nursing homes. The proposed limitation of such payments seemed designed to check such a boom, or perhaps confine it to the cheaper end of the market: it also poses questions still not resolved on quality.

In this general area of investigation too, in addition to the first Folio by the University of York, a special enquiry was commissioned from the distinguished psychiatrist Sir Ivor Batchelor (8). His report, published as *Policies for a Crisis? Some aspects of DHSS policies for the care of the elderly* (1984) was critical of the fragmentation of public policies, which have still in 1990 not been co-ordinated to meet current needs. Indeed, in 1990, the disturbing effect of this on residents and patients is already a matter for alarm, and a frequent source of media attention.

In this context, study of the regulation of the private sector, especially of homes for the elderly, was believed to be important. The Trust sponsored such a study at the University of Bath with the objective of getting behind the clichés which are so common in this area. By 1985 it was already clear that regulation was loose and inadequate.

Critical Factors

The elderly too was one of the subjects surveyed in the **Critical Factors to Policy Implementation** seminars contributing to a study (3) which was initiated in response to a suggestion from

Mr Patrick, (now Lord), Jenkin in 1981 when he was Secretary of State. This study also extended into the investigation of issues where policy implementation was being retarded.

Other subjects of special study in this area were **community mental health services** and related systems of care and innovations in a variety of health service practices. The publications which resulted from these, were *Between the Acts* (1984) and *Initiative & Inertia* (1985).

Between the Acts revealed a cycle of fragmented policies and philosophies over a long period 1959–83. *Initiative & Inertia* was the study of **critical factors** in the **implementation** of approved innovations (although there was sometimes a failure to implement). Whether the findings of these studies have had any effect is a moot point.

In much the same line of review a Forum was instituted consisting of a series of seminars on **perinatal and neonatal mortality** (138) which in effect provided clear examples of how political and policy analyses of an important subject, detached from disparate pressure groups, can reveal basic major imperfections in the system. The range of membership did however ensure the conclusions would be likely to have some impact.

Overall issues of management were raised by all of these projects, which above all, call for further official analysis to improve the information necessary for decision-making. The results pointed to threadbare public policies as well as inadequate action in the implementation of policies which are specially sensitive, since they touch large sectors of the population.

In this connection the analysis of health policy into its many components, especially with the critical factors preventing action is a central task.

It was in recognition of this that the Trust continued the grant to the **Royal Institute of Public Administration** (141) to develop **a forum on health affairs** on broad issues in the hope that such a body is specially suited to initiate debate among NHS professionals.

Information

Information was a subject in which the Trust's long-standing interests were renewed in a number of directions (134). One of the most significant aspects facing the problems of information gathering and its use is that it illustrates both the interrelationship of the different types of activities of the Trust and the

flowering of one or two initially limited studies, into a series of major developments.

Thus the grants to the Department of Mathematical Statistics and Operational Research at Exeter University, ranging over many years, had led to the creation of both a flexible **Database** and an **Information for Districts (IFD) system.** This was a major development which roused the interest and participation of a number of NHS Regions and Districts. In providing information and data for all types of management services, the system was further developed, the ultimate objective being to help towards the improvement in management, since the aim was to improve the 'intelligence' for decision-making as well as the access to sources for strategic analysis and service planning.

This major development originating from a number of grants principally to the University of Exeter involved continued activity by two of the Trust's Working Panels, the **Database Group** and the **Health Information Group** (134), which merged in 1983. The Groups had been active in utilising both exploratory and 'educational' seminars which also kept under review health information policy. There was evidence that the practice whereby different Departments of State functioned quite separately on matters even where there is common ground was confusing. The consequence is that Government policies on information were not always compatible and effective. This applied not only to **computer policy** and **information for management and epidemiology etc.,** but also to the various attitudes to and policies on **data collection, analysis,** the **various costing experiments** in vogue, as well as the somewhat crude **'indicators of performance',** being gingerly used by the Department.

Out of these activities came the publication *A Time for Decision?* (1981) a critical review of **computing policy and practice** in the NHS related to **information** policy.

A further initiative in information (as well as in a number of related policy fields) was the publication of an Occasional Paper entitled *Data Information and Intelligence* (1985) which it was hoped might be helpful to the newly constituted NHS Management Board.

To round off this effort, a supplement was planned by way of a collection of commissioned essays from acknowledged experts in their own fields on problems of the day which resulted in *'Data, Information and Intelligence'* (1985).

Research

The Trust maintained an interest in an integral part of the field of 'intelligence' **in policies for research and development** through a standing R & D group (129). This resulted in a number of publications and activities, including essays in *Matters of Moment* (1981) following up the earlier review *Five Years After* (1978). Seminars were also held to analyse the perennially neglected subject of the co-ordination of health services research at Government level, and the relationship of research where applicable to policy and to implementation. Another critical review from the Group was Occasional Paper 3, *A Fresh Look At Policies for Health Services Research* (1985), which directed attention to the problem of interpreting research results by management, as well as reviewing the status and 'management' performance of the DHSS's internal research capability. The Group anticipated that the new NHS Management Board would have to be involved ultimately in research policy.

The publication did not seek to answer the question as to the form of the central health services research capacity, which is a matter for Government and may indeed be a political decision, but instead pointed to **principles of research for management** and the need for organisational coherence between **research** and **management action.**

High Technology Medicine

Continuing on the theme of assessment of priorities through R & D, the 1983 Rock Carling monograph by Professor Bryan Jennett *High Technology Medicine,* explored an increasingly topical issue. The question of the applicability and effectiveness of **high technology** procedures as well as the pressures for 'value for money' exercises are always likely to be highlighted as central management problems at times of resource constraint in the NHS. **High technology** is of course hardly a separate category on its own, for questions of degree often make the difference between 'ordinary' and 'high technology' procedures a grey area; and always keeping in mind that expenditure on 'high tech' may not be actually excessive when compared to (say) the drug bill for the NHS. The management objective must be to provide a framework within which to address questions such as the relative values of **health service 'outputs' and 'outcomes' of medical intervention, ie., 'value for money' exercises** to discover relative benefits of different procedures etc.

It is also related to the question of what is coming to be recognised as the rationing of various health services which is coming more into the public eye and fast becoming a controversial topic. Partly this is because of the need to evaluate and judge the potentialities of scientific discoveries against increasing expectations, as well as a changing demography. All these together continue to form seemingly irresistible pressures meeting a never sufficient NHS budget.

The debate on the vastly greater cost explosion in the USA was leading to questions being asked universally as to how other countries control costs. In contrast to the position in the UK, US 'rationing' is largely by economic forces. Thus social class and possession or otherwise of insurance or other means of access to care are major determinations of utilisation; British 'rationing' on the other hand consists of the informal evolution of priorities by the health professionals, mainly doctors, who control access to particular services. Decisions as to priorities here for allocations are therefore partly conditioned by social expectation, the media, the referral, decisions by GPs etc. Nevertheless it is evident that a systematic investigation of what is actually involved in such 'rationing' which as a subject is bound to become even more acute in the future, is required. 'High technology' is one important component of such an investigation.

The proving of technical advances is yet another reason why the arrangements for **health services R & D** are seen as crucial to good management. Strong and coherent management will naturally include arrangements for the scientific assessment of new technologies.

General Practice

Another long-rooted topic still commanding attention was that of **general practice.** A Green Paper was forecast for the autumn of 1985 which was expected to give some indication of government thinking, although in the event nothing appeared. The Trust, however, continued to keep the subject in its programme.

Support was given to Oxfordshire DHA for an experiment in **educational liaison between GPs and hospital authorities** (143), an essential part of continuing education, and to South West RHA and Cheltenham DHA for a study of the effect of the participation of GPs in **small Community hospitals** (26) which resulted in their publication. Information which can flow

from General Practice is important from the point of view of patient, general practitioner and policy makers, a fact which has since been acknowledged by the Management Executive. A grant was made to finance a study in the development of **information systems in general practice, at the University of Leicester** (4).

Postgraduate and Continuing Medical Education etc.

Medical manpower and **education** generally, and an interest in the implications of the demarcations between primary, secondary, and tertiary care are issues complementary to the better known Trust initiatives in **Postgraduate** and **continuing Medical Education,** all of them subjects of vital importance to anybody interested in improvement in service. The Trust maintained its interest in this with a series of exploratory meetings and a major meeting at Leicester (120), the results of which were utilised to give background for decisions for further action.

A number of interest-free loans were made during the decade in continuance of the Trustees' policy to the further development of **medical etc centres.**

Nursing

Interest in nursing goes back to the inception of the Trust, of *Work of Nurses in Hospital Wards* (1954). **Nursing and medicine** and their relationship was the subject of a joint medical and nursing seminar in Glasgow in 1983 (119) which produced the collection of essays *Hospital Medicine and Nursing in the 1980s* (1984). Support was also given to the United Kingdom Central Council for Nursing to **review the education and training for professional practice** (20), related to the projected need of the 1990s and beyond, which produced the report *Nursing 2000* the recommendations of which have been accepted by the Government. A special grant was made to the University of Surrey to improve the **training of nurses for the mentally handicapped** (16).

Communication in Medicine

Another area in which questions which are raised perennially and indirectly raised in Professor Charles Fletcher's Rock Carling monograph *Communication in Medicine* (1972) is that of communication between all concerned in the health system. The

Working Group on Communication eventually produced four publications. *Talking with Patients* in 1980, *Doctor to Doctor* in 1984. *Communication between Doctors and those in other Caring Professions* in 1986 and *Talking and Listening to Patients* in 1988. Together, these focus on the principles of communication related to all those concerned in patient care and on the identification of common problems which have to be surmounted for effectiveness of care.

Medicine and Social Work

Closely connected to the question of communication, between doctors and social workers especially, is the perception that health care should be a seamless cover as part of Social Welfare for the individuals making up the population, which raises the question of the part of Social Workers in this cover. Different perspectives are often assumed by doctors and social workers: respectively stressing the **medical model,** the **social** or sometimes the **holistic model**. Sterile debates can often dominate such abstract contrasts: which may indeed well be a 'false antithesis' of the type discussed by Sir Douglas Black in his 1984 Rock Carling monograph, *An Anthology of False Antitheses*.

Nevertheless, whatever the validity, such contrasts are responsible for differing attitudes, prescriptions and often hostility. The 1980 Rock Carling monograph by Professor Raymond Illsley, *Professional or Public Health* (1980), was commissioned to explore such issues and in particular to investigate the role of **sociological analysis** in health and medicine policies.

One conclusion which could be drawn from the various linked seminars which have touched on aspects of this matter is that good doctor/social worker co-operation is crucial in a number of senses, from diagnosis to aftercare: in moving towards a better understanding and 'division of labour'; for better communication; and even as regards the reassessment of post-graduate medical education and the relevance of social work training from the medical viewpoint, respectively: above all in the **quality** of the care available.

Professor Fred Martin who was uniquely qualified for the task, had accepted a commission (5) to follow up his investigation of community mental health services *Between the Acts* (1984) and *Critical Factors* (1982) with a commission to consider the place of social work in what is known broadly as health care. His

sudden death, however, meant that this still increasingly important issue was not pursued during the period of review.

Costing and Budgeting

In a return to an early interest which gave rise to the *Report of an Experiment in Hospital Costing* (1952), and *Costing and Efficiency in Hospitals* (1962), and continuing to address areas of priority with implications for a number of services as well as overall allocations to Health Authorities, the Trust commissioned a reconnaissance of existing **systems of specialty costing** and also the prototypes of **clinical and management budgeting** (30), subjects which owe their higher profiles to the Griffiths Management Inquiry. There seemed to be more rhetoric than hard information about such systems and it was surprising, given the length of time which has elapsed between the inception of the NHS and the gradual development of systems to procure data required for a better understanding of the use of resources, that this area has not been the subject of more intensive research and pragmatic action by Government.

Teaching Costs

A related topic concerns the relative contributions of **the** University system and the NHS to **the costs of training and educating doctors.** A special commission to **PA Management Consultants** which resulted in *Education for Effectiveness* (1986) indicated that costing systems in both sectors are inadequate at present to allow the exploration of this topic. While it seemed that no change in the system of financing the NHS was envisaged at the time, it was felt there ought to be greater clarity about sources of finance, in case undue rhetoric in support of 'cuts' or transfers in responsibility, caused damage by default. A noteworthy factor was that it was noted in the USA that cost-control by those responsible for reimbursing the cost of health care was forcing medical education in some circumstances, to look elsewhere for its subsidies, thus being deflected from its historic mission. In Britain the danger seemed to be that both radical changes in allocations in the NHS, and cuts by the UGC (now the UFC) would lead to both sectors assuming that the other should increasingly be responsible for the costs of education. Without adequate costing systems, these disputes could become even more dangerous. Additionally, the justifiable higher costs at teaching hospitals must be analysed specially in

an age when 'specialty costing', if not 'disease costing' or 'patient costing', looms large as a concern of general management, specially in the period beginning in 1991 likely to be ruled by such concepts as 'contracts' and 'competition'.

Ethics and Research

The less tangible but perennial area of **ethics, especially in medical research,** was the subject of a series of meetings which explored the possibility of a rational approach to the problems which ethical committees have to face in these and related issues. This resulted in a substantial grant to the **Royal College of Physicians** (19) in the expectation that it would help them take a lead on this important matter which cannot be divorced from services. A grant was also made to the **Society for the Study of Medical Ethics** (6): also one to the **Wolfson College, Oxford** on the **ethical issues in the allocation of resources** (148) some of which were included in the study by the Edinburgh Medical Group: and another to the University of Southampton to study **ethical aspects of medical research** (1).

Infectious Disease

Infection provides an example of the requirement for an 'intelligence' exercise leading to later identification of practical problems. The 1982 Rock Carling monograph *The Abolition of Infection,* by Dr David Tyrrell showed that the conventional wisdom that infection was a specialty of the past, was severely misleading. Subsequent seminars (the major of which was in association with the Wellcome Trust) identified it was imperative that the major 'new' infectious diseases should be monitored individually and for their effect on other disease entities. But also and possibly more to the point for management, it was desirable to discover the reasons why the specialty of **infectious diseases** was in decline. Those identified ranged from the bureaucratic to the financial. It was concluded that the main source of regeneration of the specialty was likely to be a greater intellectual appreciation of its importance, with additional academic posts being required in order to attract candidates to the specialty and so eventually to its upgrading.

Inequalities in Health Status etc.

Inevitably there are important areas which have proved difficult to explore systematically. Perhaps the best example of this in the period was the investigation of *Inequalities in Health* which

attempted to explore in greater detail a number of issues raised by the polemical tone of the so called 'Black' Report of 1980. As Professor McKeown had already demonstrated in *The Role of Medicine* (1976) the most significant factors leading to the socio-economic and class differences in health status identified by the Black Report are outside the remit of what are considered as health services policies and so required joint action in social welfare policies. As had been noted in many publications, those problems which can be tackled strictly within a service context, such as the study of 'blackspots' in certain Districts, may indeed come into conflict with other policies involving the settling of priorities and procedures; eg. a national system of resource allocation; District and Regional autonomy etc. One of the *Nuffield York Folios (No.5), Inequalities in Health and Health Care* (1984) was an analysis of the reasons for inequalities. Another, *No.9, Does Unemployment Kill?* (1985) weighed the evidence of the relationship between unemployment and health.

Resource Allocation

There are several subjects not related to one specific service but which emerge from 'intelligence' activities as essential priorities for study in that they are fundamental in their effect on all areas of service. Prime among these is the **resource allocation process** which is notable in that the reforms introduced by the **Resource Allocation Working Party (RAWP)** had been accepted in principle by all political parties without it seems a close look at what is involved in the disruptions caused. It had proved consistently difficult to establish a continuous coherent programme of research geared to the many practical problems as a result of this policy, partly for the reason that there are so many disparate problems which the somewhat cavalier approach of Governments to **resource allocation procedures based on regional formulae** accentuated, especially because the regional formula has often been used at sub-Regional ie., District level; and partly because mobilising enough political concern to affect managerial practice designed for appropriate targets, was rendered difficult by the special interests which have burgeoned over the years, and which will always operate through pressure groups. To throw more light on the problem the Trust made a grant to the University of Manchester, to study the **resource allocation process at sub-Regional level within the North Western Region.** To highlight the problems a seminar was

organised on the various aspects of **sub-Regional RAWP** (122) in association with the National Association of Health Authorities.

Again, *From Principles to Practice* (1981) was an analysis of **resource allocation, and RAWP policies** in particular, which showed the effect of the failure to reconcile resource allocation policy with planning. The book comprised three critical essays: respectively on DHSS and NHS structure and administration as relevant to planning and policy; on the NHS planning process itself; and on resource allocation. The political, budgetary and *ad hoc* influences on planning were identified, and it was demonstrated why the RAWP policy was an *ad hoc* procedure presenting many problems rather than part of a well-integrated policy. Subsequently, this criticism was strengthened in a policy review of this major topic in the Occasional Papers series No.2 *The Policy of Resource Allocation and its Ramifications (1985).*

The effects of reallocation policies in periods of financial constraint are always likely to be far-reaching and to disturb many existing specialty interests: and must therefore always be kept under close review. It would seem from the observation in Sir Kenneth Stowe's Rock Carling monograph *On Caring for the NHS* (1988) that the RAWP policy is now in abeyance, if not dead.

Morbidity: A Suitable Case for Treatment

Clearly related to questions of **resource re-allocation** for effectiveness and indeed of **information** and 'intelligence', is the key problem of the **measurement of morbidity.** Because in a managerial sense it was evident that the use of mortality measures as surrogates for morbidities is in any circumstances, less appropriate than ever before, the Trust set up a Working Group to examine the prospects for improving **morbidity data** (135).

This Group completed its study and the conclusions were published in 1985 as *Mortal or Morbid: A diagnosis of the morbidity factor.* It is evident that there is an overwhelming case for more accurate measurements of morbidity, but Government and the management of Authorities have to accept that much work has to be done and above all resources invested, to improve the position, since existing sources of data are often inadequate, incomplete or localised. Once more this underlines the case for the necessary integration of research and management and the

need to give high priority to commissioning research in this area.

Prevention

Some of the subjects most debated, for example the application of the principle of **prevention** to health service problems, are perennial. Regrettably, prevention has become one of the great clichés of our age, rather easier to identify than to develop effective programmes. For effective action it will require much change in different areas of national life, for which several Departments of State are responsible for policies touching on the subject. It would thus involve a massive comprehensive assault by Government on developing appropriate policies, since environmental and behavioural issues are the keys to ultimate success. Action on these lines seemed an unlikely scenario in the circumstances of the early Eighties and the best action by an outside body seemed to be to keep attacking the subject to find suitable points where fruitful research with practical applications are possible.

The most immediate practical research item which came out of an exercise exploring the issue of prevention in practical Public Health terms, was a grant made to Oxfordshire DHA to detect what a Health Authority can actually do by way of **preventive policies** in the light of existing knowledge.

Additionally, a commission (24) was given to Dr Alfred Yarrow, a specialist in public health care, to explore the political implications of prevention. The result was *Politics/Society and Preventive Medicine* (1986) which was published as *Occasional Paper 6*. This highlighted the main political pressures militating against effective reform and discusses the political and social influences affecting the prospects for a 'bias to prevention'. It was hoped more optimistically than in the event realistically, that the essay would serve to open up the comprehensive debate which with the recent advent of 'Green politics' and correspondent pressures seems unlikely to be long be delayed.

Advances in Genetics

Moving from prevention at one end of the spectrum of Health to the ultimate in **clinical inquiry with implications for radical prevention,** the 1982 Queen Elizabeth the Queen Mother Fellow, Professor Sir David Weatherall produced the much praised The New Genetics and Clinical Practice. Just as

the subject of infectious diseases had been forced to the headlines, belying the complacency that it was a dying specialty, the subject of genetic research has also been highlighted as a major issue of contemporary importance for the implications for the future of health care. Sir David's admirably clear monograph traced a pathway to the understanding of the key developments and possible applications in the specialty. Identification of genetic abnormalities is of course only part of the story; with the prospect of increased intervention to cure defects at an early stage the problem of appreciation of what can effectively be done is a major implication. Currently there is a debate on general questions of **ethics** and opportunities in specific areas such as **embryonic research;** the general approach to the new genetics as expounded in this treatise provides a model for the dispassionate analysis of a highly emotive area, and places the issues of policy into the wider social perspective.

Disablement

At the opposite end of the spectrum from prevention is **disablement,** where complete cure is impossible and therefore the provision of adequate and adequately comprehensive care - or the provision of opportunities to be independent - becomes paramount. In an age which stresses 'high technology' in medicine on the one hand, and 'prevention' as the be-all and end-all, on the other, the important functions which health services (construed in the widest sense) have for the purposes of rescue and care, can often be overlooked. The subject of rehabilitation was raised initially by the Trust in the support given to Professor Thomas Ferguson as long ago as 1948 in the *Hospital and Community studies* **and to the rehabilitation demonstrations in Winchester and Salisbury.**

Lord Campbell of Croy's 1981 Queen Elizabeth the Queen Mother Fellowship, which resulted in the monograph *Disablement, Problems and Prospects in the United Kingdom*, served the valuable purpose of outlining the problems and prospects for adequate and effective services in disablement.

A major programme concerned with the subject of the **care of physically disabled persons** has become the main theme of the Trust during the final three years of the decade (45-82)(87-94)(96-155))146-152). Particulars of these are set out, together with indications of the policies to be followed in the next few

years[4] in the *Twelfth Report* of the Trust 1985/90: and much is hoped for the programme.

The main activities during the decade are listed in the Supplement to this Chapter.

[4] See pages 257 and 258

SUPPLEMENT TO CHAPTER 7
1981–90

CLASSIFICATION OF MAJOR RESEARCH and DEVELOPMENTS etc., SUPPORTED BY THE TRUST

Pages (243) – (287)

HEADINGS

1. STUDIES etc.
2. EDUCATION (Medical, Nursing, other)
3. EXPERIMENTS and DEMONSTRATIONS
4. SEMINARS etc.
5. MISCELLANEOUS

CLASSIFICATION OF MAJOR RESEARCH AND DEVELOPMENT ETC., SUPPORTED BY THE TRUST
1981–90

Principal Authority	Subject	Trust Reports	Other References
STUDIES ETC.			
1981			
1 Southampton University, Dept of Community Medicine Professor W E Waters FFCM	Ethical aspects of medical research	XI,106	
2 St Thomas's Hospital, Medical School Dr Peter West	The routine reporting of cost and workload information to clinicians	XI,88	

3	Sussex University	The Diffusion of Innovations in the Health Services	X,85	Initative and Inertia (NPHT 1985)
4	Leicester University, Dept of Community Health Professor Robin Fraser	The development and assessment of information systems in general practice as an aid	XI,86	Proceedings of the Third Int Conference on System Science in *Health Care Munich*: Springer-Verlag, Berlin. Eimeren, Englebrecht Flagle (eds)
5	Glasgow University, Dept of Social Administration Professor F M Martin	The development of community mental health services etc	XI,93	*Between the Acts* (NPHT 1959–83)
	1982			
6	Society for the Study of Medical Ethics Prebendary Edward Shotter	Development of studies in medical ethics in Scotland and support for provincial medical groups	XI,106	
7	Oxfordshire Health Authority, Dept of Community Medicine	A district strategy for prevention	XI,98	
8	Sir Ivor Batchelor	Study of DHSS policies for the Care of the Aged	XI,92	*Policies for a Crisis,* Occ Papers 1, NPHT
9	Dr Alan Snaith	Review of Management policies in the NHS	XI,89	
	1983			
10	National Perinatal Epidemiology Unit, Oxford Dr I Chalmers, MB, BS, MSc, DCH, MFCM, MRCOG	Newbury maternity care study	XI,103	
11	York University, Institute for Research in the Social Sciences, Dr K Hartley/Professor A Maynard	Health Economics & Health Services Research	XI,90	*The Public/Private Mix for Health (1982) NPHT*
	Dr K Hartley/Professor A Culyer	Research Fellowship		*Annotated Bibliography & Pamphlet Series*
	Professor A Culyer			*The Nuffield/York Portfolio*
	Professor A Culyer/Professor A Maynard	The Health Economist's Study Group		

	Principal Authority	Subject	Trust Reports	Other References
12	Royal Society of Medicine, Mr M J Carmel	Information services for clinical medicine	XI,111	
13	Thornton Baker Management Consultants	Competitive tendering in the provision of domestic, catering and Laundry services	XI,81	*Health Services Management, A Practical Guide and Handbook* (NPHT 1984)
14	Manchester University, Dept of Psychiatry Professor Neil Kessel	Project to investigate the effects of the mental health Act 1983 in clinical practice	XI,94	
15	Bath University, School of Humanities & Social Sciences (Professor Rudolf Klein)	Study of the regulation of the Private Health Care Sector; and follow-up through case studies	XI,91	
	1984			
16	Surrey University, Dept of Educational Studies & South West Regional Health Authority (Dr B Salter, Dr M Clinton, Mrs N Radford, Ms S Battle)	The training of and implications for mental handicap nurses of transferring the mentally handicapped from hospital to community care	XI,102-3	
17	Associations of Anaesthetists and Surgeons of Gt Britain and Ireland (Dr J Lunn & Mr B Devlin)	Mortality associated with anaestheia and surgery	XI,100	*Confidential Enquiry into Perioperative Deaths* (NPHT & Kings Fund 1988)
18	Association to Combat Huntington's Chorea	Education and advice development project	XI,111	
19	Royal College of Physicians of London	Ethical Issues in Medicine	XI,105	
20	United Kingdom Central Council for Nursing, Midwifery & Health Visiting (Dame Catherine Hall, DBE)	Review of nursing, midwifery and health visiting, education and training	XI,101	*Project 2000:* U.K. Central Council for Nursing

21	Cambridge University, Child Care & Development Unit, Mr J Hare, Dr M Richards, Dr R Williams	The evaluation of aspects of maternity care	XI,99	
22	Oxfordshire County Council/Oxfordshire DHA, Mrs P Baker/Dr M Gray	Care of the elderly in Oxfordshire	XI,92	
23	Bath Institute for Research into the Care of the Elderly, Dr A Dixon	Evaluation of appliances, drugs and services for the elderly	XI,97	
24	Dr A Yarrow	Preventive medicine	XI,97	*Politics, Society and Preventive Medicine* (1986)
25	South Bedfordshire Health Authority, Ms P Champion	A study of food procurement in the National Health Service	XI,89	
26	South Western Regional Health Authority, Dr C Shaw	Good practice in small hospitals	XI,86	
27	York University, centre of Health Economics, Professor A Maynard & Mr R Akehurst	Monitoring of competitive tendering	XI,83	
28	PA (Personnel Administration) Management Consultants	(1) The development of the general manager. (2) Management development and training	XI,83	*The Development of the General Manager* (NPHT 1984) *Education for Effectiveness* (NPHT 1986)
29	Thornton Baker Management Consultants	The distribution of doctors' training costs between the NHS & Universities	XI,105	
30	Manchester University, Dept of Social Administration, Mr R Steele	Examination of clinical budgeting and costing systems	XI,89	
	1985			
31	Leicester University Medical School, Dept of Community, Professor M Clarke, DPH, FFCM	A study of the health and social needs of the elderly	XI,96	*The Elderly At Home;* Health and Social Status, Health Trends 16, 3–7. Clarke M, Clarke S, Odell A, Jagger C

	Principal Authority	Subject	Trust Reports	Other References
32	Glasgow University, Dept of Postgraduate Medical Education, Professor K C Calman	Early Postgraduate Training: Implications for Service and Educations	XI,102	
33	Thornton Baker Associates	Contracting of clinical services	XI,82	*Developing Co-operation between Public & Private Hospitals* (NPHT 1986)
34	Wycombe Health Authority (Mr D H Tippens)	Computer-based personnel management and manpower planning systems for nurses	XII,31	
35	Institute for Cancer Research (Dr J Chamberlain)	Comparison of the costs of management of colorectal neoplasia	XII,31	
36	University of Wales College of Medicine, Dept of Nursing (Mr P Armitage)	Primary nursing in psychiatric continuing care		
37	Southampton University, Dept of General Practice (Professor D J G Bain)	Optimising health care among patients with chronic disorders		
	1986			
38	Exeter University, Postgraduate Medical School (Dr J H Tripp)	Services for the chronic sick		
39	Grant Thornton Management Consultants (Mr P Cuthbert-Smith)	Monitoring quality in competitive tendering	XI,81,82.XII,68	*Management & Monitoring of Contracts for Domestic Catering & Laundry Services* (NPHT 1987)
40	Aberdeen University, Dept of Political Economy, Dr I D McAvinchey	Private medical insurance, private medical care and the links with the National Health Service	XII,34	
41	Basingstoke & North Hampshire Health Authority, Mr C Kaye	Responding to health care complaints	XII,35	

42	York University, Dept of Social Policy & Social Work (Professor K Jones)	The Social characteristics and needs of facially disfigured people	XII,38	
43	Open University, Dept of Health & Social Welfare (Jointly with Colchester Health Authority) (Professor M Johnson)	Care for elderly people at home	XII,12	
44	Sheffield University, Dept of Community Medicine (Professor B Williams)	Complementary Medicine: a study of current practice in the United Kingdom	XII,37	
45	Royal College of Physicians, Disability Committee	Survey of NHS services for physically disabled people	XII,12	
	1987			
46	Edinburgh University, Dr U MacLean	The interface between medicine and social work	XII,71	*Dependent Territories,* Una Maclean (NPHT 1989)
47	King's College School of Medicine & Dentistry, Dept of Community Medicine (jointly funded with WHO) Dr (later Professor) J McEwan	The relationship between perceived health status and social deprivation	XII,33	
48	Birmingham University, Dept of General Practice, Professor V W M Drury	Pilot study of the role of practice nurses and attached nurses, and general practitioners' attitudes towards them	XII,33	
49	Manchester University, Dept of Science & Technology Policy (Dr K Green)	Health policy implications of near-patient and self-testing devices and kits	XII,36	
50	Cardiothoracic Institute, Midhurst (Professor G Cumming)	Research into a system for rostering and staff scheduling of nurses	XII,31	
51	Edinburgh University, Dept of General Practice (Professor J G R Howie)	The costs and effectiveness of general practice	XII,33	

Principal Authority	Subject	Trust Reports	Other References
52 Glasgow University, Dept of Nursing Studies (Professor A Jarvis) *later* Dept of Social Administration etc. (Professor R C Taylor)	Organisation and management of services for the provision of aids to daily living	XII,12	
53 London School of Hygiene & Tropical Medicine (Professor P Hamilton, Dr N Black)	Social history of the impact of AIDS in the UK	XII,38	
54 Disabled Living Foundation (Lady Hamilton)	The role and distribution of OT helpers	XII,12	
55 Exeter Health Authority (Mr D King)	The closure of mental illness hospitals and the development of an integrated community care programme	XII,35	*Moving on from Mental Hospitals to Community Care:* a case study (NPHT 1991)
56 West of England Mother & Baby Trusts, Southmead Hospital, Bristol (Professor G Stirrat)	Prospective population-based study of the relationship between the risk of sudden infant death syndrome and the physiological development of the baby	XII,31	
57 Institute for Social Studies in Medical Care, London (Dr A Cartwright)	Outpatients, general practitioners and hospital doctors	XII,31	
58 Leicester University, Faculty of Law (Mr J Finch, Dr J Keown)	Proposal for the establishment of a centre for Health Care Law	XII,37	
1988			
59 Keele University, Centre for Health Planning & Management (Dr C Paton)	Case studies in health service policy and management	XII,37	*Case Studies and Health Policy and Management* (NPHT 1991)

	1988			
60	Steering Committee of Healthcare Arts, National Centre for Arts in Health Care Buildings (Dr J H Baron)	Proposal for the establishment of a UK centre for the promotion of information, research and training	XII,38	
61	United Guys & Sir Thomas Medical & Dental Schools (Professor W Holland)	Review of Screening	XII,33	*Screening in Health Care:* W Holland & S Stewart (NPHT 1990)
62	King's College, London, Centre for Physiotherapy Research, Dr C Partridge & Dr M Johnstone	Physical disability and health services: perceptions, beliefs and experiences of elderly	XII,12	
63	York University, Institute for Research in the Social Sciences, Professor A Williams	Eliciting lay concepts of health	XII,12	
64	Surrey University, Midhurst Medical Research Unit, Professor G Cumming, Professor J Ashford	The efficiency and effectiveness of hospital care: study of possible changes in medical practice on the NHS hospital services	XII,32	
65	Wycombe HA, Mr K Broadey	Wycombe primary health care computing project	XII,33	
66	Kent Business School, Centre of Nursing Studies, Professor L McKenry	Development and evaluation of a ward-level process for the improvement of the quality of patient care	XII,32	
67	Basingstoke & North Hampshire HA, Mr C Kaye	The supply and use of surgical services	XII,32	
68	University College of Medicine, Cardiff, Dept of Geriatric Medicine, Professor M S J Pathy	Identification of early medical breakdown among old people	XII,13	
69	Bristol University, Institute of Child Health, Professor J D Baum	Action for the care of families of children with life threatening and terminal illness (ACT)	XII,32	

	Principal Authority	Subject	Trust Reports	Other References
70	University of Wales College of Medicine and South Glamorgan HA, Professor C Roberts, Mr G L Harrhy	Health care evaluation programme	XII,35	
71	Norfolk FPC, Professor R Emerson	Study of consumer opinion	XII,33	
72	Business Sciences (UK) Ltd, Dr G Bricker; subsequently Mr J Luckman, Mrs B J Banham	Study of services for physically disabled and frail elderly people in Newcastle-upon-Tyne	XII,14	
73	Warwick University, School of Postgraduate Medical Education, Health Services Research Unit, Dr A Szczepura, Dr J F Wilmot	Warwickshire practice feedback study: development and evaluation of information feedback systems in the primary care sector	XII,33	
74	Bristol University, Dept of Community Medicine (Professor J R T Colley & Dr A Mason)	Studies in health care evaluation	XII,35	
	1989			
75	Leicester University, Dept of Community Health, Professor M Clarke	Community studies of the elderly in Melton Mowbray	XII,14	
76	Nuffield Institute for Health Services Studies, Leeds, Dr D Hunter, Mr S Harrison, Professor A Wilson, Dr M Clarke	An examination of the implications of an internal market for the NHS	XII,36	
77	Bath University, School of Social Sciences, Professor R Klein	Study of the NHS Management Board	XII,36	
78	Faculty of Public Health Medicine, Professor W Holland	Monitoring changes in the delivery and quality of health care	XII,36	

	1990			
79	East Dorset Health Authority, Dr C J Moran	Assessment and monitoring of the young disabled living at home	XII,15	
80	Welsh Health Planning Forum, Dr M Warner	Strategic intent and direction for the NHS in Wales: District implementation	XII,36	
81	Association of Crossroads Care Attendant Schemes, Mr I Croft	The new contract culture in Crossroads Care	XII,25	
82	Leeds Western HA, Professor A Chamberlain	The provision of vocational evaluation for young disabled people	XII,15	
	EDUCATION (Medical, Nursing, other)			
	1981			
83	St Christopher's Hospice, Dame Cicely Saunders, DBE, FRCP	Facilities for teaching terminal care	XI,104	
	1982			
84	Bath Institute of Medical Engineering, Mr K Lloyd Williams Mchir	Production of a video textbook for surgical training	XI,105	
	1985			
85	Trent RHA	Seminars on Medicine and Management		*Medicine and Management I-V* (Trent RHA)
	1986			
86	Liverpool University, Dr T J Bayley	Postgraduate medical education: Consideration of future needs	XII,37	
87	Frimley Park Hospital	Postgraduate education centre (loan)	XII,42	
	1988			
88	Frimley Park Hospital Postgraduate Education Centre	Interest free loan	XII,42	

	Principal Authority	Subject	Trust Reports	Other References
89	St Michael's Hospital, Hayle, Cornwall, Dr D Seager & Sister M McNally	Establishment of ENB 913 short course on the care of physically disabled people	XII,12	
90	COMBAT, Ms S Dalby	Demonstration/training video	XII,13	
91	British Geriatrics Society, Mr R Kandt	Nurses study grants in the care of the elderly	XII,13	
92	Surrey University, Nursing Practice Research Unit, Professor R Crow	Establishment of MSc in advanced clinical practice (Cancer nursing)	XII,37	
93	National Deaf-Blind & Rubella Association (SENSE) Mr R Clarke	Education & rehabilitation course for people with Usher syndrome	XII,14	
	1989			
94	Plymouth Medical Centre	Interest free loan	XII,42	
	EXPERIMENTS/DEMONSTRATIONS			
	1986			
95	Scottish Home & Health Department, Joint Project with SHERT, Miss M Auld (later Professor P Prophit)	Experimental nurse-controlled ward for the care of the elderly	XII,31	
96	West Midlands Regional Health Authority, Regional Cytogenetics Unit, Dr J Watt	Establishing a regional DNA recombinant technology service in the West Midlands	XII,31	
	1987			
97	Royal Liverpool Children's Hospital, Bereaved Familes, Mr O Hagan	Bereaved families centre	XII,32	

	1988		
98	Edinburgh University, Dept of Community Medicine, Mr L M Jones, Dr C M U MacLean	Consumer Feedback Resource Unit	XII,35
99	London University, Dr M Floyd	Managing physical disability at work	XII,13
100	Research Institute for the Care of the Elderly, Bath, Dr R Jones	Temporary support for the Institute	XII,13
101	Frenchay Hospital, Bristol, Dept of Neurology, Dr R Langton Hewer	Disability services co-ordinator	XII,13
102	Herefordshire HA, Mr R Izon, Mr R Brown	Physical handicap services: Herefordshire personal lifestyle project	XII,13
103	Leeds Western HA, Professor A Chamberlain, Dr A Houston	The needs of and services for physically handicapped school leavers	XII,13
104	Leeds University, Rheumatology & Rehabilitation Research Unit, Professor A Chamberlain, Dr A Houston	The needs of and effectiveness of services for people with Head Injuries	XII,13
105	Bath District HA, Mr A Wall	Audiology Services Manager	XII,12
106	Basingstoke & North Hampshire HA, Mr C Kaye	Development and introduction of information services for the physically disabled and their carers	XII,13
107	Oxford RHA, Mr C Petrokofsky	Improvement of information services for disabled people in all Health Districts in the Oxford Region	XII,14
	1989		
108	North Staffordshire HA, Dr A Ward	Projects for services for physically disabled people	XII,14

	Principal Authority	Subject	Trust Reports	Other References
109	ROSPA, Mr B Morrison	Safety of elderly people at home	XII,14	
110	Gloucester HA, Mr K Jarrold	Community Care Organiser	XII,14	
111	Aberdeen University, Health Services Research Unit, Dr S J C Hamilton, Dr I Russell	Grampian stroke care initiative	XII,15	
112	Exeter Health Authority, Mr P C Jackson	Working together for younger people with physical disabilities	XII,15	
113	Disablement Services Centre (ALAC), Leeds, Mrs C Lumley	Hotel accommodation for lower limb amputees	XII,15	
114	Gloucestershire Royal Hospital, Mr J Chandra	Restructuring of out-patient services for the chronically physically ill	XII,32	
	1990			
115	Keep Able Foundation, Mr V Henny	Ability Workroom	XII,15	
	SEMINARS ETC. 1980–90			
116	Trust Seminar	Community Medicine and Epidemiology	XII,45	
117	Trust Seminar	Care of the Elderly		*The Impending Crisis of Old Age* (OUP 1981) *The Elderly. Who care? Who pays?* III,151 (Nuffield-York Folio) *Policies for a Crisis?* (Sir Ivor Batchelor 1984)
118	Trust Seminar	Health Services Research & Medical Care	XII,62	*A Fresh Look at Policies for Health Service* (NPHT 1984)
119	Trust sponsored Seminar at Royal College of Physicians and Surgeons of Glasgow	Interaction between Medicine & Nursing	XI,58	*Hospital Medicine & Nursing in the 1980s* (NPHT 1984)
120	Trust Seminar held at the University of Leeds	PGME and the Postgraduate Medical Centre	XI,79	

121	Joint Seminar with the Wellcome Trust	The Abolition of Infection	XI,54	*The Abolition of Infection* III, 140 (Dr D Tyrrell, 1982)
122	Joint Seminar with National Association of Health Authorities	Sub-Regional Resource Allocation	XI,41	*Resource Allocation Working Party* (1976) *The Policy of Resource Allocation & its Ramifications* (Occasional Paper 2, 1985)
123	Trust Seminar	Ethics in Medical Research	XI,71	
124	Seminar held at the John Radcliffe Hospital, Oxford	Prevention	XI,72	
125	Special Trust Seminar	Policies for Research and Development	XI,72,74	
126	Seminar arranged for the NHS Training Authority	Management Training in the NHS	XII,43	
127	Second seminar for NHS TA	Health Care and Medical Education		
128	Trust Seminar	Efficiency in the NHS. A View from the United States	XI,73	
129	Trust Seminar	Research and Development in Health Services	XI,72	
130	Trust Seminar	Quality of Care	XI,74	*Reviewing Practice in Medical Care* III,132 (NPHT 1981)
131	Trust Working Group	Communications in Medicine	XII,43	*Talking with Patients* (NPHT 1985). *Doctor to Doctor* III,145 (NPHT 1984)
132	Trust Working Group	Care of the Elderly	XI,68	*The Impending Crisis of Old Age* III, 133 (NPHT 1981)
133	Trust Working Group	Critical Factors in Policy Implementation	XII,43	*Between the Acts* III, 148 (NPHT). *Initiative and Inertia* (1985)
134	Trust Working Group	Information	XI,77	*Data, Information & Intelligence* (NPHT 1984) *A Time for Decision?* (NPHT 1982)
135	Trust Working Group	Morbidity	XI,78	*Mortal or Morbid?* (1985)
136	Trust Working Group	The Public/Private Mix, later the NHS Managerial Group	XII,44	

	Principal Authority	Subject	Trust Reports	Other References
137	Trust Working Group	Postgraduate Medical Education		
138	Series of Trust Seminars	Forums for Health Services Research. The maternity Services	XI,80	
	MISCELLANEOUS			
	1982			
139	The Institute of Health Services Management	Educational initiatives for Health Service Managers and Administrators	XI,87	
	1983/85			
140	Sir John Brotherston	History of the Scottish Health Service 1900-present day	XI,109	*Improving the Common Weal* (1987) (Edin. Univ. Press)
	1984			
141	Royal Institute of Public Administration	Development of Interest in Health Affairs	XI,108	
142	Green College, Oxford	Senior visiting Research Fellowships	XI,109	
143	Oxfordshire Health District, Dr Muir Gray	Clinical Assistantships for experiments in GP/hospital liaison	XI,93	
	1985			
144	Professor K C Calman	Survey of PGME Education	XI,102	
	1986			
145	St Christopher's Hospice, Dr G Ford	Equipment and part-time technician	XI,109	
146	Southampton & South West Hampshire Health Authority, Mrs H L Osborn	Inter county workshop 'Social Work in Health Care'	XII,39	
147	Local Medical Committees, Joint Programme, with the King's Fund & DHSS with equal funding	Primary health care development Fund	XII,33	

148	Wolfson College, Oxford, Centre for Socio-Legal Studies, Mr D Harris, Dr R Dingwall	Ethical issues in the allocation of health care resources	XII,35
	1987		
149	Bristol Maternity Hospital, Dept of Obstetrics & Gynaecology, Professor G Stirrat, Dr J E Cullimore & Mr W Prendiville	Evaluation of Colposcopy appointment system	XII,31
150	Royal Berkshire Hospital, Reading, West Berkshire, Macmillan Cancer Care Appeal (interest free loan)	Redevelopment of radiotherapy department	XII,42
	1989		
151	Prince of Wales Advisory Group on Disability, Mrs N Robertson	Conference on independent living and housing for disabled people	XII,14
152	Nuffield Institute for Health Services Studies, Leeds (interest free loan)	Library rebuilding	XII,42
153	Mary Marlborough Lodge, Oxford, Dr G Cochrane	To put MML library on a more secure financial footing	XII,15
154	Faculty of Community Medicine (interest free loan)	Evaluation of UK progress towards health for all by the year 2000	XII,42
155	Oxfordshire Health Authority, Mr C B T Adams	Russell-Cairns Head Injury Research Unit	XII,28
	1990		
156	Kent Business School (interest free loan)	nCare ward nursing computer system	XII,42

CHAPTER 8
POSTSCRIPT
REFLECTIONS ON THE THEME OF IMPROVEMENT

Postscript

REFLECTIONS ON THE THEME OF IMPROVEMENT

The previous chapters outline the activities of the first fifty years of an independent body concerned with improvement in the arrangements for health services, against a perspective of the highlights of the history of health care in the United Kingdom.

The idea behind the setting up of the Trust had long and strong roots. The Trust was founded, at the beginning of the Second World War as a private charity with the principal objective of promoting the co-ordination of hospital and ancillary services, since it already had become evident that something had to be done to rationalise these services in the UK to make better use of resources. In the preliminary moves which resulted in the National Health Service, the Trust had a significant role.

The 1946 Act saw the virtual nationalisation of hospitals grouped regionally in a service structure, supported by the primary care services provided by general practitioners the arrangements for both of which were centrally financed, and by those personal services provided by local health authorities. There has not been in effect too much change in the outer structure of the NHS since then. Even the most recent reforms provided for in the NHS Act 1990 have changed the formal structure relatively little. The Regions are still the 'Planners', even if now the Districts (together with the GPs) are the 'Purchasers' and the Hospitals and GPs are the main 'Providers' of services. In reality the changes are adjustments to the internal machinery which governs the financing of the elements making up the complex infrastructure of health care services, in order to provide an element of competition.

It is thus in shape much the same National Health Service with the same objectives, the essential structure of which has been little changed since 1948. It is based on a primary care mechanism for the services of general practitioners and a highly complex hospital and specialist service led by consultants and nurses. The aftercare and preventive services of various professional sorts provided largely through the agency of local government constitute the supporting social care and environmental services to the more highly profiled therapeutic services.

The administrative changes which have occurred since 1940,

have of course not been alone in influencing events. There has also been an evolution in the operation of services as a result of constant adjustments to both professional and institutional practices which have come from intense observation and criticism of performance in health care practices.

The general social and political drives for structural improvement which have been a major feature of health policies since the founding of the NHS, have been largely concerned with the way in which services can be improved through changes in the organisation of those intermediate institutions which are responsible for managing and planning services to individuals which nevertheless depend on professional personal skills. Hence too, the great emphasis these past few years on management, without regrettably a corresponding emphasis on the tools necessary for good management, principally those producing information to judge the effectiveness of services which, as the Trust has constantly urged, is a prime requirement for judging their performance and efficiency. These depend in the last resort on a wide range of research required to indicate how to fashion and hone these tools, as well as on the education and training of the many professionals who contribute to what should be the seamless cover of civilised health care to individuals.

The 1990 reforms and the anguish which has resulted in many quarters both in and outside the NHS, have accentuated the need for more and sharper research to identify the elements of potential positive improvement. There is certainly a need to place in perspective those reforms which are ideological in character and add nothing by way of quality to services. If anything the questions raised in the variety of responses to the reforms offer great opportunities to the independent observers concerned with improvement and quality.

It is against this background and perspective that the Trust has sought to fulfil its purposes and with its relatively small resources it has attempted throughout its existence, to seek out those issues which are capable of being analysed with optimum profit in the search for **quality** and **effectiveness.** The integrated strategic policy of using its resources for **research, forums/seminars and publications** have been attempts to achieve its purposes in an increasingly sophisticated world, through providing seminal opportunities for widespread discussion at influential levels, of major issues concerned with the improvement of services in this most complex of social welfare structures.

While it is important to indicate the studies supported and the themes of the seminars convened, the evidence of the constant search for 'improvement' is in the last resort contained in the publications by those who have been supported and sponsored. If 'history is the essence of innumerable biographies' these constitute an important part of the History of the Trust, being contemporary accounts of what has been gained from the 'investments' made in the efforts of individuals. Whether these have influenced events in any way is an open question; for the complexity of Health Services is such that influences on the many elements which compose their infrastructure defies simple analysis; and the essentially conservative nature of the elements of care means few startling effects from individual efforts at improvement can be easily registered, although optimistically they might occasionally be inferred. What cannot be denied is the stimulation given to knowledgeable and expert individuals to contribute to the literature of health services research and ultimately to policy generation.

It is no part of this outline of Trust History however to make judgments on the success or failure of policies and actions of a body operating in the margins of health care, however important these might be, although occasionally the narrative may sometimes appear to point to ventures which on the face of it seem to have had some influence, if one gives credence to the private attestation of individuals or to public acclaim on the basis of favourable reviews of the publications. Indeed it will always be difficult in the short term to make definitive judgments of the influence of research and comment, or for that matter even of material change of any sort in the health care field.

In an historical sense, in no way epitaphial, *si monumentum requiris, circumspice* may however be an apt observation, both for the publications and the reviews of them. Yet these are by no means lifeless monuments, for many such as those of the continuous themes of better information and constant stressing of the need for an integrated research and management policy have bearings on current problems and policies.

As for the essentially private seminar/forums, the general aim of the Trust in this particular activity has been to draw from the work and experience of a wide range of people, an extra dimension of knowledge and critical comment. This is in the expectation that all those responsible in any way for the creation and implementation of public policy, will become more aware

that there are no simple solutions for the complex problems of health, and that the way ahead to more effective services is likely to be a slow incremental process based on realistic studies of cause and effect.

* * * * *

At the time of writing (mid-1991) because of the 1990 reforms, health care in the UK is very much in the public eye and is likely to remain so while the effects of the changes which are not exactly as evolutionary as the essentially conservative nature of health care would suggest might be desirable, have been digested. Some of the difficulties likely to be encountered as a result of the 'reforms', in particular the unproven effects of competition between institutions, the introduction of contracts for services in the absence of first class information and costing systems, are referred to in the author's 1990 Rock Carling monograph *What Price Quality?* The observations there while personal, were largely based on the long experience of the Trust in the health sector, the complexity of which needs a much greater appreciation on the part of the media seeking drama, and the public responding to it, than regrettably has been the case hitherto.

It is perhaps not too optimistic to hope that overall the fundamental educational policy developed by the Trust of combining information arising from research, supported with the published accounts of results and work in progress along with private forums and seminars, indicates promising routes which perhaps should be pursued more intensively in the future as part of a broad educational policy by Government, by the Management Executive and by the key operational Authorities.

If there is a major lesson to be learnt from the observation platform which is the Trust, it is that the active participation of all these bodies in the development of such a policy, is the sure and certain way for the NHS to prosper as the unique institution it is.

CHAPTER 9
Addendum
TRUST PERSPECTIVES

Trust Perspectives

There are several specific issues some of which overlap, which together give a general perspective of Trust policy and action over the years but which are best dealt with separately from the unfolding of the narrative of Trust History.

The following notes which are based on prime documents including the periodical Reports are presented as an addendum to the Text with this objective.

1. THE GOVERNING TRUSTEES[1] AND POLICY

While the common feature of the individual Trustees over the years has been a strong interest in health services, direct or close, professionally involved or as members of Authorities, there has been perhaps one notable change from 1940. Since Sir Frederick Messer MP retired in 1960 no Trustee has been a professional politician.

The mix of the first Governing Trustees included professional politicians as well as those from business and the medical profession. The War made for a great consensus of political action on social policies which resulted in the National Health Service Act 1946, but with the withering of the consensus, post-war politics on social welfare matters became more polarised.

As the programme of the Trust developed the operational accent was increasingly concentrated on studies which would be in the main non-political but designed to add to knowledge. What evidence there is, indicates that there was a disinclination to appoint Governing Trustees who were politically active and instead to invite those whose interests lay more at the centre of health affairs. This made mainly for the appointment of Trustees who had concerns in health care services and were sympathetic towards research of an apolitical character.

The matter of appointment of new Trustees is laid down in the Trust Deed[2], and appointments are made by the Trustees after consultation with the Minister of Health. No Minister has attempted in any way to influence the appointment of individual Trustees although it is worthy as a footnote to history that in the

[1] The list of Governing Trustees with the periods of their service and their photographs are seen between on pp. 240-241

[2] See Appendix 1.

case of the original Trustees, the Conservative Minister of Health, Colonel Walter Elliott appears to have suggested to Lord Nuffield that Mr Thomas Johnston the distinguished Labour MP, then Civil Defence Commissioner and later Secretary of State for Scotland in the Churchill War Government, be included in the first list of Trustees.

A body like the Trust depends wholly on the high quality of its individual Trustees who shape its policies and whose decisions are the stuff of its history.

Apart from the principal actors concerned with the foundation of the Trust and specially noted in Chapter 2, while it would appear invidious to pick out individuals from the portrait gallery in Appendix 2, there is perhaps no inhibition with respect to the dead and a number of personalities stand out.

Thus it was Dr A Q Wells who before being appointed to the Board in 1949 was for many years Honorary Secretary of the Medical Advisory Committee which made a significant contribution to Trust policy whose determination in 1955 returned the Trust to the initial arrangements and responsibility for its own destiny. Again, Viscountess Ridley, also appointed in 1949, had a 'unique combination of charm, catholicity of interest and passion for so many varied courses central to the Trust purposes which were of the greatest importance to the Trustees' deliberations.' Lord Cohen of Birkenhead who had also been associated with the Trust from its beginning as an advisor was appointed as a Trustee in 1957 when the Trust was entering a new era. His 'extraordinary knowledge of medical practice in the context of the post-war socially conscious society in which he had played a unique part through the numerous committees with which his name was associated in the formulation of ideas in relation to health policies of many kinds was deployed as a Trustee with a deep understanding of the purposes of the Trust and what it might do in a changing environment.' In the leading role of Chairman Sir Geoffrey Gibbs was not only responsible for the successful change in direction of the Investment policy at a crucial time but his infectious charm worked wonders to bring out the best in Trustees.

Finally, none among the living Trustees will ever forget Sir Edgar Williams *(q.v.)* the Chairman during perhaps the most fruitful period in the 50 years. His never failing sharpness in wit and forensic capacities added to the gaiety and quality of approach to decisions, as well as the stimulation he gave to the

formulation of policies for the Trust, based on an all-round 'Intelligence' of health affairs and the personnel engaged in them.

Because of the change in emphasis it has always been expected of Trustees that they should take part not just in decisions but as consultants, and Chairmen or participants in those activities of the Trust in seminars and steering committees. This itself makes for a deepening sense of participation in the activities and has been important in the development of a distinct Trust **persona** as a body quite independent of the Government. This development too has a valuable operational element for foundation, in that it provides a shield against the depredation of suitors for funds for creditable projects, during special personal relationships, not easy to deny especially during the life of the Founder.

With possibly one exception, and that is in the separate field of pure and clinical research, the relative amounts of public and private resources available for research and development by Foundations means that the day in which individual Foundations could make significant impacts on public policies through relatively costly practical experiments and demonstrations has probably gone forever.

The grant-making function of the Trust however, either by way of direct grants in pursuit of policies or contracts for specific purposes has been and will always be a key element in its independence. Since it became evident in the 1950s that there was little future in merely waiting for applications for grants to arrive from appropriate bodies, it was decided by the Trust to enter the field in an indirect but positive, active way to fulfil its purposes, viz. 'The promotion of improved organisation and efficient development of hospital, medical and associated health services'.

Hence in order to implement these objectives the development of the current mix of support for research, commissions, seminars/forums, and a publications policy has meant that the Trust's work became widely known to serious observers and to the research community.

In the early 1980s the Trustees considered their future policy, as far as function was concerned. It was decided to continue the operational policy of placing the emphasis on intelligence-based contributions to knowledge, which in addition to making grants, included the use of its premises for private

seminars on important subjects, as well as provision for the carrying on of the publications policy of the Trust which had been steadily and deliberately developed with some success since 1960.

2. FINANCE

There was an early nervousness on the part of the Governing Trustees about the implications for the Trust income because of the nature of the benefaction which was based on a single industry. The shares in Morris Motors Ltd were controlled by a separate body, the Ordinary Trustees, led by Lord Nuffield, who also held tranches of Morris Motors Shares in the other Nuffield benefactions.

To alleviate this it was decided with the agreement of Lord Nuffield and the Inland Revenue to build up a Reserve Fund initially through allocating 20% and subsequently 10% of the annual dividends which was invested initially in 'gilts' but subsequently in the late 50s in 'blue chips'. With a troubled car industry this proved to be a valuable policy and although it was not until some considerable time after Lord Nuffield's death that the original holding (by then BLMC shares) comprising the Nuffield Fund was sold and reinvested also in 'blue chips', that some reasonable stability in income was achieved. In the 1970s because the original objective of separate Trustees no longer applied, it was agreed that as Ordinary Trustees retired, appointments to that body should be made from the Governing Trustees.[3]

There has been considerable inflation since the original benefaction was made and it may be of interest to indicate the comparable figures of income over the last 50 years adjusted for price by an index of change in the value of the pound.

3. THE PURPOSES, INTERPRETATION and APPROACH

While originally it was only secondary to the concept of co-ordination, since 1962 the prime purpose of the Trust as stated in the original Trust Deed with its two main amendments, has

[3] Subsequently on 31st December 1990 by a Scheme approved and established by the Charity Commission 'whatever powers or duties to the Ordinary Trustees ascribed (in the original Deed) may be exercised or shall be carried out by the Governing Trustees.'

PRICE ADJUSTMENT FACTORS (1990 = 1)		NUFFIELD PROVINCIAL HOSPITALS TRUST INCOME from Investments etc.,	
1939	27.69		
1940	25.49		
1941	23.39	1/12/39 - 31/3/41	110,475
1942	21.81	Y/E 31/3/42	92,912
1943	20.87	/43	141,488
1944	19.68	/44	92,535
1945	19.11	/45	93,490
1946	18.75	/46	95,726
1947	17.20	/47	86,787
1948	16.03	/48	119,753
1949	15.62	/49	N/A
1950	15.49	Y/E 31/3/50	119,951
1951	14.18	/51	121,210
1952	13.16	/52	138,096
1953	12.80	/53	165,262
1954	12.62	/54	149,038
1955	12.12	/55	173,539
1956	11.38	/56	202,369
1957	10.87	/57	212,303
1958	10.53	/58	218,008
1959	10.41	/59	287,761
1960	10.30	Y/E 31/3/60	381,045
1961	9.96	/61	431,324
1962	9.60	/62	447,525
1963	9.40	/63	439,350
1964	9.08	/64	450,050
1965	8.65	/65	505,032
1966	8.26	/66	512,543
1967	8.01	/67	527,640
1968	7.71	/68	322,625
1969	7.31	/69	323,776
1970	6.80	Y/E 31/3/70	333,875
1971	6.23	/71	198,985
1972	5.76	/72	258,104
1973	5.37	/73	263,622
1974	4.69	/74	321,075
1975	3.69	/75	305,538
1976	3.21	/76	260,038
1977	2.81	/77	266,463
1978	2.53	/78	282,735
1979	2.21	/79	326,419
1980	1.84	Y/E 31/3/80	456,121
1981	1.65	/81	493,831
1982	1.54	/82	586,831
1983	1.46	/83	531,899
1984	1.40	/84	560,226
1985	1.32	/85	685,925
1986	1.29	/86	813,243
1987	1.23	/87	828,716
1988	1.15	/88	1,207,310
1989	1.08	/89	1,538,607
1990	1.00	/90	1,806,115

The author is indebted to Professor C. H. Feinstein, All Souls College, Oxford for the price adjustment factors noted.

been the **improvement** of hospital and associated medical services in the Provinces. The purposes have always been interpreted liberally by the Trustees since the Trust's foundation in 1940, and the Trust Deed gives power to the Trustees virtually to take whatever action they feel necessary to further the purposes of the Trust - 'advancing the purposes of the Trust by any other means the Governing Trustees think fit'. This provides the flexibility on which policies have been formulated and implemented since the inception of the Trust.

The original Trustees took a wide view of the Trust's potentiality as a body concerned with the problems which had emerged in the late 1930s and likely to obtain in the post-war period. The Trust was prominent in the preliminary studies of the existing arrangements preliminary to the reorganisation of hospitals which was a central feature of the NHS Act, 1946 and jointly with the Ministry of Health was responsible for the hospital Surveys which produced *The Domesday Book of the Hospital Services.*

In the late Forties and early Fifties there was a phase in which the Trust was largely a grant-making body responding to applications for ventures within a general policy which was designated as 'study, experiment and demonstration'. At the same time it was engaged in 'in-house' projects, one theoretically in association with Bristol University which was an investigation into the function and design of hospitals **(IFDH),** the other a costing investigation.

From 1944 there was a common administration with the Nuffield Foundation, the staff and offices being shared. There was a phase from 1945–55 during which the Trust, even though it continued to have a separate body of Trustees and a separate endowment, in effect took a satellite position to the Foundation in its activities which lay along the lines of sponsoring and financing research. The Nuffield Foundation had been founded in 1943 and reflecting the views of its original Trustees who had mainly academic backgrounds, it had developed its own type and style of activity in research funding based broadly on research council practice.

In 1955, by mutual agreement of both bodies of Trustees, the administration of the Trust was divorced from that of the Nuffield Foundation. Subsequently it developed its own policies initially based on a specially commissioned paper 'Potential

Opportunities', accepted in 1957 by the Trustees as a guide to action.

In those early days the Trustees, in addition to encouraging the development of particular lines of policy, were mainly concerned with adjudicating on applications made to it for grants. Most of these arrived as a result of what were canvassed widely as Trust policies and priorities and what was known of the Trust through its publications and periodical Reports.

There was a period in the late 1950s when the Trust employed its own in-house **operational research (OR)** staff on selected issues. The OR Unit was a hiving-off from the Investigation into the Function and Design of Hospitals, the report of which had been published in 1955. Even before the death of the Director (Brigadier Welch) of the O.R. Unit, in 1961, it was evident that the staffing of such a unit which was concerned with short-term studies, presented great problems. The Trust then decided not to employ its own researchers directly, but rather to continue to develop a special network generally associated with suitable and appropriate University Departments, capable of carrying out appropriate research. The identification of units and individuals in this category was part of the basic 'intelligence' operation of the Trust which was developed to enable it to operate effectively.

It would be a false assumption to believe that the associations with external bodies made over many years did not change in character and scope. Rather they were extended and developed as a result of the adoption of various policies, and a variety of associations established on records of the intellectual and proven achievement. This is perhaps one of the reasons why the tendency has been for much, but by no means all, of the Trust's work to be associated with the medical profession since for a considerable time not only was most of the best research concerned with Trust policies in the social medicine and allied fields, but the kind of special initiative carried out in the case of the post-graduate medical education, has probably been invaluable in improving health services generally and not only in the Provinces. Above all of course, ultimately it is the doctor who must be persuaded to alter his mode of working if changes are to be made for service improvements. Indeed it was the success of the Trusts' policy in the post-graduate medical education field which gave it a strong base for later development in other areas of interest.

Yet the principal reason for the preponderence of Trust interest in its association with medical groups, was that fundamentally the work of doctors is the base of the **quality** of clinical services and whose approval really counts in the development of health services. When key individuals in the profession are mobilised behind sensible ideas which are likely to lead to improvements, important policies can be adopted to improve quality, so improving morale generally. Patients, who provide the weight to the eventual adoption of public policies, tend naturally to identify with doctors for their reputed skills in **therapy** and **care,** although in the case of care they have also close identification with **nurses.** In distress, they or their relatives tend to ignore the considerable contribution of managers, treasurers, statisticians or computer experts, whose efforts are somewhat taken for granted. To this extent therefore, the medical profession has to be looked to for much of the leadership in the development of policies concerned with medical care services, even if it is not always geared to this task. The apparent bias towards medical affairs does not imply that the Trust has not continued to develop stronger associations with the non-medical professions engaged in health services, but with its resources and an inevitably small core staff it has been a question of where to place its major efforts.

It has to be appreciated too, that on the whole the impact of the other principal **health professional groups** to which one should look as the sources of leadership - the managers, the treasurer, nurses - has hitherto been such that it is doubtful if they have influenced policy greatly although that might change with the 1990 reforms.

Until recently few among these groups have been prominent in the development and implementing of ideas, and in promoting change and progress. Yet it will be evident from the narrative that encouragement from the Trust has not been lacking, although there have been relatively few mechanisms for these groups to be involved in the development of health policies except on narrow fronts.

The initiative to get the **Universities** involved in the continuing education of the non-medical professions by the support given to the setting up of **Adult Education** courses on health matters at Leeds University led eventually to support for the establishment of the **Nuffield Centre** there. The funding of the **Nuffield Travelling Affairs Fellowship,** and the **Ex-**

change Fellowship with the American Hospitals Association were modest attempts to help in the professional development of administrators - and they probably have, if one can judge from the important posts subsequently held by former Fellows.

By the 1980s many of the **seminars** confirmed the need for positive steps to be taken to bring together the various strands of health policies in which the wide range of health professionals have several parts but which to be effective need the promotion of a better understanding of what constitutes good health care and what is deficient in achieving it.

There has always been a question of leadership (or rather the lack of it) in health affairs, which was to some extent clouded by the concept of consensus management which was raised to a philosophy in the 1974 'reforms'. Even now in 1990 despite the current stress on general management the emergence of paid Chairmen and a mix of executive and non-executive Directors of health authorities is also for a time likely to make policy-making and leadership questions even less clear.

The **'intelligence'** system of the Trust designed principally for the Trustees has depended a great deal on establishing contact with the range of health professionals concerned with providing services essentially personal. This has been achieved in the main from the ventures with which the Trust is connected, but also through the attraction of the private seminars which allow free expression to principal players in the multitude of scenarios which make up the drama of health care. Most of the individuals supported in one way or another by grants or commissions almost as a matter of course have taken part in appropriate Trust seminars and other associated research and development ventures. Other participants have come to notice as a result of random applications and encounters.

A continuous source of ideas and 'intelligence' is of course the burgeoning literature on health, many from publications relevant to Trust purposes and policies. Studying what is generally debated in the journals is the means of picking out major issues where there is a possibility of worthwhile intervention by an independent body. What is followed up is a question of judgement about realities. Frequently there are problems which cry out for analysis and indeed may be turned over at least once, sometimes without great return. Such major questions as the effect of changes in structure or of less tangible matters, such

as industrial strife and how it affects services, or on how ethical considerations in professional practice affect services, are interesting to consider, but do not always prove themselves to be subjects which lend themselves to the kind of investigative approach which has been used successfully in other areas; although there have always been attempts as the record of seminars show, to see how much can be done through analysis and discussion, to throw light on major issues.

4. THE QUESTION OF FUNCTION

This leads into the question of how the Trust has functioned. Experience shows that quite apart from issues of a party political nature, it is useless to enter into ventures where there is virtually little or no chance of contributing to a solution of problems, except in so far as any efforts may throw more light on the issue and stimulate a higher level of debate at both executive and public level.

(a) Optimism, Challenges and Opportunities

All new untried developments within the NHS produce opportunities for identifying problems and to place them in perspective. Such opportunities are the bread and butter of the broad church of the research community.

Thus the main task for a body like the Trust is to select a **manageable** but comprehensive programme of central concerns, ranging from the **monitoring** of the professional co-ordination of health services research by all agencies (government and NHS, as well as others), to **methodologies** for improving 'intelligence' about the state and significance of various services; about **managing changes, innovations,** and **new priorities;** about **allocating resources;** about both clinical and non-clinical **education and training;** and also about a variety of more specific **localised topics, both medical and non-medical arising from change.**

Proposed solutions to contemporary problems of health services are often relatively over-simple in character to make any real impression on the complex issues which are endemic to health matters. The true problem is often the failure to reconcile alternative over-simplified proposals for the increasingly sophisticated 'planning' required on the one hand, with newer concepts such as the current belief in the greater use of 'market' mechanisms on the other. There is plenty of evidence from

abroad about the effect of market forces either free or regulated, which is useful in evaluating proposals for solving the complex problems of health care. The history of recent reforms being touted, including those with pricing incentives in the USA[4], for example, were of sufficient interest to merit attention being drawn to them in *The Public/Private Mix for Health* (1982), although caution was exercised in drawing parallels. A superficial depiction of 'planning' and 'market' mechanisms as polar opposites may be dangerous: to be successful, viable solutions are likely to involve elements of both.

Thus a review based on the experience of 50 years of the prospects for research in the field of health care services points to a number of recurring topics in the infrastructure viz.

Renewed consideration of various aspects of the **manpower** question; Extension of the seminar programme and other commissions in **training and development for management;**

Special studies in management costing and budgeting systems; The application of 'intelligence' for better data and so for **information;**

How to achieve **inter-professional co-ordination** in order to explore more effective and efficient ways of delivering care in some specially chosen areas, particularly those of **mental illness,** the the problems of the **elderly** and those of the **disabled.**

The whole troubled question of basic and continuing education and its financing: and related to education, the deliberate use as means of communication and dissemination of knowledge, of special private **forums and seminars.**

At the more speculative end of policy relating to programmes, as complementary to the approach exemplified by the Trust's programmes there is need for occasional forays to illuminate some of health care's major problems from the viewpoint of **social theory, political analysis, and ethical consideration,** with the overall aim of adding to knowledge and improving the perspective of health services.

Such studies are complementary, through consideration of ideological, political, and professional influences upon the health service, to the kind of philosophical but more directly service-oriented reflections made by Sir Douglas Black in his *Anthology*

[4] To some extent the American influence on health care issues cannot be lightly dismissed, but they need to be put into perspective.

of False Antitheses, the 1984 Rock Carling monograph. Indeed, challenging false propositions and exploring 'conventional wisdom' by subjecting concepts which have become little more than clichés to more incisive analysis, is a perennial task for those deeply concerned about health care policies. Clearing the ground and providing renewed understanding of the context of the NHS should be consistent objectives which are never likely to be other than positive and ultimately productive.

Many of these topics relate more generally to the questions which continue to hang over **health services research,** and in particular its place in management at all levels. This is why it has always seemed to the Trust that there should be a coherent, comprehensive research policy for the NHS to reflect service problems and as an essential ingredient of management policy.

The earliest **grants** awarded by the Trust, which in those days were the main aspect of the Trust's programme, tended to pose implications related to current public and professional policies in a very complex series of services. While there is now a more sophisticated approach to problems by Health Authorities, current resource constraints make experiments following study impractical by Health Authorities hard pressed for funds. The pressures on, and continuous change in the management arrangements of the last dozen or so years has tended to dissipate the optimism that management would be able to draw together the tangled skeins of research and policy: although ultimately they will have to.

An important challenge in the Eighties therefore was to harness the Trust's experience and its adoption of the role as an 'Institute' to a judicious use of the grant-making functions together with suitable seminars and publications. Examples of promising avenues of approach explored were the **comparative evaluation of health services; helping to fund projects at centres for investigation of the needs of client groups (such as the elderly and the disabled); providing 'seed' money to encourage co-operation between different specialties or different institutions with a common responsiblity for the health needs of a definable population.**

Apart from the identification of areas for study the Trust has to include the means of receiving applications which incorporate ideas requiring the special energies of individual researchers. This requires policies not only to identify good ideas but also to ensure good communication.

Research work, however, will always be incomplete unless Health Authorities apply some of the lessons of research. The superficial logic that difficulty with the availability of public funds will automatically lead to good applications for grants coming to private sources such as the Trust, is belied by the fact that regrettably, by the mid-Eighties health service research units and the back-up facilities essential first to publication and then to the practical application of results of research were fewer on the ground than ever before, because of the lack of a deliberate central policy for health services research. This is a problem which will be recognised by the best of management.

The Trust's **publishing programme** originally reflected the need to gain attention for the type of study which might have had difficulty finding an outlet elsewhere. This might have been due to the awkward length of an essay or paper, for example, or to the more general fact that health services research was a less recognised field with fewer outlets than many other types of medical, social and political research. Many of the Trust's early publications were on quite specific subjects and indeed it can be seen in retrospect that localised analyses often raised significant questions for management.

In this context, Trust history indicates an independent body can act advantageously as a supplementary contributor to the 'intelligence' needed for the formation of policy by those agents with official responsiblities: helping where it is appropriate to highlight issues and pointing to deficiencies, without pretending to be able comprehensively to develop a complete model of structure or action which is more appropriate to those responsible in the machinery of government.

In this way it has above all, recognised it has a **function as an educator** and so contributing positively, indicating the means to improve long-term and broader strategies. These above all, to be credible, must be practically geared to improving services through assessing the compatibility of different policy and administrative initiatives; suggesting informally how incentives and structures might be changed; seeking to influence through the written word; and through demonstrations where possible. All these form part of the role of the independent body concerned with improvement.

As essentially a non-political body, the Trust in its activities has had to steer a delicate course between any move which could be construed as supporting 'radical' proposals which are mark-

edly and ideologically partisan, and suggestions for incremental change which are inadequate or too deferential to current orthodoxy. Informal constructive influence through the publication of factual evidence must be the objective.

The approach has been to build on past experience and on research largely through publications, supplemented by the promotion of discussions between professionals in seminars. That however does not rule out occasionally trying to reach a wider audience of intelligent consumers making up a broad band of the population covering all political pressures. Non-partisan contributions to solutions, can of course sometimes be radical as well as incremental. Publishing proposed solutions based on rigorous research which cut across political party lines, as any reform of social welfare may do, may often be desirable, though difficult, as long as presented without comment.

The objective of a comprehensive research policy is to help promote the improvement of hospital and associated medical services and opportunities must be grasped to place the results into public view. Overall the objective of the Trust is thus of constructive, non-partisan policy analysis.

(b) Helping the Quest for Leadership: and Improved Morale

Such a policy is essential in the development of good leadership.

Leadership is crucial to morale, and it is doubtful if the NHS system as it has operated until recently has lent itself to the easy natural emergence of outstanding leaders constituting a mode of leadership which can be exercised to affect the whole system. At the clinical levels where the various medical and environmental problems converge, and about which there is strong public consciousness, the recognisably outstanding clinician may shrink from extending a leadership capacity founded on personal clinical skills, to the hurly-burly of administrative operations. At the same time the outstanding clinician's influence in therapeutic matters is pervasive beyond clinical matters, and is exercised not infrequently well beyond his specialty and profession, if not always as a signal contribution to the general efficiency. It is of course almost against the current culture which places a premium on consensus to encourage a sense of 'old-style' leadership, especially in health services given the broad and rich variety and individuality of the professions involved. It is evident because of this, that ideally what has to be sought before reforms

are legislated is the encouragement of attitudes to the management of health services, responsive enough to realities but also capable of embracing a series of compromises which contrive to allow people of a wide variety of professions and sub-professions with different kinds of traditions (and who are not so anxious about their economic futures as to move easily to industrial action), to work willingly together for the effective operation of services designed for the relief of suffering. Any reforms instituted are bound in time to be measured for effectiveness against these requirements. This said, and accepting that this is the ultimate aim of change, with the present state of society, and the regrettable tendency towards alienation between professional groups and special interests which exists, the main immediate policy a body such as the Trust can adopt is to some extent seeking educationally to stimulate intellectual activity about the issue of how effective leadership can be encouraged and developed in institutions of a complex character, and then try to have the matter widely debated in relation to the NHS. The general objective of such a policy would be to point to deficiencies in form and to distinguish what compromises are necessary, on the theory that that is the ultimate alternative to what seems to have been developing during the past few years which seems to be leading to alienation and chaos; with effects on quality of services and the chief sufferers likely to be the patients.

Another part of the spectrum of the influence of administration and form of system on leadership and on morale, is the effect in periods of financial restriction of the **centralisation of policies** designed with the admirable intention of improving services in the UK by narrowing through such a method as RAWP, the apparent wide divergencies which occur geographically both in quantity and quality of services. When such policies involve robbing Peter to pay Paul, however sophisticated the means used to deploy resources to better effect and thus redress imbalances, they are never likely to get universal approval.

The constant action, reaction and reversion of policies over the past 50 years shows that there is little support for revolutionary attitudes in the health sector of society. Redeployment of resources where there are 'losers' as well as 'gainers' can only be effected over a long time-scale, because to do otherwise with limited resources would be nonsense politi-

cally, and thus, practically. Yet this fact of political and administrative life does not seem to have sunk into public consciousness: nor has the fact integral to such a policy that there is no scientific absolute in developing formulae which depend on data of differing character. Consequently, what a body such as the Trust can do to some effect, is to ensure suitably qualified individuals or groups are given opportunities to analyse the questions thoroughly from an unbiassed viewpoint and if possible to seek better means of action, if only to identify the difficulties and bring about a possible improvement in the quality of decisions and therefore morale. By such means it can also assist conceptual thinking about how effective re-distribution can be improved practically, and in so doing, again contribute from an unbiassed position to raise the level of administrative and public debate.

The Trust is known for the careful preparation for **seminars** and the quality of its publications. Every time the Trust launches a publication that gets attention, and most of them have tended to do so in both reviews and editorials, interest is quickened outside, which adds to knowledge of its work. The fact that it has now become known as a respectable publisher in the field is important in stimulating people to seek it out for support of studies likely to end in publication, or even occasionally to submit manuscripts for publication for subjects within known policies.

The seminar programme has, of course, an educational aspect too, but what is possibly a more difficult question is the wider dissemination of knowledge acquired through research, seminars etc., for the Trust has in the past been content to take the line that certain of the ideas which emerge will be taken up and widely discussed. In practice, this has been particularly true for conceptual speculation especially such as for example those raised in the monographs by **Doll, Cochrane, McKeown,** and to some extent **Fletcher** and **Dollery.**

The lessons of such experiences are bound to affect future policy and the Trust has therefore to take into consideration the realities of power and influence. It is quite clear that an objective in addition to the wide dissemination of knowlege to improve services is to get important information to the people in authority who are capable of being influenced, and in special positions to effect desirable changes in pursuit of the purposes of the Trust. While it is relatively easy to pick out those in the

service areas of the health sector who might benefit, it is the identification of those groups likely to influence policies and the leads to them, that presents most of the problems of communication. Contrary to some beliefs, it is realistic to postulate that these are rarely the people concerned with the day-to-day administration of operating authorities, although theoretically with the recent emphasis on management these ought to have, and in future will probably have, a greater influence than at present.

Hitherto real progenitors of change are mainly to be found in the administrative divisions of the Health Department and their advisors who sometimes are distinguished practitioners, sometimes academics, sometimes (though not recently) trade unionists. Those who have most influence on the content and direction of policies which have their effect on the organisation of services are often somewhat below Ministerial and Permanent Secretary levels although clearly the politicians and Departmental heads are important. More often than not those who in the long-run influence events are in the administrative class from Deputy Secretary to Principal level.

Theoretically there has always been a series of two-way exchanges between the Department and the operating levels, through meetings with Chairmen of Health Authorities as well as the separate professional officer, etc. groups: but more often than not, certainly in the past, the lower levels of administrative power have been in effect presented with series of options (or political dilemmas) which have been worked over by civil servants. This may already have changed in detail with the advent of the Management Executive but the nature of the groupings at these lower levels has tended to mean in effect a *divide et imperia policy.* The associations of RHA, DHA Chairmen, Authorities, Managers, Medical Officers, etc., have rarely had the effective staffing, or the necessary continuity and permanence to develop a group dynamism on, say, a number of ideas which might in the event, produce alternative policies: although the National Association of Health Authorities etc., in its recent form may be an exception to this.

A new factor in the power system is the **Commons Select Committee on Health Services** whose progress and influence will be watched with interest. It is not clear yet whether it will ever have a staff of effective power, although it can always assemble an impressive array of advisers. There is nothing to

prevent it however inviting bodies like the Trust or the King's Fund (as was suggested by the Guillebaud Committee in 1955) to look at certain questions in its sphere of interest.

The complexity of the set-up in health was the reasoning behind the idea of the Trust improving the dissemination process through a modest 'Chatham House' operation by way of the private forums/seminars, in which the key people can be sought to discuss major issues, if only to get important subjects properly exposed and ventilated.

There are of course numbers of groups other than those directly involved in service concerned in the progress of change. While it is important to get the academics into proper perspective (quite often they are not the powerful agents of change many assume them to be), their peculiar position in the intellectual world and the exchange of ideas, makes them necessary participants in discussions and in the exploration of ideas. Indeed the basis of Trust publication policy (and this has applied too, to many of the seminars) is the compromise made in encouraging the setting out of arguments for the all-rounders, the intelligent laymen and professionals of all kinds in the health care field. It has involved a process of constant reviews of what constitutes the likely evidence for each publication. It is important to realise the range of interests has made it necessary to try and hit targets selectivly, which means there has to be a flexible publishing policy which incorporates in it, provision for precis, as well as for longer papers, designed for a wide sweep of interested professional as well as members of Authorities, Councils, etc.

A continuing speculation has been about possible methods to achieve better and more widespread communication and dissemination of research results beyond the research community. the lack of means for stimulating thinking at and two-way exchanges between the administrative, professional and intellectual levels other than through publications is possibly the weakest link in the chain of service needs, health services research and the dissemination of information and ideas arising from it, to improve services. The advent of the Managerial Executive could well change this for the better.

5. HEALTH SERVICES RESEARCH

1. The World of Research

Although it seems a relatively new subject, health care research is really as old as the hills and over the centuries many references

can be found to research activities in relation to health care. (See the Rock Carling Monograph *What Price Quality?* (1990).)

Medical research, however, has taken a special direction in the United Kingdom as a result of the National Health Service when the question of how to improve services has become important because health care is publicly funded: and by far the greatest financial source for health care research is Government. A body such as the Trust which has been involved in research practically since it was founded, as evidenced by the Hospital surveys which were instituted in 1943, has a special interest. Because of the advent of the Government itself into the research field which the Trust had advocated, and the more recent entry of other funding agencies, it is particularly interested in the effect on its own attitudes to the problem of how and whose funds, particularly Government with its relatively high proportion of research funds available, are allocated. It is clear that decisions reached about the objectives of research to be funded, by the major funding authority, are of great importance, and the management and direction is a subject for particular debate by the research community too.

It is notable that this question is of interest elsewhere and recently the Institute of Medicine of the National Academy of Sciences in the USA have produced a report with a preface of some relevance since it incorporates the attitude behind the Trust's policy in 1971 following the Rothschild Report viz.

> the process of allocating funds for US health sciences research seems to be an issue that draws constant complaints and fuels desire to do something about it. Important policy decisions on how to expend funds most effectively on research operations, research training and research equipment and facilities have become issues of intense debate, interminable consternation, and frequent misconceptions both among those providing the funds and those competing to receive them.

It is of course not only the funding but also the concept of research and development as an integral part of health care services which has fallen far behind what is necessary to point the way to improvements to achieve optimum results from the vast resources deployed and the extensive knowledge that exists on matters of health. It has been a particular question for the Trust whether or not the existence of a National Health Service should presume a national policy on all aspects of health, to include health care research as a means to help non-political judgements on how to improve the arrangements for health matters.

Right from the very beginning the Trust did not wait merely to be the object of grant applications for health services research but took positive steps to go out and seek gaps in service and knowledge and answers to questions which seemed fundamental to the purposes of the Trust.

It is significant too it was the Trust itself that persuaded the DHSS to produce the first compendium of Departmental supported research in *Portfolio for Health* (1971) in which the policy of the DHSS was set out to public view for the first time. The developing programme of the Department was subsequently published by the Trust in *Portfolio for Health. 2* (1973).

Following the Rothschild Report and its acceptance by the Government the Trust decided to monitor how the Government was operating its research policy. It published a series of books and essays on this question in 1974, 1978 and 1985. The way in which Government funds are utilised for research is a matter of public importance.

2 Selectivity: Analysis: Commission

The general line of approach which has been adopted by the Trust from its inception has been to act as an independent observer of hospital and associated medical services. By 1948 the plan was to commission **studies, experiments and demonstrations.** In the 1960s there was a change in emphasis in that because of the increasing cost of **experiments and demonstrations** in relation to the resources of the Trust the potentiality of financing these became much less, and greater emphasis was placed on studies and 'intelligence' reviews.

At the same time there was a decline in the volume of random applications to the Trust for grants generally. This was probably the resultant of three forces.

The *first* derived from the increasingly vast cost of creating new alternative services within the NHS framework, which means that to be effective, the Health Departments and Authorities have to be involved virtually from the beginning in all innovative schemes.

The *second* was the result of the ever-increasing sophistication of peer review, and the rising cost of all research and development (R and D) which meant that projects had to be both more imaginative and scientific in conception than ever

before if they were to stand much chance of securing an approval.

The *third* lay in the vastly increased resources allocated by the Health Departments from the 1960s for health services research and development.

The research community has never believed there are enough resources available for research, and that they have been used to the best advantage given the extent of the problems. This consequently provides opportunities for bodies like the Trust, not only to fill the gaps of worthwhile studies but more generally.

It was increasingly evident there was a need for independent thought and judgments on the many pressing problems presented and identified and a more critical view had to be taken of long-held general concepts which affect arrangements for **care, cure, and prevention.** The very complexity of such issues as **screening,** the assessment of the **effectiveness** of medical intervention and its cost as between **institutional and community care,** and **priorities for action** related to the cost of **modern medicine** is in stark contrast with the over-simplification and trivialisation which inevitably abound in the discussion of policies in health care on all sides of the political and professional spectra.

The Trust's approach to research and its place in health affairs pointed to the need for a more balanced view of the realities than existed. Apart from questioning the management and policies concerned with publicly funded research, it was designed to encourage better based criticisms and judgments about what can be done practically, than tends to be present in much of the comment and observation in the media, which inevitably shapes public attitudes.

The effect of this on Trust policy was to accelerate the trend towards the recognition that the best policy would be for the Trust to act more and more as an independent agent for the **brokerage and development** of ideas, and for the encouragement of ever sharper critiques of underlying concepts. Such a policy gave greater accent to the Trust's role as 'Institute' with the primary objective of the improvement of health services. Its resources were accordingly utilised more and more, for 'intelligence' work to sharpen the focus on issues not fully covered by the Health Departments' operation in this field; indeed, the need

for independent activity on this front is always likely to be acute since it would require a degree of liberalism in policy, not always to be found in the bureaucracy to respond quickly to the needs of speculation and inquiry into certain aspects of health services likely to lead to controversy. There is no such inhibition on the part of independent bodies with their many connections, to cultivate a spirit of enquiry concerned with all levels of service.

Part of the trouble, of course, is that the NHS, which has practically a monopoly in health services, is something of a misnomer in that it is not a service in the sense that, for example the armed forces are with their General Staff Organisations, all with a firm Intelligence base on which action can be confidently taken. There are of course various internal Departmental policies within each Department of State, but it has never been easy to identify a comprehensive Governmental policy at a single nodal point for the health of the public, including environmental and industrial issues with interrelated short-, medium-, and long-term considerations developed into integrated plans of action. It is moreover impossible to improve the personal health care services unless they can be seen not just as clinical services but in the full context of all the influences on the health of individuals in the society in which they live.[5]

The Trust's efforts since its foundation and increasingly over the years, became largely devoted in effect, albeit in a modest way, to selecting its interests in an 'Intelligence' approach to aspects of health care which appear neglected, to the asking of more relevant questions about improvement and how best to illuminate if not to answer them. Before the view of the holism of health was widely (and now fashionably) held, the Trust pointed to the importance in using popular methods for a wider sweep of purposes, from containing the incidence and prevalence of diseases, to the evaluation of the effectiveness of screening techniques and of therapies. This approach became a priority in policies regarding health affairs.

Central to this overall policy was the belief that there had to be a better understanding universally of the vital forces affecting health in Society and what could be done about them. The main thrusts of the Trust's enquiries, the mechanisms for which became a three-pronged attack of **grants for research, a**

[5] The influence of the fledgling Managment Executive on this has still to be proved.

private seminar/forum programme and a publications policy, can be seen to have been devoted to a succession of probes into issues which are fundamental to a better understanding of what determines health and what can be done about it by way of public and private policies. This goes beyond reviewing the effect of existing institutions by seeking a better conceptualisation of the complex issues which affect the health of the public.

To do this effectively involves the mobilisation and analysis of the best available 'intelligence', and the sharpening of various techniques to explore, review and attempt the synthesis of contemporary concepts, policies and activities, with a view to pointing to future action. This policy requires the selection of issues and poses the need for special and differential analyses of a myriad of often separate and sometimes apparently contradictory policies.

As a necessary complement to this, a major policy was to develop a publications programme in an effort to help the creation of a literature for a wide dissemination of the results of research and of relevant ideas from experts from a wide variety of disciplines working in the health field.

The need for the establishment of a literature on health generally to increase knowledge and understanding as a result of research and analyses demands no justification at any time, but the publication of essays and books not exclusively on work supported by the Trust but within its purposes, in time became in itself an important part of the Trust's policy in creating an atmosphere of serious enquiry in which many disciplines can participate with benefit for all. That these also led frequently to the highlighting of gaps in knowledge and to speculation and projections about future developments hardly needs pointing out. The catalogue of books published indicates the wide range of interests of the Trust and the liberal interpretation of its purposes, which has been a feature of the Trustees' policies since the beginning.

6. THE PUBLISHING POLICY

(a) Feeling the Way

The first publication of the Trust was 'A National Hospital Service' 1941, a memorandum on the co-ordination of hospital services to illustrate its purposes. Five years later the Trust produced *The Hospital Surveys*, subheaded *The Domesday Book of*

the Hospital Services to outline the extent and importance of the Hospital Surveys undertaken in association with the Ministry of Health. Both these publications were intended to indicate not only the Trust's major interest at the time but to underline the urgent necessity of a National Hospital Service, the summary being published just before the 1946 Act.

By 1948 the first fruits of its research support were coming in. The first publication of those was of a Scottish experiment in the employment of severly disabled men called *The Haven Products*. The principal researcher behind this was Professor Ferguson the Professor of Public Health in the University of Glasgow. Later, that year, Professor Ferguson also produced the first of his *Hospital and Community Studies* on hospital treated sickness amongst the people of Stirlingshire. This was largely a collection of studies which delved into the background of people who were treated in hospital in Stirlingshire. This was followed up the next year with a second study of those people in Ayrshire who were treated in hospital. Based on these studies Ferguson, in association with Dr A N Mcphail, produced in 1954 further reports in the *Hospital and Community* published by Oxford University Press for the Trust, which showed that the hospital 'population' in those areas tended to come from particular groups of people related to families and social class.

In 1952 the Trust published a Report on the study it had carried out in-house into **hospital costing.**

Two years later it published the Report of the study of the work of **nurses in hospital wards** which called for the better use of the skills of nurses, and thus preceded by nearly 40 years the recent critisisms by the National Audit Office on the use of nursing skills.

During the next 10 years the Trust's publishing policy was mainly to assess manuscripts which came out of work it had supported and to decide whether or not to publish them either under its own imprint or by Oxford University Press. The most notable and seminal of these publications were the report of the longitudinal Study *A Thousand Families in Newcastle-upon-Tyne* (1954) and *Good General Practice* (1954) which was a report of a survey of general practice undertaken by Dr (later Lord) Taylor. These were followed by *Studies in the Functions and Design of Hospitals* (1955) based on the investigations sponsored and financed by the Trust originally in association with the University of Bristol. Another publication on the early identifi-

cation of a problem which is still chronic at the moment was that of the *Rehabilitation of the Elderly Invalid at Home* (1957) which was an early experiment in the restoration of activity after illness amongst old people in their homes in Belfast.

The direction of the major activities of the Trust was already moving towards studies and in 1957 and 1958 the disturbing reports of two studies on 'sterilisation in hospitals' viz. *The Planning and Organisation of Central Syringe Services* (1957) and *Present Sterilising Practice in Six British Hospitals* (1958) were published which in turn led directly to the major outstanding study reported in 1963 on the principles and practice of central sterile supply, published under the title *Central Sterile Supply* (1963) by the Oxford University Press for the Trust.

It also published in 1960 *Casualty Services and their Setting* which was the report of a study carried out by a distinguished group of clinicians after the first Christ Church Conference in 1957, on the future of Health Services. This particular book caused a great deal of comment because although it was written in a low key to avoid scarifying headlines, it did indicate there was a major problem about the adequacy of the emergency services of many hospitals and suggested solutions which were subsequently taken up e.g. having Consultants in charge of Casualty Services.

Another important investigation which again directly stemmed from the 1957 Christ Church Conference resulted in *The Demand for Medical Care* (1960) which was the report of a case load study in the Barrow and Furness group of hospitals which indicated that the planning of hospital beds at the rate of 6 acute beds per 1,000 population which was the current target was excessive. This supported the earlier findings in the Norwich and Northampton studies carried out under the investigation into function and design of hospitals which appear in Chapter 5 in the IFDH Report. This was the basis of the important comment by the Department of Health in the Hospital Plan of 1962 that fewer beds seemed to be required than had been previously thought necessary.

It was already evident too, that **social work** was an important element in what should be the seamless role of health care and the report by Barbara Rogers and Julia Dickson entitled *Portrait of Social Work* (1960) which was a study of the social services in Rochdale gave a great deal of weight to the notion that 'social' work should be closely allied to 'medical' care.

In the meantime, studies were mounted by the Trust to enquire into other issues fundamental to the efficiency of hospitals in the treatment of patients. One of these planned as a follow-up to the Trust's earlier initiative in hospital costing was *Costing and Efficiency in Hospitals* (1962), which was the report of a study by Charles Montacute, the Treasurer of Gloucester Hospital Management Committee. Its recommendations pre-dated by many years the recent official decision that the Accounting Services in hospitals should be improved to produce the costing data which are required for management and policy purposes.

Another Study led by Dr (later Sir) Claus Moser then of the London School of Economics, indicated the Trust's interest in the utilisation of available data on health services other than medical. It was commissioned to point to and assess the data available about **dental health and dental services.** The Report was published as *Dental Health and Dental Services* (1962).

The symposium held in Christ Church, Oxford in 1957 to attempt to estimate the possible shape of things 20 years later gave a fillip to the notion of the use of seminars as a means of assessing current trends.

A symposium designed to give the current state of a particular service was one on **mental health.** The proceedings, based on a number of papers by distinguished psychiatrists on the epidemiology of mental illness, were published in 1962 under the title *The Burden on the Community* (1962). The authors and participants were in time to become some of the leading practitioners in psychiatry in the country.

There had been an awakened interest in **operational research** in health services, again because of the concern felt about the information which was either lacking or not being used properly to throw further light on the quality and extent of health services available to the population. A symposium was held in Oxford, chaired by Professor (later Sir) Maurice Kendall, Professor of Research Techniques at the London School of Economics, on **Operational Research in Health Services.** The papers and proceedings published under the title *Towards a Measure of Medical Care* (1962) were important position papers on the current state and future pontential of operational research.

Ad hoc surveys by Trust commissioned groups were those commissioned to review the **organisation of diagnostic x-ray departments** so fundamental to the diagnosis of illness, and the

chronic problem of **waiting in outpatient departments.** Reports were published under the titles *Towards a Clearer View* (1962) and *Waiting in Outpatient Departments* (1965) which pointed to much needed reforms.

The early interest in hospital and community stimulated by the studies by Professor Ferguson of Glasgow blossomed into *Further Studies in Hospital and Community* (1962) which underlines the seamless robe of health care.

The question of the **social environment** in which health care exists was examined in the first Rock Carling Monograph by Sir John Charles, the recently retired Chief Medical Officer of the Ministry of Health, who in his monograph *The Social Context of Medicine* (1962) gave an historical and contemporary review of the subject of medical care in its social context. Many of the observations made on health care in society are still relevant today.

The Trust's interest in basic studies was further stimulated by the warm reception which had been given to the publication of the results from the research already supported, and a number of specialised ventures were financed.

In 1963, in addition to the much acclaimed *Central Sterile Supply*, the Trust published a series of important books on matters of common concern viz. *Geriatric Nursing, The Causation of Bus Driver Accidents, Hinges of Administration* which was a survey of the characteristics of hospital administrative and clerical staff, and the survey which resulted in the publication *Food in Hospitals* which drew attention to the need for a closer look at this important aspect of patient care.

All of these books were major contributions to a fundamental understanding of several contemporary problems. From the vantage point of 1990 it is sobering that despite the attention given to them many of the questions raised have tended to recur over the years since and indeed are still with us.

1963 ended with Sir Robert (later Lord) Platt's thought-provoking Rock Carling monograph *Doctor and Patient* which drew attention to the need for awareness on the part of Government of the effect of actions by Government on professional morale and ethics.

(b) Taking Stock

In 1963 it was felt that the Trust should perhaps make public some observations about its policy on publications. Hitherto the

publishing policy of the Trust had been based on the fact that those concerned in the particular activities which the Trust had sponsored and funded had not always found it easy to secure suitable and timely outlets for the reports on their work. The projects supported tended to be a little out of the mainstream of the mainly clinical interests on which the major medical periodicals and learned journals generally concentrate. It was therefore still not easy for those directly involved in health service research and development to gain the necessary confidence and practical criticism by securing appropriate outlets either for preliminary communications about their research or for the swift dissemination of results at the conclusion of the research. A publication policy was accordingly designed to close gaps in the means of communication at a time when there appeared to be a great deal of public attention and some quickening of interest generally in health service research and its application. At the same time the Trust felt it should not exclude the possibility of publishing the results of research financed by other bodies on subjects coming within the Trust's general purposes.

The publication policy decided upon was based on the assumption that certain of the manuscripts submitted would be

1. of Book length
2. of Essay length say up to 10,000 words which would be collected in a series entitled *Problems and Progress in Medical Care* or
3. of a total length of about 35000 words, hence the *Occasional Hundreds* and
4. The *Rock Carling Series* which would consist of specially commissioned position papers.

Experience showed that the essays in the *Problems and Progress* series which had been established in 1964 were likely to be of two kinds, that is preliminary communication of results which might become the subject of longer works, and final reports, possibly not requiring greater elaboration than the essay form provides. It was believed the volumes would meet a special need since there were few outlets in Britain for serious essays of up to 10,000 words on social and health care studies. Because of the growing awareness of the need for a wide range of studies of the infrastructure of health care, the backgrounds, methodologies

and implications of much research in this field required to be communicated at rather more than digest level for positive critical review. Too often the only alternative to the short article is the book, the form, length and price of which may be quite as frustrating to impact and influence as the inevitably brief extracts appearing in the medical press or in the more sociologically inclined journals.

The *Rock Carling* series, started in 1962, was an attempt to invite each year a distinguished person to review in a monograph, to be published by the Trust, the state of current knowledge and ability and to speculate about the future of some subject within the purposes of the Trust.

The *Occasional Hundreds* series which was established in 1971 was the result of the belief that a number of manuscripts merit publication of longer length than that of the essay. It was an attempt to demonstrate that the results of research and their implication for health policy are capable of being adequately covered by books, the size of which is probably about the size of a 'Novella'. This is not to say that the Trust in this series deliberatly set researchers the task of confining what they had to say to within 100 pages (say about 35,000 words only) but this was given as a target, the achievement of which would not be too hard on either author or reader.

In addition to the *Rock Carling* monograph series mentioned above, in 1980 there was added the *Queen Elizabeth The Queen Mother monographs* the fruits of a Fellowship founded in the name of the Trust's Patron on the occasion of her 80th Birthday. The objective of this was to commission monographs on subjects geared as far as possible to the areas of known interest to Her Majesty Queen Elizabeth The Queen Mother and within the purposes of the Trust.

Originally Trust publication policy was limited and based on the fact that appropriate outlets for research reports on health services did not exist, either of book length or of lengths suitable for the major journals. It was felt there ought to be a number of very well defined series offering opportunities for subsidised publication for suitable manuscripts of differing complexion and length.

It had become evident that the essays in the *Problems and Progress* collections which tended to be disparate in length and content were by no means certain of getting to the right readership at the right time. Indeed, occasionally some essayists

chosen for a specific collection were tardy in submitting suitable manuscripts and the whole collection was delayed. Since the establishment of the series in the 1960s it was noticed that occasionally some of the freshness of an essay particularly on policy was inevitably lost in the wait for other essays to complete a volume. Sometimes too it was suspected that the immediacy of the thrust of a particular communication had been lost in a volume in which the essays had little common theme. This was the reason for the launching in 1984 of the series of *Occasional Papers* arising from commissions and ventures of the Trust concerned with policy matters of the moment and designed to indicate the way to improvement of services.

With the advent of the great interest in the 70s and 80s in health economics and their relationship to public policy, a series of *Nuffield/ York Portfolios* was established in 1985 under the editorship of Professor Culyer of the University of York, designed to publish short essays in the main by health economists on health care subjects.

Another series established was the result of commissions to management consultants which were concerned with issues of important current policy, for example, competitive tendering and management training. This resulted in the early 1980s in a management series consisting of books published as a result of commissions to Thornton Baker (now Grant Thornton) and P A Management Consultants. These dealt with issues of the day and were published as practical suggestions to Health Authorities.

7. MEDICAL EDUCATION

There is a long history of Trust interest in medical education as one of the most important keys to the **improvement** of quality in health care.

The initial common factor concerning the Trust and medical education was Sir William Goodenough, the first Chairman of the Trust, who in 1942 became the Chairman of the Interdepartmental Committee on Medical Education.

The Goodenough Committee's recommendations included some concerned with the improvement of health services which was being seen as the principal objective of the Trust. An extension of this was the recognition that postgraduate and continuing medical education in particular, is the basis of good health care service. This belief indeed was the reason for the

Trust's initiative in 1961 to convene the celebrated Christ Church conference. Earlier among its first grants the Trust financed University Chairs in **Social Medicine,** in **Paediatrics,** in **Plastic Surgery** and **Psychiatry,** all of which were concerned with subjects which the Trustees felt were neglected but fundamental to good services at the time, and to their improvement in the future.

The Trust's notable interest in 1961 in Post Graduate Medical and Continuing Education had therefore strong roots. The initiative was undertaken because it was felt that throughout the Provinces it would be important to try and stimulate interest in the subject at each District General Hospital, each of which it was hoped would become in a sense a Teaching Hospital. Because at the time the tide was running powerfully in favour of establishing facilities in hospitals for Medical Education at postgraduate level in the medical profession itself, this policy of the Trust *qua* catalyst proved to be a great success, especially so since part of the policy was to help the development of Postgraduate and Continuing Education amongst general practitioners, through association with the Medical Centres.

Looking back to 1961 and comparing the position then with that now, the immediate problems then looked relatively simple to solve. Indeed, this is perhaps best reflected in the stark simplicity of the reports in The Lancet and The BMJ of the Christ Church meeting which, however, had the effect of catalysing the ferment which then existed about a number of questions related to medical education as a whole. The Trust's advantage, however, lay in its ability to take the proposals further by stimulating local action which it did through its grant and loan programmes.

Thus the action taken by the Trust in 1961 to offer capital grants towards the building of medical centres attracted a great deal of capital from local sources. But perhaps the major effect was that it also encouraged the mobilisation of action in many parts of the country on the part of the medical establishment interested in postgraduate and continuing education. The Trust's immediate objective was to stimulate the belief that better arrangements for postgraduate and continuing medical education would have an improving effect on health services generally in the Provinces.

The longer-term objective of establishing the principle of postgraduate and continuing education as a legitimate charge on

service funds raised at the Christ Church conference was achieved with the eventual issue of Circular (64)69 which also confirmed that provision should be made for educational facilities generally in District General Hospitals.

Four years later when it became evident that the time had come to be more selective in further support until there was experience of various experiments in train, a team was commissioned to survey the experience since 1961. The result was the publication of a report which proposed some experiments in methods of education and studies of the needs of postgraduate students. More importantly, however, it listed a number of questions which should be addressed by those responsible in educational and service circles for the formulation of policy. This report was published in full in the *BMJ* as *Assessment of Postgraduate Medical Education* in September 1965.

This led the Trust to set up three Working Parties on **vocational training** for **general practice, psychiatry** and the **administration of hospital and public health services.** In their reports published in 1967 these working parties set out the major elements of training which should be addressed in each of these fields. A common conclusion of all the Working Parties which accorded with the outcome of policy discussions by the Trust Medical Advisory Committee that there was the need for a study of the existing situation in postgraduate education with special reference to the inter-relationships and co-ordination of the many educational and service bodies involved. The report of this study was published by the Trust under the title *Postgraduate Medical Education: Retrospect and Prospect* (1967).

The Trustees acted on a recommendation of the report and made a grant to finance for a period of three years a secretariat for the Central Committee for Postgraduate Medical Education which had been convened in 1966 as an unofficial discussion body with an advisory role but without resources to co-ordinate all the interests in the main education bodies. Within the three year period, the Government had stepped in and financed as replacements of the Committee, Councils for Postgraduate Medical Education in England and Wales, in Scotland and in Northern Ireland.

The next move by the Trust was the convening of another conference in 1973 on the model of the original Christ Church conference to look at the current position of postgraduate medical education and the prospects for the future, including the

work and impact of the Council. The Report and proceedings were published by the Trust under the title *The Way Ahead in Postgraduate Medical Education* (1974).

Subsequently, Sir George Pickering was invited by the Trust to consider the place of postgraduate medical education when he was reviewing medical education as a whole. His personal views were incorporated in *Quest for Excellence in Medical Education,* published by the Trust in 1978.

Some three years later, in 1981 the Trust was approached again about whether it would consider looking once more at the general question because of the problems which were arising. The indications were not so much dissatisfaction with the way in which the many and varied Post-graduate Medical Education centres were operating, but because their functions had in certain cases changed considerably over the previous 20 years. At the same time because general practitioners had responsibility now for their own vocational programmes, there was some belief that it might be better if they carried out their own educational programmes independently and away from hospital centres. There was indeed feeling in some quarters that because of the variety of other professionals required to support general practice this might be best done on site in general practitioner centres.

In the initial reconnaissance it was obvious there was little consistency in the way in which the subjects of postgraduate and continuing medical education were being approached in most of the regions and in the districts. This was hardly surprising, since apart from the requirements of higher specialty training, there were problems arising from clinical attachments of undergraduates, and certain districts were probably providing more teaching facilities for undergraduates than had been provided in one or two of the smaller teaching hospitals before the 1939-45 war. Again, many of the centres which had been provided in the newer district general hospitals as part of the service, were now being used for the further and continuing education of other professional groups concerned in medical care.

All of this added up to an extremely complex situation which is bound up with the use of resources in the organisation of postgraduate and continuing medical education as an activity almost completely funded by government through two Departments of State, i.e. the then DHSS and the DES.

A major objective of the recommendations of the original Christ Church conference which had been virtually a 'summit' meeting of the then luminaries of medicine, had been to point to the need for a focal point for postgraduate and continuing education: and in the spirit of the suggestion of every major hospital being a Teaching Hospital, the District General Hospital was nominated as the ideal.

It was accepted that pluralism of effort has a great deal to offer by way of initiatives, but without an identifiable framework recognised by all participants pluralism can sometimes equal chaos. Sir George Pickering in his *Quest for Excellence* appealed for a careful examination by both Health & Education Departments for a single body to be responsible for medical education as a whole, in the light of current circumstances and in the realisation that medical care embraces the Greater Health Care Professions which contains a range of health professions other than medical.

After more than 40 years of the NHS, it would be ingenuous to believe that with all the vested interests involved this can be achieved easily, but the history of the Trust's involvement in education indicates there is still a strong case for some speculation about future objectives and the policies to achieve them. The past 25 years have seen appreciable changes in the way in which some specialties in medical care have developed; and as is being revealed in most sectors of interest concerned with the end-result of services, it is questionable whether the present haphazard arrangements for all specialties concerned, clinical and non-clinical, constitute the best use of resources to achieve improvement in quality.

It is ironic that although this is a major problem for management in their search to achieve effective services for patient welfare, which is the major objective of the NHS, it is doubtful if it figures high on any of the lists of managerial policy. It is a difficult problem, success in the solution of which is impossible to evaluate numerically but in which the medical profession must have a key role. Certainly it would be important for future health care services for a start to be made to look at what is actually happening in the broad field of education for health services generally, and in particular in the medical centres. There is a need for a sketch of terrain based on more facts than are currently available and to point the way ahead.

8. SOCIAL, COMMUNITY, AND PUBLIC HEALTH MEDICINE

(a) Changes in Emphasis

The Chairman of the Trust's original Medical Advisory Committee, Sir Farquhar Buzzard, Regius Professor of Medicine in Oxford, in his 1941 Harveian Oration to the Royal College of Physicians was among, if not the first, to refer to **Social Medicine** and its place in service for the first time in a scientific meeting.

Subsequently, in 1943 the Trust financed the first Chair of Social Medicine in the United Kingdom in Oxford, the first occupant being Dr John Ryle, the then Regius Professor of Physic in Cambridge University. Immediately afterwards, the Trust founded in Oxford the Institute of Social Medicine with the objective of concentrating on the role of Medicine in Society and introducing the subsequent curriculum of the Medical School. This action was in recognition by the Trust of the many social factors which determine the health of individuals and the population and thus affect medical practice and care. Two years later they financed a similar Chair in the University of Birmingham, the first occupant being Tom McKeown. The Department in Birmingham also included the subject of **Industrial Medicine,** for which the Minister of Labour, not the Minister of Health was responsible.

The importance placed on the subject of Social Medicine by the Trust in its early days can be judged from the fact that the Medical Advisory Committee considered founding a third Chair, at the University of Leeds. This was not however proceeded with, because it was felt that because of the many and necessary calls on the Trust Funds it would be better to institute the principle of supporting only one project in each category as a demonstration of the worth of the idea.

As a corollary to secure the important base of good information to the concept of the social factors in medical care the Trust set up two Bureaux of Health and Sickness Records, in Oxford and in Glasgow. The arrival of the NHS saw the dissolution of the Bureaux but it was clear the initiative was an important demonstration of the need for good data to the newly fledged NHS. It also indicated the Trust's belief in the need for developing good **information** services concerning the many and varied problems touching on the health of the public.

As a further token of this, the Trust supported the work

being carried out by the Professor of Public Health in Glasgow, Thomas Ferguson, who was concerned with developing good data in a series of studies in Central Scotland. Two of his conclusions were that a considerable proportion of patients attending hospitals seemed largely to be drawn from the same families and social classes, and tended to return more frequently. A complementary conclusion was that rehabilitation and health promotion services were required

A further stimulation to the question of **information** as the basis of **public health policy** was the setting up in-house in 1949 of the Investigation of the Function and Design of Hospitals (IFDH). A particular feature of the results from that study gave a special boost to the need for good statistical bases not merely for design purposes but for renewing the demand for services. This involved the application of the 'queuing' theory to admission waiting lists in Norwich and Northampton to establish whether the number of beds in the acute hospitals was sufficient to meet the demands of the population; and thus to record more scientifically than ever before, what was necessary by way of change to meet the realistic demand for hospital inpatient and outpatient services. With the advent of the NHS, the IFDH Study as a whole gave a fresh emphasis to the Trust's interest in investigations concerned with matters of public health and the importance of an irrefutable statistical base for the determination of policy.

The pursuit of this interest has continued throughout the years since and in recent years as a development of the co-ordination policy, it has incorporated examinations of policies concerned with the application of modern **information technology** such as computers in medicine to the production of appropriate information in **all** specialties and to management. The various strands of this interest can be detected in the grants which have been made by the Trust over the years.

In the public health sector among these investigative studies were projects the results of which indicated a growing belief in the need for improving information assessing the **quality** of health care practices in many of its aspects. Thus in 1968 a Trust-convened group produced the seminal collection of essays *Screening in Medical Care* which reviewed the evidence of the reliability of a number of screening procedures. Regrettably little management interest seemed to have been taken of the implications of this. It is interesting that a recent (1990)

publication of the Trust, **Screening in Health Care: Benefit or Bane?** stengthens the case for the closer association of such studies in the realm of public health management policies.

In 1976 in the book *A Question of Quality* it was pointed out that the need for **quality assurance** was likely to become a pressing question in the future and that good information relative to assessment of quality of all clinical procedures was essential. This is likely to be of the utmost importance in the future in the successive changes of terms which have occurred in the specialty from **Social**, to **Community** to **Public Health Medicine.** The latter was given special point in 1989 with the conferring of Statutory responsibility for reporting on the health of 'populations' being placed on Directors of Public Health.

The founding of the **Faculty of Community Medicine** for which the Trust gave a grant to assist the drawing up of a constitution, in 1971, and its change in name to the Faculty of **Public Health Medicine** is also significant in the development of the up-dated Public Health movement, increasingly being concerned with outcomes of care.

(b) A Widening Scope

Some of the most notable aspects of the Trust's association over the years with 'Social', 'Community' and its new nomenclature 'Public Health' Medicine, are strikingly similar to those issues picked out specially on the recent Report on Public Health of the independent Institute of Medicine of the American National Academy of Sciences in Washington DC. Much of it is concerned with the question of what is defined as the 'Public Health', a movement there which has a long and distinguished history.

Among their observations which strike a familiar note here is that there seems to have been a failure of public policy related to existing institutions concerned with the health of the public.

As in the USA, there has been little indication here of an identifiable co-ordinated policy to which all the relevant bodies and agencies providing services concerned with the health of the public can relate closely.

The history of the provision of health care for the public related to what had been conceived down the years as attainable ideals, leads to the conclusion that there is still some distance to go before the ideal can be attained. With all the current attention being paid to the conservation of the environment

there seems bound to be in time a fresh approach to the question of public health to make use of all the elements in existing professional expertise recognising the limitations set by the political process. It has clearly to bring into its scope the effect of medical practice which is fundamental to health care for the population as a whole. It is undeniably necessary to make use of all the current knowledge bases and their application.

Part of the problem in the UK is that there are several Departments of State involved in questions of Health other than the Department of Health, which poses questions of structure and the roles of Government and the various Health Authorities in the special linkages necessary in co-ordinating public policies on environmental health, mental health, social services and in arrangements for the care of the elderly and indigent, as well as services provided by the 'private' agencies concerned in these matters. It has to be recognised that overall the policies adopted must be long-term and have to reflect political, managerial and fiscal restraints.

Finally there is the major question of **education** for and the **promotion** of knowledge on matters of health both individual and public which, because it is the basis of understanding on the part of the public as well as of health professionals about what is required, must have a high priority in a civilised society. This is clearly an important issue of public policy for the future.

9. PRIVATE MEDICINE

In his history of the British United Provident Association[6], Sir Arthur Bryant noted that great changes took place in the British Hospital system during the period immediately prior to the Second World War: for there was a system even if at first glance there did not appear to be so. While it had grown up in a haphazard, illogical and characteristically British way, by 1938 the hospitals in Britain were claimed to be among the best, if not the best, in the world.

Not only had there been immense improvements in the standards of nursing and treatment but there was also a vast increase in the total number of beds. This had a bearing on the origins of the Trust.

Up to late in the 19th century hospitals were regarded purely

[6] Acknowledgement is made to BUPA for the use in this note of certain material included in Sir Arthur Bryant's History.

as places for the treatment of the very poor, for whom there was no possibility of nursing at home. Although the Voluntary Hospitals had been established and operating for centuries, with the 1929 Public Health Act, Local Authorities began to develop their own systems of hospitals for their communities separate from the voluntary hospitals. Indeed in effect for the first time, hospital treatment, in cases of serious illness, began to be available to all classes in the community.

The voluntary hospitals supported almost entirely by charity and served by doctors of the highest quality giving their services free, were unique and until the 1929 Act began to take effect in the best of Local Authorities, they offered a system superior to the other residential institutions for the treatment of the sick provided by the Poor Law Guardians who administered the workhouse infirmaries and asylums.

Most of the famous voluntary hospitals were also teaching hospitals where the consultants taught the thousands of students who were to become the future doctors in the country.

That the 'system' was ready for the move to rationalisation reflected in the terms of the Trust Deed may be gathered from the data. By 1939 there were over 1100 independent Voluntary Hospitals and more than 1500 local government hospitals. These provided nearly 180,000 beds in the hospitals of the local statutory authorities, and 80,000 in the voluntary hospitals, in addition to the beds in private nursing homes and the pay-wards of the larger voluntary hospitals catering for the upper and middle-class patients under suitable conditions. Included in these numbers were specialist hospitals, isolation, tuberculosis, mental hospitals and maternity homes, many with private rooms.

With new developments in surgery and anaesthetics necessitating costly and elaborate equipment and highly skilled nursing, home treatment for serious illness was becoming increasingly impracticable. 'The Whole Trend in Modern Medicine', Joseph Chamberlain had declared as early as 1881, 'is towards treatment in institutions'. For many middle-class patients the cost of modern nursing and surgery in private institutions was prohibitive.

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The finance of the system was multi-faceted but non-comprehensive, reflecting the lack of a governmental social

welfare policy and system. The private rooms in the nursing homes and voluntary hospitals were financed mainly by charges to the wealthier patients who separately paid the fees of the specialists and consultants who attended them.

The hospitals owned and administered by the local authorities were maintained out of rates and taxes while the public wards in the voluntary hospitals which catered for about a third of the nation's hospital patients were supported partly by voluntary payments collected by almoners from those who could afford to make some contribution, however small, towards their stay and treatment, and partly by charitable subscriptions, collections and endowments which at one time had been their sole source of income.

About the middle of the 19th century, however, these voluntary bodies had also enjoyed a growing source of income through associations with contributory schemes of pre-insurance, under which working men, in employment, clubbed together to provide for treatment in sickness by small weekly payments in times of health. In many cases these were supplemented by payments made to hospitals by their employers.

Under the National Insurance Act of 1911, this system was supplemented by a statutory, compulsory scheme, under which, in return for contributions of 4 pence a week to an approved society to which the employer contributed a further 3 pence and the State 2 pence, manual workers in employment became entitled to free medical treatment from a general practioner or panel doctor, and to cash payments when incapacitated by sickness.

The Friendly Societies were given a place in the administration of State Sickness Benefits while continuing to offer ancillary services such as convalescense not included in the National Panel scheme, and to provide benefits for those not covered by it. During the 20s and 30s many Provident Clubs became linked with particular hospitals under such schemes giving their contributors the moral, if not the legal right to treatment.

In London in 1922 the King Edward's Hospital Fund which had been founded on the Diamond Jubilee of Queen Victoria and which was under royal patronage to improve hospital standards in London, pioneered the formation of the Hospital Savings Association, under which persons with earnings from £4 up to £6 per week according to the size of their families,

could obtain free hospital care in the general wards of the voluntary hospitals in return for 3 pence a week or 12 shillings a year. More than half a million contributors joined the Association during its first 7 years and similar schemes in other parts of the country met with widespread support, notably in Birmingham and Coventry. By the 1940's there were several hundred such schemes listed in the Hospitals Year Book, with nearly 10 million members.

Provident Association Schemes were somewhat different. They started with the meeting called in 1921 by Sir Arthur Stanley, Treasurer of St Thomas's Hospital, which resulted in the formation in 1923 of the British Provident Association.

One result of the British Provident Association's success, was the formation in 1927 of an exploratory committee in Oxford, under the chairmanship of the Rev. G B Cronshaw of Queen's College and Treasurer of the Radcliffe Infirmary. The moving spirit, however, was Alderman William Hyde, later to become the first Secretary of the Trust, who with Mr (later Sir) William Goodenough (the first Chairman of the Trust and Lord Nuffield's adviser on hospital and other charitable matters) founded in that year and, thereafter managed, the Oxford and District Provident Association. The success of this Association led to the founding in 1932 by Mr Hyde and the Regius Professor of Medicine, Sir Farquhar Buzzard of the Oxford University Provident Association, under the chairmanship of Buzzard (later to become an original Trustee), which by the end of the War had a membership of more than 2,000 undergraduates. In 1937 a National Association of Provident Associations was formed with Mr Hyde acting as Secretary.

Thus by 1939 the British hospital system, such as it was, was catering for all classes, offering free hospital treatment for the indigent, aged and unemployed. Contributory Provident Schemes, mostly with income limits, linked with National Insurance for those in manual employment, and a variety of voluntary schemes of the Provident type, still mostly small and unco-ordinated for middle and upper-class patients, who were expected to meet the full cost of an illness themselves.

The 1939-45 War virtually halted any development and gave a special emphasis to central government direction through the emerging health scheme. In particular it highlighted the illogicallities, the haphazard development and overlapping of the existing libertarian British health and hospital system and

leant force to the criticism that it was inegalitarian and offered least of all to those most needing hospital care and treatment. Again, by breaking down class barriers and causing all parties to live and work in closer proximity the experience of the War gave strong credence to demands for a health service covering the entire nation on a non-discriminatory basis and financed out of taxation.

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This then was an important part of the backgound to the Trust's birth in 1939. In accordance with its purposes, it advocated a national hospital system, at first by the closer association of the voluntary and statutory hospital systems reflecting Lord Nuffield's hope that in course of time a truly national system might be evolved

'which would embrace all that is best of both public and voluntary effort with the maximum of economy to the state and to the private purse'

Its earliest actions were encouraged by the Government and fitted closely into the arrangements which, following the Beveridge Report 1942, the Minister of Health in 1944 in the White Paper *A National Health Service* outlined his plans for the future.

Just as people are accustomed to look to public organisations for essential facilities like a clean and safe water supply or good highways, accepting these as things which the community combines to provide for the benefit of the individual without distinction of section or group so they should now be able to look for proper facility for the care for their personal health to a publicly organised service, available to all who want to use it. A service for which all will be paying, as tax payers and as rate payers and contributors to some scheme of National Insurance.

The advent of the National Health Service 1948 did give a special emphasis to the Provident Associations in respect of private beds which were provided for under Section 5 of the National Health Service Act 1946. At the beginning of the War there were 37 small Provident Associations for middle-class patients all operating different schemes and tables of benefits, but only 9 had joined the newly formed National Federation of

Provident Associations which on the insistence of the Trust demanded actuarial support for their schemes.

The Trust had taken a leading part, largely because of the way in which Hyde had earlier foreseen the problems and was able to persuade Lord Nuffield to make available through the Trust a guarantee of £150,000 which eventually became the Nuffield Provident Guarantee Fund with Sir William Goodenough and Mr Wilfred Hobbs (an Ordinary Trustee of the Trust) as Trustees and Mr Hyde as Manager. Its purpose was to guarantee the solvency of new associations and so free them from financial worries in their initial years, and by creating a national provident cover with uniform standards to promote 'the formation of a single, united National Association'.

With the help of actuarial advisers and with Sir Farquhar Buzzard, who was a Trustee of the Trust as Medical Referee, the Fund produced tables of benefits and contributions, a set of regulations involving membership and a classification of surgical operations as major, intermediate and minor. It was subsequently decided to form a Central Provident Association the members of which enjoyed a guarantee from the Nuffield Provident Guarantee Fund if they met the required standards.

Hyde's work, as Secretary of the NPHT, had brought him into contact with a large number of people interested in the future of health services in every part of the country and there seems little doubt that Lord Nuffield's Guarantee and the part played by the Trust as an intermediary laid the groundwork for what eventually became the BUPA.

Before the advent of the 1946 NHS Act there was also, however, the important question of the development of new voluntary hospitals and the Trustees asked one of their number Mr. (later Sir) Noel Mobbs a noted industrialist to look at the question of the raising of finance for new building. The result was the setting up of the Nuffield Health and Social Services Fund in March 1943 the majority of Directors of which were Trustees. It was intended that the Fund through publicity should seek sources of finance to achieve its development objectives. In the event it did not proceed to do so since the White Paper on the NHS seemed to sound the death-knell of the existing system of voluntary hospitals. The Fund was, however, used later to 'hold' the real estate of the Harlow Health Centres, the building of which was financed by the Trust from 1953 to 1959.

In general there are few opportunities for a registered

Charity to enter the private sector except for exploratory seminars or commissioning such studies as resulted in *The Public/Private Mix for Health* to place the sector in perspective in the whole world of comprehensive health care.

APPENDICES

APPENDIX I

Trust Deed

dated 25th June 1940

with variations approved
by Charity Commission
to 31st March 1990

9th	May	1952[1]
5th	July	1955[2]
15th	August	1962[1]
4th	October	1965[3]
14th	January	1974[4]

VARIATIONS:

1. The addition of the enabling clause *re* Purposes. I.F 'and the promotion of improved organisation and efficient development of hospital, medical and associated health services throughout the Provinces.'

1. *also:* the deletion of the restriction of the Trust's Offices to the City of Oxford.

2. The freeing of the restriction on the sale of Stock in Morris Motors Ltd.

3. Variations regarding the appointment of the Chairman and Governing Trustees.

4. The discharge of Barclays Bank Trust Company as Custodian Trustee.

DATED 25th JUNE 1940.

THE NUFFIELD PROVINCIAL HOSPITALS TRUST.

Trust Deed

ANDREW WALSH & SON,
Oxford.

Original Stamped with 10/-

Duplicate Stamped with 5/-

This Trust Deed is made the Twenty-fifth day of June One thousand nine hundred and forty BETWEEN THE RIGHT HONOURABLE WILLIAM RICHARD VISCOUNT NUFFIELD OF NUFFIELD O.B.E. F.R.S. M.A. Hon. D.C.L. Hon. LL.D. (hereinafter where separately referred to called " Lord Nuffield ") of the first part LORD NUFFIELD BARCLAYS BANK LIMITED whose registered office is situate at 54 Lombard Street in the City of London and WILFRED HOBBS of the Mill House Streatley in the County of Berks Chartered Accountant (hereinafter together called " the Ordinary Trustees ") of the second part the said BARCLAYS BANK LIMITED (hereinafter where separately referred to called " the Bank ") of the third part and WILLIAM MACNAMARA GOODENOUGH J.P. of 54 Lombard Street aforesaid Deputy Chairman of the Bank FRANCIS LAWRENCE BLAND J.P. of Rookwood Copdock Ipswich in the County of Suffolk a Director of the Bank EDWARD HOBLYN WARREN BOLITHO D.S.O. of Trengwainton Heamoor in the Duchy of Cornwall a Lieutenant-Colonel retired in His Majesty's Army SIR EDWARD FARQUHAR BUZZARD Baronet K.C.V.O. M.A. M.D. F.R.C.P. F.R.S.M. of Christ Church in the University of Oxford SIR WILLIAM JENKINS Knight M.P. J.P. of 3 Mount Pleasant Cymmer Port Talbot in the County of Glamorgan THE RIGHT HONOURABLE THOMAS JOHNSTON P.C. M.P. of Monteviot Kirkintilloch Dumbartonshire Scotland ARTHUR NOEL MOBBS O.B.E. of Stoke Park Slough in the County of Bucks Company Director THE RIGHT HONOURABLE LORD EUSTACE PERCY P.C. of Rector's Lodge King's College in the City of Newcastle-on-Tyne ERNEST GEORGE ROWLINSON J.P. of 36 Dalewood Road in the City of Sheffield SIR CHARLES HERBERT SMITH Knight of The Bracken Barnt Green in the County of Worcester Chartered Accountant KATHERINE JANIE STEPHENSON C.B.E. J.P. of Bodenham House Salisbury in the County of Wilts Spinster and THE RIGHT HONOURABLE FREDERICK JAMES MARQUIS BARON WOOLTON J.P. of the fourth part.

WHEREAS Lord Nuffield has transferred to the Ordinary Trustees One Million Units of Ordinary Stock of the nominal value of Five Shillings each in Morris Motors Limited (a Company incorporated

under the provisions of the Companies Acts 1908 to 1917) to be held by them upon the trusts and subject to the provisions which should be set forth in a Deed to be executed by the parties hereto

NOW for the purpose of declaring such trusts and making such provisions THIS DEED WITNESSETH as follows :—

1. IN this Deed the following expressions shall bear the following meanings :—

(A) " The Stock Units " shall mean the One Million Units of Ordinary Stock of the nominal value of Five Shillings each in Morris Motors Limited transferred by Lord Nuffield to the Ordinary Trustees as recited above.

(B) " The Company " shall mean Morris Motors Limited.

(C) " The Nuffield Fund " shall mean the Stock Units so transferred as aforesaid and any other stock or shares or securities in the Company becoming vested in the Ordinary Trustees at any time and from time to time as a result of their ownership of the Stock Units and any money or other property (including stock or shares or securities in the Company) at any time and from time to time paid or transferred to them by Lord Nuffield to advance the Purposes of the Trust (hereinafter defined) ; and shall where the context so admits include the investments from time to time representing the Nuffield Fund.

(D) " The Auxiliary Fund " shall mean any money or other property at any time and from time to time paid or transferred by any person other than Lord Nuffield to the Governing Trustees (hereinafter defined) to advance the Purposes of the Trust (also hereinafter defined) ; and shall where the context so admits include the investments from time to time representing the Auxiliary Fund.

(E) " The Provinces " shall mean Great Britain (excepting the County of London and the area for the time being included in the Metropolitan Police District) and Northern Ireland.

(F) " The Purposes of the Trust " shall mean the co-ordination on a regional basis of hospital and ancillary medical services throughout the Provinces and the making of

financial provision for the creation carrying on or extension of such hospital and ancillary medical services as in the opinion of the Governing Trustees are necessary for such co-ordination.

(G) " The Governing Trustees " shall mean the said William Macnamara Goodenough Francis Lawrence Bland Edward Hoblyn Warren Bolitho Sir Edward Farquhar Buzzard Sir William Jenkins The Right Honourable Thomas Johnston Arthur Noel Mobbs The Right Honourable Lord Eustace Percy Ernest George Rowlinson Sir Charles Herbert Smith Katherine Janie Stephenson and The Right Honourable Baron Woolton and their successors the persons for the time being holding the office of Governing Trustee under the provisions hereof.

2. THE Ordinary Trustees shall retain the Stock Units and any other stock or shares or securities in the Company from time to time forming part of the Nuffield Fund in their present state of investment and the statutory power of investment and of varying investments shall not apply to the Stock Units and any other stock or shares or securities in the Company from time to time forming part of the Nuffield Fund PROVIDED NEVERTHELESS that during the life of Lord Nuffield the Ordinary Trustees shall have power with the written consent of Lord Nuffield to sell all or any of the Stock Units and any other stock or shares or securities in the Company from time to time forming part of the Nuffield Fund or any part thereof and the provisions contained in Clause 3 of this Deed shall apply to the proceeds of any such sale.

3. THE Ordinary Trustees shall hold any investments from time to time forming part of the Nuffield Fund (other than the Stock Units or any other stock or shares or securities in the Company) ON TRUST either to retain the same in their then state of investment or to sell the same and shall hold any money from time to time forming part of the Nuffield Fund (including the net proceeds of sale of any investment sold under the last preceding trust) ON TRUST either to place the same on deposit or current account at the Bank or to invest the same in any investment of any nature whatsoever and in any part of the world with power to vary such investments for others of a like nature.

4. THE Governing Trustees shall hold any investments from time to time forming part of the Auxiliary Fund ON TRUST either to retain the same in their then state of investment or to sell the same and shall hold any money from time to time forming part of the Auxiliary Fund (including the net proceeds of sale of any investment sold under the last preceding trust) ON TRUST either to place the same on deposit or current account at the Bank or to invest the same in any investment of any nature whatsoever and in any part of the world with power to vary such investments for others of a like nature.

5. THE Ordinary Trustees shall hold the Nuffield Fund and the Governing Trustees shall hold the Auxiliary Fund UPON TRUST to apply the income and capital of the said Funds in saving harmless and keeping indemnified the Ordinary Trustees the Governing Trustees and any persons appointed by the Governing Trustees under the provisions hereof to be members of any Board or Committee or Officers of the Trust and each of them and their respective executors administrators and assigns estates and effects from and against all actions proceedings claims and demands costs damages and expenses arising out of any breach of trust or any act deed matter or thing whatsoever made done executed omitted or neglected by the Ordinary Trustees the Governing Trustees or any such person appointed by them as aforesaid in the execution or the purported execution of the trusts hereof or otherwise howsoever in relation to the premises save only any breach of trust arising from the wilful default of the person who is sought to be made liable AND SUBJECT thereto shall hold the capital and income of the said Funds UPON TRUST to apply the same in promoting the Purposes of the Trust in accordance with the provisions of this Deed.

6. THE income of the Nuffield Fund and of the Auxiliary Fund shall be applicable to the following objects :—

(I) to defraying the expenses of the Ordinary Trustees and the Governing Trustees and of any Boards Committees or Officers appointed by the Governing Trustees under the powers hereinafter contained incurred in inaugurating carrying into effect and administering the scheme created under the provisions of Clause 15 of this Deed ;

(II) to defraying the expenses of any appeal to the general public or to any other persons to make gifts of any kind to advance the Purposes of the Trust ;

(III) to making annual or occasional grants to any person or body of persons or corporation for the purpose of establishing or extending or maintaining voluntary hospitals and ancillary medical services throughout the Provinces;

(IV) to advancing the Purposes of the Trust by any other means the Governing Trustees think fit.

7. IF any money or property shall be paid or transferred by any person other than Lord Nuffield to the Ordinary Trustees to advance the Purposes of the Trust the Ordinary Trustees shall forthwith pay or transfer the same to the Governing Trustees and such money or property shall form part of the Auxiliary Fund.

8. THE Ordinary Trustees shall have power at any time and from time to time at their discretion to transfer or pay over to the Governing Trustees any property (other than the Stock Units or any other stock or shares or securities in the Company) or any money forming part of the Nuffield Fund and such property or money shall thereupon cease to form part of the Nuffield Fund and shall form part of the Auxiliary Fund.

9. ANY part of the capital of the Nuffield Fund may with the consent of Lord Nuffield be treated at any time as though the same were income produced by the Nuffield Fund during the then current year.

10. THE Ordinary Trustees shall add to the capital of the Nuffield Fund any part of the income of the Nuffield Fund not expended during any year by them PROVIDED HOWEVER that any sum so added to the capital of the Nuffield Fund may at any time be treated for all the purposes of this Deed as though the same were income produced by the Nuffield Fund during the then current year.

11. THE Governing Trustees may at their absolute discretion add all or any part of the income of the Auxiliary Fund in any year to the capital of the Auxiliary Fund PROVIDED HOWEVER that any sum so added to the capital of the Auxiliary Fund may at any time be treated for all purposes of this Deed as though the same were income produced by the Auxiliary Fund during the then current year.

12. SUBJECT to the provisions of Clause 14 hereof the Governing Trustees may at any time apply any part of the capital of the Auxiliary Fund as though the same were income produced during the then current year.

13. (A) THE management administration and distribution of the Auxiliary Fund shall be vested in the Governing Trustees and the Ordinary Trustees shall not be concerned therewith.

(B) THE Governing Trustees shall in each year allocate the income of the Auxiliary Fund to such of the objects set out in Clause 6 of this Deed and in such proportions as they think fit.

(C) IN relation to the Auxiliary Fund only the Bank shall be Custodian Trustee and the Governing Trustees shall be Managing Trustees within the meaning of the Public Trustee Act 1906.

14. (A) THE Governing Trustees shall have power to accept gifts of any kind made by subscription or donation or otherwise for special objects which in their view conduce to the furtherance of the Purposes of the Trust and subject to special conditions (not being inconsistent with the terms of this Deed).

(B) SUCH gifts shall form part of the Auxiliary Fund but the Governing Trustees shall apply them to the special objects and in accordance with the conditions specified and stipulated by the donors.

15. THE Governing Trustees shall forthwith inaugurate and carry into effect a scheme for carrying out the Purposes of the Trust and shall do all such acts and things as shall appear to them in their absolute discretion to be necessary for or conducive to the inauguration and carrying into effect of such scheme.

16. THE Governing Trustees shall have full power :—

(I) to create or appoint such Regional Divisional and Central or other Boards or Committees and such officers to administer the scheme referred to in Clause 15 of this Deed and such advisory or other bodies and officers to assist in such administration as the Governing Trustees shall in their absolute discretion think fit;

(II) to make rules for their own guidance and for regulating the constitution functions and procedure of any

Board Committee or other body so created or appointed by them and the duties and powers of any officer so appointed by them ;

(III) to delegate to any such Board Committee or other body or to any such officer all or any of the powers and duties reposed in the Governing Trustees under the provisions of this Deed PROVIDED that if the Governing Trustees shall in writing so direct any such Board Committee or other body or any such officer shall also have power to delegate to any person or persons the powers conferred on it or him by the Governing Trustees.

17. (A) THE Governing Trustees shall on the Thirty-first day of March in each year prepare and submit to the Ordinary Trustees an estimate and accounts showing respectively (a) to which of the objects set out in Clause 6 of this Deed they propose to allocate the income of the Nuffield Fund during the then current year and in what proportions and giving any further details of their proposed expenditure the Ordinary Trustees may require and (b) the income and expenditure of the Nuffield Fund during the then preceding year.

(B) IN the event of the Ordinary Trustees rejecting any such estimate as aforesaid the Governing Trustees shall amend such estimate in accordance with the requirements of the Ordinary Trustees.

(C) IN the event of the Ordinary Trustees approving such estimate as aforesaid the Governing Trustees shall expend all sums paid to them by the Ordinary Trustees out of the Nuffield Fund in accordance with such estimate and any variation thereof subsequently authorised by the Ordinary Trustees.

18. (A) THE Ordinary Trustees shall consider the estimates submitted to them by the Governing Trustees under the provisions of Clause 17 hereof and approve or reject the same.

(B) IF the Ordinary Trustees shall reject any such estimate they shall state in writing their reasons for such rejection.

(C) IF the Ordinary Trustees shall approve any such estimate they shall pay to or to the direction of the Governing Trustees out of the income of the Nuffield Fund the amount of such estimate.

19. THE Governing Trustees shall have power with the consent of the Ordinary Trustees to borrow money for the purposes hereof and to charge the capital of the Auxiliary Fund and the future income but not the capital of the Nuffield Fund with the repayment thereof PROVIDED that (I) this power shall not be exercised so that the total amount at any one time owing shall exceed in the first year the sum of One hundred and twelve thousand five hundred pounds and in each succeeding year a sum equal to the combined income of the Nuffield Fund and Auxiliary Fund of the preceding year and (II) provision shall be made for the repayment out of income of each sum borrowed under the power herein contained within five years of the date on which it was borrowed.

20. THE Ordinary Trustees other than the Bank shall hold office during Lord Nuffield's pleasure and the power of appointing a new Trustee in place of any Ordinary Trustee shall be vested in Lord Nuffield during his life and thereafter the statutory power of appointing new Trustees shall apply to the Ordinary Trustees PROVIDED that no appointment shall be valid whereby the number of the Ordinary Trustees is increased beyond four.

21. (A) THE said William Macnamara Goodenough Francis Lawrence Bland Edward Hoblyn Warren Bolitho Sir Edward Farquhar Buzzard Sir William Jenkins The Right Honourable Thomas Johnston Arthur Noel Mobbs The Right Honourable Lord Eustace Percy Ernest George Rowlinson Sir Charles Herbert Smith Katherine Janie Stephenson and The Right Honourable Baron Woolton shall be the first Governing Trustees.

(B) ONE-THIRD of the first Governing Trustees (other than the Chairman) shall retire from office on the First day of January One thousand nine hundred and forty-three one-third shall retire from office on the First day of January One thousand nine hundred and forty-five and one-third shall retire from office on the First day of January One thousand nine hundred and forty-seven and the Governing Trustees appointed in their place shall hold office for the period of five years.

(C) THE selection of the Governing Trustees to retire in accordance with the preceding sub-clause shall be made by ballot.

(D) A RETIRING Governing Trustee shall be eligible for re-appointment.

(E) THE statutory power of appointing new Trustees (other than the Chairman) shall apply to the Governing Trustees PROVIDED that before making any appointment the appointors shall consult the Minister of Health for the time being but without being bound by his decision.

(F) THE number of Governing Trustees including the Chairman shall not at any time be more than fifteen nor less than six.

(G) THE said William Macnamara Goodenough shall be the first Chairman of the Governing Trustees.

(H) THE Chairman for the time being of the Governing Trustees shall hold office for his life during Lord Nuffield's pleasure and after Lord Nuffield's death the then Chairman and each succeeding Chairman shall hold office during his life or until he signifies in writing to the remaining Governing Trustees his desire to be discharged or becomes in the opinion of the remaining Governing Trustees unfit to act in the trusts hereof by reason of absence abroad or incapacity.

(I) THE power of appointing a new Chairman of the Governing Trustees shall be vested in Lord Nuffield during his life and after his death in the Governing Trustees other than the Chairman.

22. THE Ordinary Trustees and the Governing Trustees respectively shall act in all respects in conformity with any resolution passed by a majority of them respectively and any act done in the execution of the trusts hereof by a majority of the Ordinary Trustees or of the Governing Trustees shall be as valid and effectual as if the same had been done by all the Ordinary Trustees or all the Governing Trustees as the case may be.

23. (A) WILLIAM HYDE of 16 King Edward Street in the City of Oxford C.B.E. J.P. shall be General Secretary of the Trust and shall hold office during the pleasure of the Governing Trustees and the Ordinary Trustees.

(B) THE duty of the General Secretary of the Trust for the time being shall be to act as Secretary to the Ordinary Trustees the Governing Trustees and to any general or central council or other similar body created by the Governing Trustees under the powers hereinbefore contained respectively and to perform the duties respectively required of him by such bodies as aforesaid.

(C) SUCCEEDING General Secretaries shall be appointed by the Governing Trustees and the Ordinary Trustees and shall hold office during the pleasure of the Governing Trustees and the Ordinary Trustees.

24. THE Trust shall be called "The Nuffield Provincial Hospitals Trust" and its offices shall be situated in the City of Oxford.

25. (A) THE Bank shall be entitled (in addition to the fees to which it is entitled under the provisions of the Public Trustee Act 1906 in respect of the Auxiliary Fund) to remuneration for its services in carrying out the Trusts relating to the Nuffield Fund at such a rate as may from time to time be agreed between the Bank and the remaining Ordinary Trustees PROVIDED that the rate so agreed as aforesaid shall not at any time exceed a rate calculated in accordance with the scale of fees of the Bank relative to trustee business then in force.

(B) THE Bank shall be entitled to act as banker in connection with the trusts relating both to the Nuffield Fund and to the Auxiliary Fund for all purposes upon the usual terms existing between banker and customer.

26. SO long as the Bank shall be an Ordinary Trustee all trust moneys and securities forming part of the Nuffield Fund and all title deeds and documents relating thereto shall be held exclusively by the Bank but the other Ordinary Trustees shall have all reasonable facilities for access thereto.

IN WITNESS whereof the parties hereto (other than the Bank) have hereunto set their hands and seals and the Bank has caused its Common Seal to be hereunto affixed the day and year first above written.

SIGNED SEALED and DELIVERED by the above-named The Right Honourable William Richard Viscount Nuffield of Nuffield in the presence of

NUFFIELD (L.S.)

ENA BERRY,
27 Sandfield Rd., Oxford,
Secretary.

THE COMMON SEAL of Barclays Bank Limited was hereunto affixed in the presence of

E. H. GALSWORTHY, *Director.*

P. J. DIBOLL, *Assistant Secretary.*

T7687

Seal

SIGNED SEALED and DELIVERED by the above-named Wilfred Hobbs in the presence of

ENA BERRY,
27 Sandfield Rd., Oxford,
Secretary.

W. HOBBS (L.S.)

SIGNED SEALED and DELIVERED by the above-named William Macnamara Goodenough in the presence of

DRUCILLA K. HORWOOD,
54 Lombard Street,
London, E.C.3
(Spinster).

W. M. GOODENOUGH (L.S.)

F. L. BLAND (L.S.)

SIGNED SEALED and DELIVERED by the above-named Francis Lawrence Bland in the presence of

PATIENCE R. BLAND,
Copdock, Suffolk
(Spinster).

SIGNED SEALED and DELIVERED by the above-named Edward Hoblyn Warren Bolitho in the presence of

R. W. SMITH,
c/o Barclays Bank Ltd.,
Penzance,
Bank Manager.

E. H. W. BOLITHO (L.S.)

SIGNED SEALED and DELIVERED by the above-named Sir Edward Farquhar Buzzard in the presence of

L. F. HERBERT,
Solicitor, Oxford.

E. FARQUHAR BUZZARD (L.S.)

SIGNED SEALED and DELIVERED by the above-named Sir William Jenkins in the presence of

J. MITCHELL CLAYTON,
Treasurer,
Neath Rural District Council.

WILLIAM JENKINS (L.S.)

THOMAS JOHNSTON (L.S.)

SIGNED SEALED and DELIVERED by the above-named The Right Honourable Thomas Johnston in the presence of

JAMES H. LONDON,
25 Palmerston Place,
Edinburgh, 12,
Civil Servant.

A. NOEL MOBBS (L.S.)

SIGNED SEALED and DELIVERED by the above-named Arthur Noel Mobbs in the presence of

L. F. HERBERT.

SIGNED SEALED and DELIVERED by the above-named The Right Honourable Lord Eustace Percy in the presence of

JANET TAYLOR (Spinster),
King's College,
Newcastle-upon-Tyne, 2,
Secretary.

EUSTACE PERCY (L.S.)

E. G. ROWLINSON (L.S.)

SIGNED SEALED and DELIVERED by the above-named Ernest George Rowlinson in the presence of

L. F. HERBERT.

C. HERBERT SMITH (L.S.)

SIGNED SEALED and DELIVERED by the above-named Sir Charles Herbert Smith in the presence of

L. F. HERBERT.

KATHERINE JANIE STEPHENSON (L.S.)

WOOLTON (L.S.)

SIGNED SEALED and DELIVERED by the above-named Katherine Janie Stephenson in the presence of

T. RIVERS,
Warminster, Wilts,
J.P. for Wilts.

SIGNED SEALED and DELIVERED by the above-named The Right Honourable Frederick James Marquis Baron Woolton in the presence of

ALICE MARY SHEPHARD (Spinster),
Vincent House, London, W.2,
Clerk.

APPENDIX II

List of Publications 1940–1990

1941

1. **A National Hospital Service:** A memorandum on the co-ordination of hospital services NPHT

1946

2. **The Hospital Surveys:** The Domesday Book of the hospital services NPHT

1948

3. **Haven Products:** A Scottish experiment in the employment of severely disabled men
A. E. Turner, T. A. Stirrat and *T. Ferguson* NPHT

4. **Hospital and Community:** I. Hospital-treated sickness amongst the people of Stirlingshire
Edited by *T. Ferguson* NPHT

5. **The Nuffield Provincial Hospitals Trust. First Report.** A record of the progress of schemes and descriptions of new projects, 1939–48 NPHT

1949

6. **Hospital and Community:** II. Hospital-treated sickness amongst the people of Ayrshire
Edited by *T. Ferguson* NPHT

1951

7. **The Nuffield Provincial Hospitals Trust. Second Report.** A record of the progress of schemes and descriptions of new projects, 1948–51 NPHT

1952

8. **Report of an Experiment in Hospital Costing** NPHT

1954

9. **The Work of Nurses in Hospital Wards:** Report of a job-analysis by the Nuffield Provincial Hospitals Trust NPHT

10. **A Thousand Families in Newcastle-upon-Tyne:** An approach to the study of health and illness in children
James Spence, W. S. Walton, F. G. W. Miller and *S. D. M. Court* NPHT/OUP

11. **Growing Old in Common Lodgings:** A survey of elderly men and their living conditions in Belfast common lodging houses
E. Miriam Sargaison NPHT

12. **Good General Practice:** A report of a survey
Stephen Taylor OUP

13. **Hospital and Community**
Thomas Ferguson and *A. N. McPhail* OUP

1955

14. **Studies in the Function and Design of Hospitals:** Report of an investigation sponsored by the Nuffield Provincial Hospitals Trust and the University of Bristol NPHT/OUP

15. **The Nuffield Provincial Hospitals Trust. Third Report.** A record of the progress of schemes and descriptions of new projects, 1951–5 NPHT

1957

16. **The Planning and Organisation of Central Syringe Services:** A survey by the Nuffield Provincial Hospitals Trust NPHT

17. **Rehabilitation of the Elderly Invalid at Home:** An experiment in restoration of activity after illness amongst old people in their homes in Belfast
G. F. Adams, F. M. McQuitty and *M. Y. Flint* NPHT

1958

18. **Present Sterilising Practice in Six Hospitals:** A survey by the Nuffield Provincial Hospitals Trust NPHT

19. **The Nuffield Provincial Hospitals Trust. Fourth Report.** A record of the progress of schemes and descriptions of new projects, 1955–8 NPHT

1960

20. **Casualty Services and their Setting:** A study in Medical Care, Report of a survey of the Nuffield Provincial Hospitals Trust NPHT/OUP

21. **Portrait of Social Work:** A study of social services in a northern town
Barbara N. Rodgers and *Julia Dixon* OUP

22. **The Demand for Medical Care:** A study of the case-load in the Barrow and Furness Group of hospitals
Gordon Forsyth and *Robert F. L. Logan* OUP

1961

23. **The Nuffield Provincial Hospitals Trust. Fifth Report.** A record of the progress of schemes and descriptions of new projects, 1958–61 NPHT

1962

24. **Costing and Efficiency in Hospitals**
Charles Montacute OUP

25. **Dental Health and Dental Services:** An assessment of available data
C. A. Moser, Kathleen Gales and *P. W. R. Morpurgo* OUP

26. **The Burden on the Community:** The epidemiology of mental illness. A symposium
Introduced by *Denis Hill* OUP

1. Hospital and out-patient clinics, *W. Malcolm Millar, George Innes* and *Geoffrey A. Sharp.* 2. Conducting a psychiatric survey in general practice, *W. I. N. Kessel.* 3. Interview surveys, *Ann Cartwright.* 4. The selection and ascertainment of relevant social variables, *F. M. Martin.* 5. Clinical and social factors relevant to outcome, *Michael Shepherd.* 6. Evaluation of treatment and services, *Peter Sainsbury* and *Jacqueline Grad.* 7. Current research work in psychiatric epidemiology in the United Kingdom, *K. Rawnsley.* 8. Some targets for future epidemiological research, *G. M. Carstairs.*

27. **Towards a Measure of Medical Care:** Operational research in health services. A symposium
Foreword by *Gordon McLachlan* OUP

1. Problems for operational research in the National Health Service, *J. O. F. Davies.* 2. Medical care investigation in the health service, *J. H. F. Brotherston.* 3. Calculating the scale of in-patient accommodation, *Norman T. J. Bailey.* 4. Studies in medical care: an assessment of some methods, *Gordon Forsyth* and *Robert F. L. Logan.*

28. **Towards a Clearer View:** The organisation of diagnostic X-ray departments. A survey by the Nuffield Provincial Hospitals Trust OUP

29. **Further Studies in Hospital and Community**
M. McKenzie, R. D. Wren, I. M. Richardson, A. Main, R. W. F. Harnett, A. P. Curran and *T. Ferguson* OUP

30. **The Social Context of Medicine.** Rock Carling Fellowship 1962
Sir John Charles NPHT

1963

31. **Geriatric Nursing:** A study of the work of geriatric ward staff
G. F. Adams and *P. L. McIlwraith* OUP

32. **Central Sterile Supply:** Principles and practice
Nuffield Provincial Hospitals Trust OUP

33. **The Causation of Bus Driver Accidents**
W. L. Cresswell and *P. Froggatt* OUP

34. **Hinges of Administration:** A survey of the characteristics of hospital administrative and clerical staff
J. R. Griffith and *E. T. Rees* OUP

35. **Food in Hospitals**
B. S. Platt, T. P. Eddy and *P. L. Pellett* OUP

36. **Doctor and Patient:** Morale, ethics, government. Rock Carling Fellowship 1963
Sir Robert Platt NPHT

1964

37. **Problems and Progress in Medical Care:** Essays on current research. First Series
Edited by *Gordon McLachlan* OUP

1. Studies in the spectrum of medical care, *R. F. L. Logan*. 2. The morale and effectiveness of general hospitals, *R. W. Revans*. 3. Operational research in nursing, *Irene James, Alex Barr, C. Butler, M. J. Tobin* and *J. O. F. Davies*. 4. The family doctor diagnostic centre, *Richard Scott*. 5. The social work content of general medical services, *Joan Collins*. 6. The assessment of prescribing: a study in operational research, *C. W. M. Wilson, J. B. Banks, R. E. A. Mapes* and *Sylvia M. T. Korte*. 7. The Anglesey mental health survey, *Alun Jones* and *H. Lewis Miles*. 8. Mental illness in hospital and community: Developments and outcome, *B. M. Mandelbrote*. 9. The chronic mentally ill—movements in a rural area, 1900–1961, *E. G. Oram* and *M. C. Knowles*. 10. Mental health social work in hospitals and local authorities: a comparison of two work situations, *G. F. Rehin, Hazel Houghton* and *F. M. Martin*. 11. The population of epileptic colonies, *Kathleen Jones* and *Aileen Tillotson*.

38. **Standards for Morale:** Cause and effect in hospitals
R. W. Revans OUP

39. **Radiation and Health.** Rock Carling Fellowship 1964
Professor W. V. Mayneord NPHT

40. **The Nuffield Provincial Hospitals Trust. Sixth Report.** A record of the progress of schemes and descriptions of new projects, 1961–4 NPHT

1965

41. **Focus on Nurse Recruitment**
D. C. Marsh and *A. J. Willcocks* OUP

42. **Waiting in Outpatient Departments:** A survey of outpatient appointment systems by the Nuffield Provincial Hospitals Trust OUP

43. **A Balanced Teaching Hospital:** A symposium at Birmingham. Edited by *Professor T. McKeown*, with a foreword by *Sir Robert Aitken* OUP
A. L. d'Abreu, W. Melville Arnott, R. H. Cawley, K. W. Cross, Christie W. Gordon, J. C. Heather, Douglas Hubble, Wilfred Mills, J. H. Sheldon and *W. H. Trethowan*

44. **Medical Education in Britain.** Rock Carling Fellowship 1965
Professor R. Milnes-Walker NPHT

1966

45. **Book and Journal Services for Doctors and Nurses**
J. E. Morpurgo NPHT

46. **The Planning and Organisation of Medical Book and Journal Services in Regional Hospitals:** A guide for librarians
The National Book League NPHT

47. **Problems and Progress in Medical Care:** Essays on current research. Second Series
Edited by *Gordon McLachlan* OUP

PART I. **Studies of hospitals out-patient services.** 1. The Edinburgh hospitals, *Richard Scott* and *Margaret Gilmore.* 2. Two non-teaching hospitals in south-east England, *Jocelyn Chamberlain.* 3. Hospitals in the North-East Scotland Region, *E. Maurice Backett, Greta Sumner, James Kilpatrick* and *Ianthe Dingwall-Fordyce.* 4. A London teaching hospital, *John Butterfield* and *Michael Wadsworth.* PART II. **Studies of function and organisation.** 5. The transitional hostel in the rehabilitation of the mentally ill, *Robert Z. Apte.* 6. Cost-effectiveness and the engineering services in hospitals, *William Carson* and *T. W. Mayer.* 7. The evaluation of an experimental pre-discharge ward, *D. J. Newell, A. Zinovieff* and *L. W. Hunt.* 8. An experiment in communication between GPs and hospital staff, *C. J. H. Mann.* 9. The future of the maternity services: a suitable case for study, *Richard Shegog.* 10. Cervical cytology: a scrutiny of the evidence, *E. G. Knox.* 11. The level of dental health: the field for study, *N. David Richards* and *Arthur J. Willcocks.*

1967

48. **The Flow of Medical Information in Hospitals**
English Electric Leo Marconi Computers Ltd OUP

49. **Medical Record Linkage**
E. D. Acheson OUP

50. **Appointment Systems in General Practice**
J. M. Bevan and *G. J. Draper* OUP

51. **Vocational Training in Medicine:** Reports of three working parties on vocational training for general practice, the psychiatric services and the administration of hospital and public health services
Foreword by *Sir George Pickering* NPHT

52. **Postgraduate Medical Education:** Retrospect and prospect
John Revans and *Gordon McLachlan* NPHT

53. **Prevention of Cancer:** Pointers from epidemiology. Rock Carling Fellowship 1967
Sir Richard Doll NPHT

54. **The Nuffield Provincial Hospitals Trust. Seventh Report.** A record of the progress of schemes and descriptions of new projects, 1964–7 NPHT

1968

55. **Social Casework in General Practice:** A report on an experiment carried out in a general practice
J. A. S. Forman and *E. M. Fairbairn* OUP

56. **Custom and Practice in Medical Care:** A comparative study of two hospitals in Arbroath, Scotland, UK, and Waterville, Maine, USA
J. Simpson, A. Mair, R. G. Thomas, H. N. Willard and *H. J. Bakst* OUP

57. **Problems and Progress in Medical Care:** Essays on current research. Third Series
Edited by *Gordon McLachlan* OUP

1. Birth-weight and perinatal mortality in England and Wales 1956–65, *J. R. Ashford, F. S. W. Brimblecombe* and *J. G. Fryer*. 2. Medical manpower in the National Health Service, *Stuart L. Morrison*. 3. Manpower planning in the National Health Service, *Robin Shannon*. 4. The staffing of the maternity services, *A. J. Willcocks*. 5. Child Guidance Service: a pilot study, *N. W. Timms*. 6. Problems of hospital communication: an experimental study, *Hazel Houghton*. 7. Reviewing some applications of computers to medicine: a tale of two philosophies, *Richard F. A. Shegog*.

58. **Computers in the Service of Medicine:** Essays on current research and applications, vol. I
Foreword by *Professor Brian Flowers*. Edited by *Gordon McLachlan* and *R. A. Shegog* OUP

1. Introducing a computer to a hospital. Experiences of the experiment at Birmingham, *E. G. Knox*. 2. Electronic processing of hospital records, *K. W. Cross, J. Droar* and *J. L. Roberts*. 3. The identification of patients and their records in a hospital using electronic data-processing equipment, *J. W. Dale* and *J. L. Roberts*. 4. Patient identification on a regional basis, *G. Innes* and *R. D. Weir*. 5. Computer applications in patient follow-up, *J. Crooks*. 6. A computer-based system for handling clinical data, *F. Kennedy, A. G. Cox, A. I. M. Glen, A. D. Roy* and *C. E. Sundt* . 7. Towards automated electrocardiogram interpretation, *T. D. V. Lawrie* and *P. W. Macfarlane*. 8. Data processing in a clinical biochemistry laboratory, *T. P. Whitehead, J. F. Becker* and *M. Peters*. 9. Radiotherapy treatment planning, *R. F. Parr* and *J. A. Newell*. 10. The computer and drug prescribing, *O. L. Wade*. 11. The development of drug monitoring for side-effects within a hospital medical

information system, *R. D. Weir, J. Crooks* and *D. C. Coull.* 12. The Exeter Community Health Research Project, *J. R. Ashford* and *N. G. Pearson.*

59. **Computers in the Service of Medicine:** Essays on current research and applications, vol. II

Edited by *Gordon McLachlan* and *R. A. Shegog* OUP

13. The systems analysis of a large out-patient department, *G. A. Debenham.* 14. Systems analysis and hospitals, *F. T. C. Harris.* 15. Errors in a hospital record system, *J. W. Dale* and *J. L. Roberts.* 16. Automatic coding of a diagnosis, *A. M. Scott.* 17. Economical coding of medical terms, *S. Saengbangpla* and *A. Young.* 18. The medical record and the computer, Part I, *A. E. Bennett* and *W. W. Holland.* 19. The medical record and the computer, Part II, *M. Deane* and *W. W. Holland.* 20. The prediction and stimulation of surgical admissions, *R. D. Weir, G. B. Fowler* and *I. Dingwall-Fordyce.* 21. The development and implementation of a computer-based hospital information system, *F. D. James.* 22. The next ten years? *R. D. Weir.* 23. Twenty years after or cloud nine attained, *D. White.*

60. **Hostels in Hospitals?** The analysis of beds in hospitals by patient dependency

J. S. Meredith, M. A. Anderson, A. C. Price and *J. Leithead* OUP

61. **Gateway or Dividing Line?** A study of hospital out-patients in the 1960s

Gordon Forsyth and *Robert F. L. Logan*, with contributions by *F. Smith* and *P. A. Brazier* OUP

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Jozef Van Langendonck
Edited and introduced by *Gordon Forsyth* OUP

The main text is based on a translation of the updated version of *De Harmonisering van de Sociale Verzekering voor Gezondheidszorgen in de EEG*, by Jozef Van Langendonck.

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106. **The Nuffield Provincial Hospitals Trust. Ninth Report.** Covering activities during the years 1970–1975 NPHT

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107. **Questionnaires in Medicine:** A guide to their design and use

A. E. Bennet and *K. Ritchie.* Foreword by *W. W. Holland* OUP

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APPENDIX III

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