KING EDWARD'S HOSPITAL FUND FOR LONDON

A Report prepared for the Fund

by

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on

The Work of

HOSPITAL ALMONERS IN THE LONDON AREA

10, OLD JEWRY, E.C.2

Hospital Almoners in the London Area

Report by Sir Harold Claughton

Introduction

1. In February, 1948, I was asked to undertake on behalf of King Edward's Hospital Fund a preliminary survey of the situation, both present and prospective, of the Hospital Almoner Service in the London Area. I entered upon this task, which has proved to be one of quite absorbing interest, without much more knowledge of the field to be surveyed than is possessed by the average citizen.

It was felt that the best way in which I could become better educated was by paying personal visits to a cross-section of hospitals, and Mr. Ives, who has helped me in every possible way, was kind enough to arrange my programme.

Before starting on my tour, however, I had the advantage of conversations with the Secretary to the Institute of Almoners, Miss Steel, and of visiting the premises of the Institute. I also began to collect some of the literature relevant to my subject. As a result, I opened my campaign feeling considerably better equipped than previously, though still very much aware that I had a great deal to learn. In particular, I realised that the present-day Almoner Service has been steadily built up, mainly by the vision and devotion of individuals, over the last 50 years.

Visits to Hospitals

2. I began my tour on 12th February, 1948, and finished on 18th June. In all, I visited 42 hospitals made up as follows :—

Voluntary hospitals	31
L.C.C. hospitals	6
County Council hospitals ..	4
Cottage hospitals	1
	42

Excluding for the moment the Cottage hospital, the range of hospitals varied in patient population from 828 to 88 beds and from 475,240 to 9,405 out-patients per annum (the figures are for 1947).

The Almoner Departments (excluding clerical staff) varied from 21 to nil. I was received everywhere not only with the utmost courtesy but also with the greatest interest in my quest—and this applies both

to the Almoner Staff and to the House Governors or Medical Superintendents as the case may be.

3. After my first two visits (to the Middlesex Hospital and to University College Hospital) Mr. H. W. Arnold, one of the King's Fund Bursars, was, through the kindness of Mr. Ives, seconded to me. I cannot speak too highly of the value of the services which he has rendered.

4. Almost from the outset, I saw that it would be extremely difficult to get together comparable data unless I could plan some common form of approach in the shape of questions mainly pertinent to the Almoner Service as a whole but allowing opportunity for bringing out problems particular to the individual hospital. I therefore prepared a questionnaire for my own guidance and this I used as the basis for all my conversations.

I was somewhat surprised—and also rather gratified—to find that however widely the answers given might vary, I did not, as time went on and my experience developed, have to add much in the way of essentials to my original formula. In other words, when I have got to the end of my talk and asked whether there was anything that I had missed, the answer—except in one or two " specialist " cases—was that the field had been covered. As a matter of interest, I attach to this Report a copy of my form of questionnaire (see Appendix A).

5. The procedure which I followed throughout with only one or two unavoidable variations was first to have a short talk with the House Governor or Medical Superintendent ; then to bring in the Head Almoner and to develop the conversation more generally ; and lastly to make a tour of the hospital in order to see for myself the accommodation provided for the Almoner's Department as a whole and the distribution—or sometimes the concentration—thereof and to meet the Assistant Almoners.

6. Let me first of all set down certain general impressions which I have formed as a result of my visits :—

(i) First and foremost, I came away with a very high opinion of the quality of Head Almoners as a body. Naturally I saw less of the Assistants—but after all it is in the main the Head Almoner who makes or mars the Service in the individual institution.

(ii) With only two exceptions, I found no reason to doubt that the Department is now regarded as an integral part of the hospital's organisation. The two exceptions were the two hospitals which possessed no Almoner Staff at all, and in one of these the lack of Almoner service was keenly felt.

(iii) There is growing recognition on the part of the Medical Staff of hospitals that the work of the Almoner is an essential complement to the work of the Doctor *vis-à-vis* the individual patient. There are variations on this theme which I will touch upon later.

(iv) Relations with the Nursing Staff appear to be uniformly good and co-operative. Periodic lectures on social medicine by Head Almoners to the Nursing Staff and also, where applicable, to Medical Students are uniformly accepted as desirable in principle. Only in a comparatively small percentage of cases has it been found possible to put this principle into regular practice.

(v) By and large, the accommodation provided in the Almoner Departments is inadequate or at any rate unsuitable. This is a very serious matter for a Service which depends so much for the effectiveness upon the atmosphere and surroundings in which intimate conversation with the patient can be conducted. It is moreover a grave handicap to the Almoner Student who is carrying out her practical training. Often it is not just a question of superficial floor area. In several cases I have been shown quite spacious rooms with two or three Almoners working together without any attempt having been made to secure privacy by partitions or even screens. It seems to me that the essential aim should be to provide for Almoners individual offices, however small. Location must remain of academic interest until building becomes again possible but in theory the Almoner should work as near as possible to the clinics to facilitate close collaboration with the medical staff.

The Westminster is perhaps the best example of how these problems of accommodation can be dealt with in a modern hospital building.

(vi) In the hospitals which I visited, wastage in personnel in the profession has, apart from the depredations of matrimony, been refreshingly slight. The figures for the field as a whole resulting from a recent survey made by the Institute are less encouraging. Taking the two last complete years: in 1946 as against 107 new certificates granted, resignations totalled 69; the comparable figures for 1947 being 203 (including 102 trained under the "short course") and 65. A sample analysis of 250 Almoners retired since 1933 showed:—

(*a*) that marriage was the main cause of retirement (53·5 per cent.);

(*b*) that the age-groups of under 25 years and of 25 to 29 years contained 65 per cent. of the retirement ; and

(*c*) that no less than 25 per cent. of the sample taken resigned either before actually starting work at all or after having worked less than one year (the figures are 12 per cent. and 13 per cent. respectively).

7. So far I have dealt with impressions which relate mainly to the position up to date. There are however many other matters of importance which are a blend, so to speak, of past, present and future. I propose to deal with these section by section.

STAFFING AND DISTRIBUTION

8. The present position may fairly be described as haphazard. Some Hospital Boards have been enlightened and progressive : others very backward. (More than once I have been told : " The Board—or the Chairman—has no real idea of what Almoning is all about "). This contrast is shown in clear relief in the case of the Voluntary Hospitals though in the case of the Teaching Hospitals there does seem to appear something in the nature of a balanced scheme in relation both to qualified staff and clerical assistance. My impression is, however, that this balance as between the different hospitals in this particular group is fortuitous rather than planned and this impression is strengthened by quoting the case of St. Thomas's who have an Almoner staff of 21 (including one at Godalming) plus 24 Almoner Clerks (including two Cashiers). The annual cost to the hospital is £14,431. Let us revert for one moment to Voluntary Hospitals as a whole and contrast this with the state of affairs at the Memorial Hospital, Woolwich, which possesses one Almoner and nine Clerks at an annual cost of £2,942, and where the Almoner's duties include the care of medical records, registration, assessment, appointments, admission and clerical administration in the case of private patients. Admittedly, the Woolwich Memorial is far smaller than St. Thomas's both in bed complement (130 compared with 500) and out-patient attendances (71,712 compared with 394,825) but my point is that while somebody could perhaps introduce a good argument for the ratio at St. Thomas's, nobody could produce any argument for the ratio at the Woolwich.

9. There seems to me to be a crying need for taking up at high level the question of a policy for the *distribution* of Almoner Staff. The Institute provided me with a list of 95 hospitals in the Metropolitan Area with a total Almoner complement of 297. This, if shared out, would give a fraction over three Almoners per hospital, whereas in fact the distribution figures vary from one with 21 Almoners, one with 13,

three with ten, to 39 with one. The short point is that up to the present while there has been a sufficiency, perhaps even an amplitude here and there, over all there has been a shortage. The new grouping of hospitals immediately raised the whole issue of distribution in an acute form. I think it is essential that there should be established some sort of minimum staffing standard. It must inevitably be based on the number of patients dealt with (in the case of acute hospitals) because this is the only measurable factor. But the actual amount of medico-social work to be done will depend on this *plus* considerations such as the type of area served and the specialities dealt with. Having decided on a minimum standard (and here a suggestion made at my visit to the Central Middlesex merits consideration, viz., one Almoner and Clerk per 100 in-patient beds and the attached out-patients which feed them), it is at the *Regional Board level* that any increase on the minimum might best be assessed because at that level only can there be a wide view of the whole area to be served. If it is left to individual Management Groups, the more progressive ones will tend to be over-staffed at the expense of the others, for, apart from the question of cost, there is also the vital factor of the shortage of trained Almoners. I would make clear that this suggestion conveys no implication of " direction " of individual Almoners by Regional Boards on the lines perhaps unavoidably followed by the L.C.C. though I feel that some degree of direction within the Management Groups is probably inevitable. I must also add that the question of distribution in the comparatively large group now designated as Teaching Hospitals seems to me to present a new problem to be thought over.

10. I must not leave this matter without a word on the clerical assistance allocated to Almoner Departments. My view is that a weakness lies here, not in the recruitment of the shorthand-typist class but in the lack of encouragement offered to people in the category, either actually or potentially, of administrative assistant. Quite a lot of work hitherto done by the qualified Almoner could effectively be devolved upon a competent assistant leaving the Almoner freer to concentrate on the duties to which her training has been primarily directed. And quite a lot of work of this nature will remain even under the New Look which came compulsorily into fashion on July 5th, 1948. I do not advocate a nationally recognised register of Almoner administrative assistants—the temptation to try and make do with the less expensive article is too obvious.

11. But I do advocate the establishment and encouragement of an administrative assistant grade, with a sufficiently attractive starting rate of salary and a not too depressing " ceiling." Recruitment could be both from the ranks of the shorthand-typist grade and by direct appointment, by careful selection, from outside.

The Training and Selection of Almoners

12. The general consensus of opinion held by the 40 Head Almoners with whom I have talked is in favour of the present method of training with emphasis in favour of the University background during the earlier stage. (The sour critic might argue that the Sergeant-Major is not prone to find fault with his own Regiment in the presence of outsiders). Normally, students take three years to qualify as Almoners. The first two years are spent in studying for a University Diploma or Certificate in social studies (alternatively a degree in social science subjects may be taken). The third year is devoted to practical work of various kinds including in particular eight months' training under supervision at a hospital. After the first two years, the candidate has to be accepted by a Selection Committee of the Institute.

The "Short" or "Emergency" course, established mainly to meet the gap in recruitment due to the war, condenses the whole period into six months' theory and six months' practical. It is for candidates, mainly ex-Service, between the ages of 25 and 35. Here I think it appropriate to say that I have no doubt in my own mind as to the value of the University course. At the same time it does under present conditions tend to create a bottleneck for recruitment, though this may expand with the general expansion which the universities of this country are in process of bringing into operation.

13. On the *practical* side of the present course, it has once or twice been suggested that this should be lengthened. Against this, I think it can be accepted that only a limited amount can be learnt by those still holding only student status and still of tender years. On this basis, the practical training should aim at giving the young student an introduction to all branches. In this field, the progressive assumption of responsibility is perhaps the best teacher. The danger is that this progress may by force of circumstance make too rapid a start e.g., by the fledgeling being flung straight away into a single-handed post. It should, in my view, be a *sine qua non* that for the first year after qualification an Almoner should work under supervision.

14. On the *theoretical* side, I am reluctant to express an opinion. It was only after I had finished my tour that I learnt that the Institute had set up a Working Party to consider and report on the Training and Recruitment of Almoners. That body of experts will be far more competent than I am to assess, for example, the suitability from the Almoner point of view of the present courses in social studies.

15. I would comment, however, that the emphasis in favour of the University background seems to derive in large part from the feeling that the general contacts and "atmosphere" thereby obtained

constitute assets otherwise difficult of attainment. That is not to say the course itself is ideally constituted for the special purposes of the potential Almoner, and no doubt the Working Party will bring this aspect of the matter under careful analysis.

16. Meanwhile, there are three special processes of training which call for some remarks.

(i) *The Short Course.*—This, created to meet the conditions arising from the war and now moribund, can surely claim to have amply justified its existence. An obvious criticism which I have encountered is that too much had to be crammed into too short a space. On the other hand the comparative maturity and wider experience (including in many cases experience of taking responsibility) have enabled the majority of those who have qualified through this channel to get on top of their work quite quickly and to keep on learning as they go. There have, of course, been misfits, but by and large the experiment has been so successful that it seems appropriate to put the question whether an improved and lengthened short course—say six months' theory and 18 months' practical—open to those of slightly riper years (say 25 and over) might not be the right answer to the " man-power " situation still prevailing in the profession. The longer practical course suggested is, I think, more likely to be productive of good results in the case of this category of students than in the case of the younger group referred to in para. 13 above. The alternative might be to increase substantially in numbers the new King's Fund Almoner Bursaries now about to start on their first experimental year (see below)—or to do both.

(ii) *The L.C.C. Course.*—This is a four-year course for a University extension Diploma pursued by people already in full employment. As such it does not commend itself to me as the appropriate kind of training for this particular field. It also is moribund—and personally I should not advocate any attempt at resuscitation.

(iii) *The King's Fund Almoner Bursaries.*—This experiment, as I have said, is about to be launched. After the advertisements had been issued I made a special point of obtaining the reaction of Head Almoners to the idea (curiously enough most of them had missed reading the advertisement). Opinion was uniformly favourable—often enthusiastic. Advantages instanced were the entry into the profession at a more mature age and with a wider academic background, and the potential

acquisition of a body of research workers. Unfortunately the field presented for this first year was mainly composed of "Juniors." I incline to think that in future the Bursaries should specifically aim at attracting a more mature age-group.

17. Lastly under this heading I come to the factor which has so much to say to the welfare of the Profession, namely, *selection*.

As Henry Mess says in his "Voluntary Social Services since 1918," "Social work demands certain qualities of character and temperament, lacking which nothing of much value is likely to be achieved."

To add "social medicine" to this dictum heavily underlines the whole passage.

I do not advocate the introduction of any system on the lines of Stoke d'Abernon, but I do suggest that the Institute should once again consider very critically the question whether the procedure at selection stage is still capable of improvement. I realise that the candidate has already been subject to selection before acceptance for the Social Studies course. (She is then, usually, very young.) But in my view the really critical time is at the end of the practical course. A personal interview at that moment would, perhaps, be more revealing than a sheaf of "progress reports." It may well be that the present procedure has no chinks in its armour—but if there is even a possibility of improvement, the subject is worth pursuing.

The Work of the Almoner

18. So much has been written on what an Almoner should and should not do, that I hesitate to attempt further definition.

The Interim Report of the Social and Preventive Medicine Committee of the Royal College of Physicians (October, 1943) is a valuable document and in the section on "The Arrangement of Social Medicine within the Hospital" defines under eight headings the function of an Almoner's Department (pp. 23 and 24). The Report of the Almoner's Advisory Committee of the Middlesex Hospital (November, 1947)—another excellent contribution—attempts crystallization in the statement that "the present conception of an Almoner is of a person who is qualified to assist with the practice of social medicine."

19. This is very true as far as it goes—but does not perhaps display the whole truth.

Social Service is, and will remain, as much an essential as social medicine.

The Almoner must fill the rôle of guide and mentor to the individual patient. She is the medium through which the statutory and voluntary

services are made available to the patient. Increasingly she will act as the beneficient intermediary and intelligent interpreter between the machine of State and the sick citizen—especially the poor sick citizen. There is no-one else who is really in a position to give practical, commonsense and sympathetic assistance of this nature, and it demands qualities not only of head but of heart.

20. The Almoner's contribution to *Social Medicine* is in effect a more easily measurable quantity—though no less important. Naturally, various matters arise under both these headings for example :—

(*a*) *Organization*

The result of my visits shows that the Unit system has become well established. Even Almoners who did not practise it were in favour of the principle mainly on the ground that it strengthens the link between Almoner and Clinician, as well as between Almoner and Patient.

(*b*) *Interviewing*

In theory, it is generally accepted that the ideal principle is that the patient should see the same Almoner throughout.

(i) *In-patients.*—The practice as regards In-patients is more or less standard—they are all seen as soon as possible after admission. There seems much to be said for interviewing all patients who are recommended for admission, i.e., all except emergencies: that is the critical time when fears may be allayed and plans formulated. It may be too late after the patient has been admitted to the ward.

(ii) *Out-patients.*—The fundamental issue is whether all new Out-patients should be seen or only those referred by the Medical or Nursing Staff. The "reference" principle has been widely accepted because where the number of patients dealt with is very large it is the only way of coping. But several Almoners have expressed serious doubts about the system and prefer to carry out a lot of interviews which on the face of it seem likely to be unproductive for the sake of the occasional needy case which might otherwise remain latent. The argument against is that thereby they may have insufficient time to give any case their thorough attention.

The point has been put that the real answer is to "educate" the Medical Staff. On the surface of it this seems sound and plausible. But the fact is that few patients are prepared to

talk about their personal problems to a clinician or consultant who may be somewhat awe-inspiring and is certainly very busy. One can hardly expect a clinician to acquire the sort of "second-sight" which senses a social factor without the patient saying anything. Almoners say that they themselves do acquire such a faculty with long experience but to expect doctors to do the same would be to cry for the moon.

What then is the answer? I think perhaps a combination of the two systems. In certain clinics, e.g., Neurological, T.B., Cancer—a social problem almost inevitably accompanies the disease and all new patients should see the Almoner. In others the "reference" system could be worked. Only an experienced Almoner can decide which clinics fall into which category. It seems to me that the Institute might well consider the problem and perhaps issue some recommendations for the guidance of Management Committees and Head Almoners.

(*c*) *Records*

These form what may be described as both the reference and the working library of the Almoner. I have found no evidence of any difficulties arising by reason of the medical records not being made available to the Almoner when required, or *vice versa,* but there does exist a main issue in the relation of the social record to the medical record. Generally, the present practice is not to include any social record in the patient's medical folder unless specially requested.

The Almoner keeps her own social case-records and advises the clinician when she thinks desirable. This is probably adequate—but more ideally a brief social summary (the L.C.C. social card is a good pattern) should be included in the Medical Notes of every case treated as a "social" case by the Almoner. But this could only be done if the system whereby patients never handle the notes relating to themselves were made universal.

Incidentally, no useful purpose can be served by the automatic recording of social data where no social considerations or complications arise.

(*d*) *Co-operation with the Medical Staff*

This varies in intensity at different places and generally speaking it is of course the Medical Staff who call the tune though a lot depends on "Almoner personality." The situation seems to have made rapid improvement within

recent years. At some hospitals I heard that the Old Brigade —and particularly the Surgeons—were a little reluctant to admit that the work of the Almoner could make a considerable contribution to their own work. At others the interest was less on the part of the younger staff—but this applies mainly in the case of the County Council hospitals where the assistants in the medical world pass through and elsewhere with some rapidity.

(*e*) *Research*

I raised at each visit the question whether any individual contributions to research, e.g., on the social implications of sickness or on the assessment of social factors involved had been carried out either by the Head Almoner or by members of her staff. I think the answer is that this has only been touched on the fringes anywhere. As I have hinted earlier, the King's Fund Bursaries may in due course produce a team. In a sense, however, the excellent work done at the London by the Almoner concerned with the industrial rehabilitation of cardiac cases may be said to fall within the field of applied research work, whilst the practical approach, involving visits to men actually at work in factories, represents medico-social work at high level.

(*f*) *Home visitations*

The limitation on this field of activity is mainly time. There is of course, usually a close follow-up, involving home visits in special cases, e.g., cancer, diabetes, etc., but the view has been expressed that generally speaking the primary need for the Almoner is within the hospital, and that the follow-up should be provided for through close collaboration with outside bodies concerned with Health Work, Rehabilitation, etc.

Personally I think that the comment of the Royal College of Physicians Committee referred to in para. 18 above is apposite, viz. :—

> " It is probably wise to leave this matter at the moment with the suggestion that nothing should be done to prevent Almoners from visiting patients in their homes, if the circumstances so direct."

(*g*) No comment by me is needed on the everyday duties which all Almoners carry out at high-level efficiency, e.g., arrangements to enable treatment to be carried out ; convalescence ; transport ; advice on social, domestic and economic problems ; assistance through social service agencies ; after-care ;

rehabilitation and housing problems. But at the present time the last item produces more headaches and almost heartbreaks than all the others put together.

(*h*) There is, however, in connection with everyday duties one problem, namely the extent of the Almoner's administrative functions. Apart from a few outstanding exceptions there seems to be a very general acceptance of the view that Almoners should not be made responsible for purely routine or administrative work—Registration, Appointments, Medical Records and the like. (At the Westminster the Almoner is responsible for custody, etc., of Medical Records). At the same time, there are certain border-line activities of a semi-Almoner, semi-administrative character such as making arrangements for surgical appliances. One point of view is that this is a purely routine procedure which may be done by a separate department : another, held very strongly, is that the Almoner should be closely involved because she is in the best position to deal with the sort of difficulties that often arise, especially with children. I am not clear which policy would be supported by the Institute. I need not now stress the question of assessment, so long, so widely and so misguidedly held to be the Almoner's *raison d'être,* since this function now joins other lost causes. I would however remark that the new Act will not necessarily eliminate all financial problems within the scope of Almoners—sickness benefit, for example, must remain but a pale substitute for the wage-packet in the family ; and no golden dawn breaks for the aged chronic.

Representation

21. The problems confronting the Head Almoner, if beyond her powers to solve without further authority, are taken by her to the House Governor in the Voluntary Hospitals and to the Medical Superintendent in the Council Hospitals.

If she fails to get satisfaction on a question which she regards as fundamental there is always a channel of appeal. I do not think I need detail the procedure, which varies at different institutions, because my experience has shown that the relations between the Head Almoner and the Administrative Head of the Hospital are uniformly most happy. Looking to the future however, everything should be done to prevent the adoption of any principle based upon the L.C.C. procedure under which ultimate responsibility for Almoner Departments rested, not with the Medical Authorities, but with the Welfare Department.

22. To my mind, the ideal system would be for the Almoner to have direct relationship with the Medical Committee of the hospital. I do not by this mean to imply any side-tracking of the Administrative Head of the hospital to whom the Almoner would remain in the same relationship as all other Departments of the hospital organization. But direct relationship with the Medical Committee would automatically strengthen the feeling, wherever that is still a little weak or rather vague, that the Almoner's Department was part and parcel of the hospital system and not just a collection of "laity."

Salaries

23. The general feeling, as expressed to me, was that the present salary scales were adequate at the top but not quite adequate during the early stages of the Almoner's career. One point made was that an Almoner working single-handed at a hospital was at a financial disadvantage compared with a Head Almoner with staff at another hospital although the volume of work and of responsibility might be even greater in the former case than the latter. At one County Council hospital it was pointed out that in the County Scheme Almoners were treated as Public Health Officers and got four weeks' holiday. Now that holidays are graded according to salary the Head Almoner is the only one who still gets a month.

I will now gather up one or two loose ends before dealing with some general issues not already covered.

Male Almoners

24. There is general agreement that a real need exists for male Almoners in certain specialised fields (V.D. for example is an obvious case). I certainly accept this view (I have met one male Almoner, who is doing general social work with both men and women patients and is specializing on epileptics), but I have come away from my tour with a strong conviction that in the main field it is the woman who pre-eminently possesses by nature and by instinct the qualities essential to the cause.

The Chronic Sick

25. This is outside my brief but I have visited one hospital dealing almost exclusively with chronics and on the Almoner's side of this problem there is no doubt that it represents more social work, particularly in the case of the aged, than seems to be generally recognized. That work moreover is of a nature which makes an especial call on the quality of patience. The question whether the chronic sick should ever constitute the main population of any one hospital is definitely outside

my sphere. Nevertheless I cannot refrain from saying that I do not think it a satisfactory policy either for the hospital or for the patient.

SAMARITAN FUNDS

26. I hope that latitude will be given to continue these, as such, under the new Act.

BIBLIOGRAPHY

27. I enclose (Appendix B) a list of the literature which I have consulted on the subject. It is not very considerable in quantity but some is of first-rate quality. It is interesting—and perhaps a little surprising—that the two contributions to the subject which I have received from the U.S.A. do not enable me to point any moral as to how far that great country has out-distanced our own in the subject with which I deal. I am even bold enough to think that just for once they might learn a little from us. But possibly that is just my ignorance.

THE NO-ALMONER HOSPITAL

28. The last visit of my tour was paid to a hospital with a bed-complement of 800 and an Out-patient attendance of 230,000 and no Almoner Staff. (The Oldchurch County Hospital). Apparently the Essex County Council have set their face against the introduction of Almoners to any of their hospitals under the impression that the work of an Almoner was confined to assessment for which the Assessment Department of the County Council provided all that was necessary so that Almoners would constitute a redundancy.

Comment seems equally redundant.

THE COTTAGE HOSPITAL

29. This group is of course *sui generis*. I visited one specimen. There was no Almoner and no real Almoner problems. If such problems should arise, the solution might be found through the help of Health Centres, though in the main the new grouping will probably provide the answer.

30. Now, at last, I come to the remaining major considerations. These are :—

I. *For consideration by the Institute :—*

(*a*) *What are the numbers to be aimed at in the Profession under the new Act ?*

Obviously, I can attempt no estimate but equally clearly it is a key question. One immediate problem, at which

I have already hinted, is that in the new grouping some hospitals with Almoner Staff will be tied up to hospitals with none. There are also the wide open spaces provided by the isolationism of the Essex County Council and perhaps others. I have no knowledge of the position in the rest of the country but the Institute of course has, either directly or through its Regional Committee Representatives. This leads me to :

(*b*) Do the Institute feel that their present organization is sufficiently flexible and also sufficiently co-ordinated to deal with the situation now arising throughout the whole area over which their writ at present runs ?

II. *For consideration both by the Institute and King Edward's Hospital Fund.*

If, as I think likely, the problem of increased recruitment to the Profession is considerable, in what way can the King's Fund (assuming their willingness) best render assistance, bearing in mind the area limitations imposed by their constitution ? It seems to me that there are at any rate three possible directions in which aid might be given—and these not necessarily alternative :—

(i) By increasing the number of Almoner Bursaries.

(ii) By providing financial assistance for candidates under a revised form of Short Course, if the suggestion outlined in para. 16 (i) is developed.

(iii) By encouraging the provision of Administrative Assistants in the London Area.

(iv) By the King's Fund setting up a small Committee with representation from the Regions and the Profession, with certain specific functions, e.g., to make an annual survey for the next few years of the staffing and distribution within the metropolitan area ; to watch progress made with training schemes ; and to advise on the Bursaries Scheme.

III. *For general consideration.*

In a sense the whole future of the Almoner Profession is in the melting pot.

It is of the utmost importance that the Ministry should be impressed with the view that the disappearance of the assessment factor will leave the Profession freer to exercise the functions for which it is specifically trained and to which it should be primarily devoted. There is real urgency for

this. In the next few months Regional Boards and Management Committees will be framing policy: and bound up in that policy is the destiny for years to come of the Almoner Service.

At the top, the Ministry is well aware of all that the Almoner Service stands for, and of its value both actual and potential.

But the machinery of the Ministry is not at present well adapted to the consideration of Almoner policy and practice *per se*. (There have, I am credibly informed, been cases where, when an Almoner problem has been under discussion at Headquarters, a nurse has been called in as the "Internal Expert.")

What seems to me to be required is for the Ministry to constitute a Department—or even Sub-Department—staffed by persons whose duty it will be to specialize in the questions affecting the whole Almoner field and to be the Department of reference for all such matters which are of Ministry level.

I would urge that all possible influence be brought to bear upon the Ministry to give serious and sympathetic consideration to this suggestion.

31. And that, I think, is all I have to say at present. I have tried to concentrate mainly on what I feel to be essentials.

It has been a profoundly interesting and, thanks in large measure to Mr. Arnold's co-operation, a very happy task. I am grateful to King Edward's Hospital Fund for entrusting me with it.

I attach an index summary for convenience of reference.

(Sgd.) HAROLD CLAUGHTON.

July 30th, 1948.

Index Summary

Appendix A

Questionnaire used as Basis for Interviews

1. (1) No. of in-patients : chronic or acute.
   (2) No. of out-patient attendances.
   (3) No. of new out-patients.
   (4) No. of casualty attendances.
   (5) Any " Associated Institutions " ?

2. (1) No. of Almoners.
   (2) No. of clerical or " administrative " assistants.
   (3) Accommodation.
   (4) Annual cost to hospital.
   (5) Wastage.

3. *Methods of Work.*
   (i) Departmental or in-patients and out-patients organization ?
   (ii) Does patient see same Almoner throughout ?
   (iii) Interviewing—all in-patients ?
   all new out-patients ?
   subsequent interviews ?
   before or after clinician ?
   (iv) Collaboration with Medical and Nursing Staff.
   (v) Does Clinician see Almoner at end of out-patient session ?
   (vi) Attitude of Medical Staff to Almoners.

4. Is Department now an integral part of hospital in the field of (*a*) social service, (*b*) social medicine ? Do duties include :—

   Under (*a*)—
   (i) Arrangements to enable treatment to be carried out, e.g., surgical appliances and instruments, convalescence, transport, etc.
   (ii) Advice on problems affecting family, home life, employment ; assistance through social service agencies ?
   (iii) After-care, rehabilitation and housing problems.
   (iv) Home visitations.

   Under (*b*)—
   (i) Advising clinician on, e.g., social background, family history, etc., of patients ?
   (ii) Does Almoner have access to Medical Notes ?
   (iii) Is Almoner's report included in patient's medical records ?
   (iv) Are doctors allowed full access to Almoner's records ?
   (v) Is Social Medicine included in the curriculum for Students and Nurses ? How many hours ?

5. *Representation.*
   (i) To whom, or through whom, is Almoner responsible ? Secretary or Medical Superintendent ? Medical Committee ?
   (ii) Is there an Almoner's Sub-Committee ?
   (iii) Is there any method of personal representation of needs, difficulties, etc. ?

For hospitals with small, or no, Almoner staff

A. By whom is the work, elsewhere carried on by Almoners, done. Is this system considered more desirable than employing Almoners ? If so, why ?

B. Alternatively, what is the reason for, so far, not having developed an Almoner's Department. ?

C. Are the functions of an Almoner known to the Hospital authorities ? Have they ever tried them—and given it up ?

General.

I. What view is taken of the present method of training and selection for the profession—theoretical and practical ? Is university background thought essential, and why ?

II. What view is held of the employment and training of " Administrative Assistants " ?

III. What view is taken of the future of Almoners after the Act has come into force ?

IV. What part should the Almoner play in :—

Teaching, e.g., social implications of sickness ?

Research, e.g., assessment of social factors involved ?

V. What views are held on the present salary scale ?

VI. What view is taken of the new Almoner Bursaries ?

Appendix B

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