PRACTICE OBSERVED

Family Practitioner Committees

Family practitioner committee independence: what will it mean?

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For many general practitioners the new status of family practitioner committees as autonomous authorities (which starts on 1 April 1985) may seem to be just one more administrative change in the health service. Some may think that it is a thinly disguised return to the position of the Executive Councils before 1974. Though it may look like an administrative device to tidy up the anomalous position of the family practitioner committees (which were virtually forgotten during the turbulence of the 1982 reorganisation of the National Health Service), it has been generally welcomed by general practitioners as a unique opportunity to develop the contribution and the voice of primary care in the NHS.

A forgotten sector?

Several months after the guidelines for the 1982 reorganisation of the NHS were laid down in July 1980 the Department of Health and Social Security issued a consultative paper (HN(81)10) outlining options for the future administration of family practitioner committees. Having been preoccupied with promulgating a new structure for the hospital services, the government was now left with the dilemma of how to slot in the family practitioner committees. Because the number of health authorities had increased from 90 to 192 the previous "coterminosity" between family practitioner committees and area health authorities had gone (table I). It was conceivable that a new family practitioner committee structure might have been proposed, increasing their number to 192 to maintain a one to one relation with health authorities. But this would have greatly increased administrative costs (apart from the turbulence caused by the transfer of records and staff) and would have been contrary to the main purpose of the reorganisation, which was to reduce the burden of administration.

TABLE I—*How family practitioner committees presently relate to district health authorities*

40 FPCs relate to 1 DHA
20 FPCs relate to 2 DHAs
17 FPCs relate to 3 DHAs
7 FPCs relate to 4 DHAs
4 FPCs relate to 5 DHAs
2 FPCs relate to 6 DHAs

So this option was not floated. Instead, the discussion paper gave three options and left the interested parties 10 weeks to choose which they preferred. These options and the arguments for and against are summarised in table II.

At the outset the debate about the future of family practitioner committees seemed to be couched in administrative and legislative terms. In the consultative paper the need to develop the contribution and voice of primary care in the NHS was given little prominence, though this view subsequently prevailed in official thinking after the case for independence had been won and the necessary legislation was being enacted. This shows the shift of emphasis that occurred; this view fitted easily into current government policy once it was recognised that an expanding primary care sector might contribute directly to the overriding aim of containing the rising costs of the NHS.

Finally, the possibility of abolishing the family practitioner committees was not raised, though the royal commission on the NHS had recommended the "abolition of family practitioner committees in England and Wales and the assumption of their functions by health authorities as a step towards integration" only two years previously (para 20.57).[1] The government did not question the need for a distinct and separate body to administer the contracts of family practitioners. These contracts were recognised to be qualitatively different from those of health service employees, and the bodies responsible for their administration had to be based on different principles from those appertaining to employment contracts. Family practitioner committees are firmly wedded to the notion of partnership: they are composed of half lay and half professional members, their style of operation is consensual, and they are statutorily obliged to consult with each local representative committee (dental, medical, pharmaceutical, and optical) on all matters concerning their part of the family practitioner services. It was rightly assumed that these important and necessary arrangements could not be transferred to an employing authority.

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TABLE II—*Three options considered*

For	Against
(i) Keep present arrangements	
Least change and minimises administrative turbulence	Administratively complex: up to six district health authorities need to agree to agency or consortium arrangements for family practitioner committee accommodation and staffing
No new legislation required.	
Better for staff development and mobility.	
(ii) Give family practitioner committees status of independent health authorities	
Preferred by contractor professions and the family practitioner committees	Requires existing legislation to be amended; new arrangements for funding and controlling expenditure on staff and accommodation, and greater involvement of Department of Health and Social Security in work of family practitioner committees
Could make family practitioner committees more effective; they would discuss and work with district health authorities on basis of equality.	
Avoid administrative complexities.	
Direct responsibility on accommodation and staffing	
Improve administrative efficiency by joint consortium arrangements for the purchase and provision of management services	
(iii) Relate family practitioner committees to regional health authorities	
Avoid administrative complexities of (i) and one body would be concerned in resource allocation—for example, management services and computers.	Requires amendments to legislation. Regional health authorities would become concerned in local matters—for example, staffing and accommodation; not consistent with their primary strategic role. Family practitioner committees would still be dependent on other health authorities. Could weaken "collaboration" between family practitioner committee and district health authority.

HN(81)10. March 1981 (consultation completed by 31 May 1981).

Parliamentary opposition to independence

Independence was achieved against enormous odds; a wide range of influential and powerful bodies had to be neutralised if not persuaded. The General Medical Services Committee, and in particular the sheer tenacity of its past chairman, Dr John Ball, played a crucial role in ensuring that the government did not falter in its commitment to legislate for family practitioner committee independence. Originally it was hoped that the 1983 Health and Social Services Bill would have achieved this. Unfortunately, as that Bill was being hastily enacted during the closing hours of parliament before the 1983 general election, the opposition party insisted that the specific clause giving independence to family practitioner committees should be withdrawn. In the customary hurried horse trading the government conceded the opposition's request. The Minister for Health, Mr Kenneth Clarke, however, gave an immediate undertaking:

"Only this afternoon, Dr John Ball, of the General Medical Services Committee, came to see me to express the British Medical Association's very strong concern about the way in which the provisions had been dropped. I gave Dr Ball and others an undertaking, which I gladly repeat to the House today. When the government return to office it is our intention at the earliest possible opportunity to reintroduce these provisions in a new Bill."

Hansard 1983 May 11: col 878.

The Minister added that the government remained convinced that the family practitioner services would benefit most from being administered by independent free standing committees whose main concern and objective was to develop the primary care services, the NHS's first line of contact with the public. Just over a year later this promise was fulfilled when the 1984 Health and Social Security Bill was enacted.

The opposition to this change had been considerable. Politicians of all parties (the policies of the Labour Party and SDP/Liberal Alliance favoured integration with district health authorities) initially feared that family practitioner committee independence could work against cooperation between family practitioner committees and district health authorities. Others questioned whether there could be sufficient "control" over the contractor professions, and some probably thought that this would create an untidy administrative arrangement, lacking clear lines of accountability. In particular, the National Association of Health Authorities argued strongly against giving family practitioner committees independence on the grounds that it would divide rather than integrate health care provision at the local level.

Those who favoured independence believed that the new status would be a crucial catalyst for change and development. It would enhance the standing of primary care in the health service, allowing family practitioner committees to stand on an equal footing to district health authorities. Though this new status was initially regarded as a convenient (if not the preferred) administrative and legal solution to the problem of fitting family practitioner committees into the new NHS structure, it acquired a momentum and importance of its own.

The aims of independence, as now perceived by ministers, are to improve primary care, the planning of local health care, and collaboration between family practitioner committees and other services provided by local government and also to increase the administrative efficiency of family practitioner committees and their accountability to the DHSS.

Framework for independence

The independence that family practitioner committees will shortly enjoy is delineated by a framework of statutory and administrative constraints; relations between them and the DHSS will be based on the principle of delegation with matching accountability. Family practitioner committees will obviously have to act in accordance with legislation; this includes the terms of service of general practitioners and the other contractor professions, the regulations governing family practitioner committee procedures, and the various NHS Acts. Family practitioner committees are also required to implement government policy—for example, the programme to transfer patients who need long term care to the community ("Care in the Community" (HC(83)6)). They are also required to obtain value for money in the provision of family practitioner services. Figure 1 illustrates this range of constraints within which family practitioner committees must work. The most specific constraints apply to the comparative small proportion of total expenditure on family practitioner services (less than 2% on average) allotted to the administration of the family practitioner committees themselves. Thus manpower targets and cash limits will be firmly applied to this part of the family practitioner committees' spending. This is not surprising and is no different from their present position in relation to the district health authorities. The only change is that in future they will be directly accountable to the DHSS on these matters.

The new financial and accounting arrangements between family practitioner committees and the DHSS are analogous to those that exist for district health authorities. It is recognised that family practitioner committees, unlike district health authorities, do not have control over many of the factors that determine expenditure for the family practitioner services. The DHSS will therefore not hold them to account for the total volume of their expenditure. They will, however, expect to see family practitioner committees exercise such discretionary powers as they have to secure value for money, and they are required "to pay the utmost regard as public bodies to their responsibilities for the use of public funds" (HN(FP)(84)37. "Family practitioner committees: accountability arrangements").

Specifically, family practitioner committees will be required to satisfy the DHSS that they are: (*i*) administering arrangements for the family practitioner service correctly and efficiently; (*ii*) implementing government policy; (*iii*) remaining within administrative cash limits and manpower targets; (*iv*) playing their part in cooperation with health and local authorities; (*v*) providing the family practitioner service component for the comprehensive district health authority plan; (*vi*) keeping the public informed of their activities.

On this last requirement family practitioner committees are exhorted to make information about their activities more widely known (after paying due regard to confidentiality) and required to involve community health councils in defining the aims of and policies for the family practitioner services in their localities. This may encourage family practitioner committees to publish annual reports; several, such as Avon, Croydon, Norfolk, and Surrey, already do so. Some seasoned observers may recall that the former Executive Councils published annual reports before they were brought within the health authority structure.

The accountability process for family practitioner committees will comprise annual scrutinies (which may be conducted by correspondence) and more detailed periodic performance reviews, undoubtedly similar to those already operating for district health authorities (see fig 2 for sequence and a summary of these reviews). These exercises will enable DHSS officials to analyse key documents, including the financial returns and accounts and annual programmes. The officials will review what progress has been made towards achieving agreed objectives during the past year and will assess proposals for two years ahead. Work is already in hand in establishing performance indicators to apply to family practitioner committee administration. The purpose of these is to provide a means of comparing one family practitioner committee's performance with that of family practitioner committees generally and to monitor changes over time in individual committees.

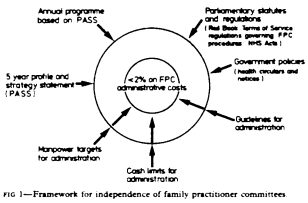


FIG 1—Framework for independence of family practitioner committees

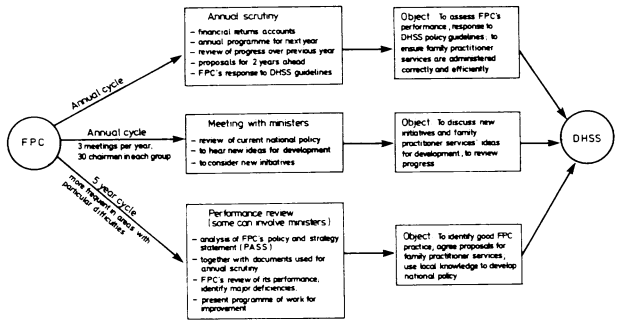


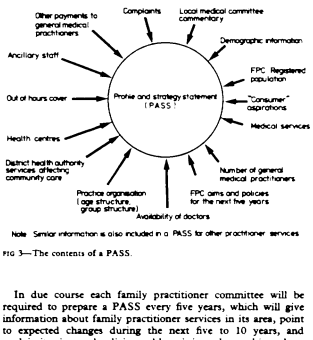
FIG 2—The accountability process

Every five years a more detailed and rigorous performance review will be undertaken, and this will be based on a family practitioner committee's "policy and strategy statement" (see below), together with the documents referred to above. These periodic reviews will be used to identify and promulgate good practice. Where there are particular local difficulties these performance reviews may be carried out more often than the five year cycle. In addition, ministers propose to meet family practitioner committee chairmen annually in three groups to review progress and policies relating to the provision of family practitioner services.

Some may be critical of the amount of information family practitioner committees will be required to assemble for these reviews; the DHSS retort is simply that the aim in compiling profiles and strategies, programmes, and other performance review documents is to use the information that family practitioner committees should already be using for their own management, consultation, and planning.

PASS: new acronym in NHS vocabulary

The family practitioner committee's "profile and strategy statement," or PASS as it will undoubtedly be known, will have a key role in making it directly accountable to government and more open to public scrutiny and help in developing cooperation with district health authorities and local authorities (see fig 3).



Note Similar information is also included in a PASS for other practitioner services

FIG 3—The contents of a PASS.

In due course each family practitioner committee will be required to prepare a PASS every five years, which will give information about family practitioner services in its area, point to expected changes during the next five to 10 years, and explain its aims and policies and how it intends to achieve these in this time scale. The PASS will serve as the family practitioner committee's contribution to the district health plan and enable the family practitioner committee to carry its management, planning, and accountability responsibilities in an informed way. The likely contents of a PASS are summarised in figure 3. The DHSS has emphasised that the PASS is not intended to be a free standing plan; it should represent the direction in which the family practitioner committee has agreed with district health authorities and local representative committees—that is, the local medical committees—its services should develop. Any planning by district health authorities that has implications for family practitioner services should not be undertaken, or proposals finalised, without reference to the family practitioner committee and the local representative committees. Of course, there may be differences of view; a PASS may be at variance with the district health plan. If this was important it would be regarded as indicating a failure of collaboration, but differences will arise and these should be jointly recognised and proposals made as to how these will be tackled.

Relations between family practitioner committees and district health authorities

It is understandable that once the issue of independence had been settled in principle the future arrangements for collaboration between the district health authority and family practitioner committee became a major preoccupation. It still seems strange that the term collaboration rather than, say, cooperation should have been used. The conventional dictionary definition of the term offers the act of assisting or cooperating with the enemy occupier of one's own country or working jointly on an artistic or literary production. No doubt there are sound historical precedents for talking about collaboration between family practitioner committees and district health authorities, and in any event it may convey a firmer and more prescriptive tone.

Apart from the need to ensure that there is effective cooperation between the family practitioner services and the hospital and community health services, the relative distribution of family practitioner committees to district health authorities (see table I) meant that formal machinery had to be devised for this purpose. The report of the DHSS joint working group on collaboration between family practitioner committees and district health authorities makes detailed recommendations of how this should be achieved; it exhorts both to promote mutual understanding and respect, to identify and pursue common goals and policies, to share information, and to create formal and informal arrangements for cooperation. In addition, the report lists some specific topics on which the two authorities should work together (table III).

TABLE III—*Family practitioner committees and district health authorities: examples of areas of collaboration*

(*i*) The impact of the quality of family practitioner services on accident and emergency services
(*ii*) Open access for general medical practitioners to district health authority diagnostic/therapeutic services
(*iii*) General practitioner hospital beds
(*iv*) Waiting times for (*a*) first appointment, (*b*) for admission for treatment.
(*v*) Length of hospital stay
(*vi*) Policies for particular groups—for example, the mentally ill.
(*vii*) Community nursing services.

Wider implications: will the family practitioner committees acquire new teeth?

Their newly acquired independence not only affects the relations among the family practitioner committees, district health authorities, and the DHSS. Other changes are being introduced that could make family practitioner committees more assertive and independent. Firstly, their chairmen and members are now appointed directly by the Secretary of State, although those members from the professions are appointed from nominees of local representative committees (including local medical committees). Secondly, the DHSS will ensure that there is a balance between lay and professional members, and it will be expected that in each family practitioner committee the chairman and his or her deputy would not both be drawn from the lay public or the profession. A further change will affect the secretariat of some local medical committees. In future family practitioner committee staff will not be able to hold appointments as secretaries of local medical committees, although those staff already doing so will be allowed to continue.

Already some effects of these changes are apparent. The influence of professional representatives in the Society of FPC Administrators is becoming less pervasive, and in future it is likely to become a more assertive and independent body, a national voice of the family practitioner services that is not necessarily in accord with the views and policies of the contractor professions. A flavour of what may lie round the corner is to be found in Mr John Williams's presidential address to the 1984 annual meeting of the society:

When I was a young administrator it was preached to me that it was always in our interests to be seen to go along with the policies of the General Medical Services Committee. They were our strongest allies and they had a right to expect us to be with them. This was trotted out time and again. Whilst it probably makes sound sense if we think in terms of protecting ourselves, I always questioned this policy. Whilst agreeing that the General Medical Services Committee is a powerful lobby and in the main our interests were mutual, there could come a time when their interests and ours were almost bound to clash. They quite rightly are interested in preserving and improving the lot of the general practitioner. Our interests are in running a good service and in doing so ensuring that contractors in abiding by their terms of service give the National Health Service value for money. . . . We want the GMSC to be our friends, but surely friends can disagree

without falling out. If not that friendship is not worth very much. What I find upsetting is that some family practitioner committees, in their anxiety not to rock the boat, tend to regard the wishes of the professions as having a degree of priority greater than they merit.

Journal of the Society of FPC Administrators 1984;11:195-8.

Mr Williams goes on to spell out the implications of this new assertiveness and warn of the dangers of a too cosy relationship with the professions.

There are also some more immediate problems to be resolved. Both family practitioner committees and local medical committees will soon have to absorb increased demands on their resources. The family practitioner committee will be required to deploy staff on collecting and analysing the data required for the scrutiny and review procedures. Concern has already been expressed that they lack sufficient middle management to direct this work and the additional task of computerisation, and it appears that no extra funds will be available for this. Local medical committees are likely to face a similar problem; if their input into planning is to be at all effective they will also require additional professional and administrative resources. It is unclear how these will be found.

Finally, the long overdue Green Paper on the future of the family practitioner services casts an uncertain shadow over the family practitioner committees' newly acquired independence. Nobody knows what further duties and responsibilities may be subsequently delegated to the family practitioner committees.

Reference

1 Royal Commission on the National Health Service. *Report*. London: HMSO, 1979. (Cmnd 7615.) (Merrison report.)

100 YEARS AGO

The rapid transit of troops up the Nile by boats, and along its banks on camels, still goes on. Somewhat more than half the entire number of boats have already passed up the cataracts; they are now over a considerable portion of their troubles, and have a fine stretch of smooth water before them, right up to Korti, which is the concentrating station just now, from which a dash across the desert is being attempted by a portion of the force; while an advance of another portion of the troops along the river towards Merawi is, I believe, intended, with a view of punishing Stewart's murderers. Every nerve is being strained by the authorities, military and medical, to push up men and stores with all rapidity, as Gordon cannot go on holding out indefinitely, and the season for active operations is slipping by apace, leaving us a narrow margin of scarcely three months before the hot season and exhausting Khamsin winds are on us. So far, the general health of the troops is certainly satisfactory, though the death-rate from enteric fever is very high. This disease continues to be prevalent, and of a decidedly severe type, attributable no doubt to the fact that the men very often overlook the early and painless diarrhœa, and continue their journey either by boat or camel, in their wish to get up to the front; all the time eating their ordinary ration of salt beef and biscuit, and not reporting themselves sick until prostate, and unable to go on any further. As met with elsewhere, this disease in the Soudan chiefly singles out young soldiers; and those of a florid complexion, with fair hair, suffer from the malady in its worst form. The range of temperature is typical. I have seen no hyperpyrexia, nor have I heard of any such cases; the usual head-symptoms, such as apathy, a tendency to stupor, and occasionally partial deafness, are to be noticed. The patients, as a rule, take their nourishment well, but profuse and uncontrollable diarrhœa exhausts the sufferer. The evacuations are extremely fetid. Few remedies seem to have any power of even temporarily moderating this most distressing symptom, which is not only most troublesome to the poor sufferer, but breaks his rest at night. One very remarkable case of enteric fever lately came under my notice. A very fine and robust looking soldier, 24 years of age, for some days complained of feeling out of sorts, listless, and that he had obscure pains in his joints, principally in his shoulders and elbows, and down his legs. His joints were examined, but there was no sign of anything rheumatic, and, as there was only slight feverishness, he was kept for a couple of days under observation on milk-diet, but with no medicine. His comrades hinted that he was shamming, as he had been heard to say that "he wouldn't go on any further," or words to that effect. There was nothing whatever, either abdominal or otherwise, to lead to a suspicion of enteric mischief, until, all of a sudden, on the third day, violent and general peritonitis set in, and soon proved fatal, perforation being found after death. Obscure cases of this kind occur now and again in military and naval practice. In days gone by, I have heard of one or two cases of thoracic or abdominal aneurysm only discovered after death, where the man, if not actually punished as a malingerer, was looked upon with very great suspicion. Therefore, the greatest caution is necessary, so as not to do an injustice, while the interests of the service, and the chance of meeting a professional schemer, must not be overlooked. Another very severe case of enteric fever came under my notice. A remarkably fine robust soldier, aged 24, of dark complexion, had a temperature of 104·8°, or thereabouts, on several evenings, and a pulse of 108, strong and bounding. Violent haemorrhage from the bowel came on the tenth day, and lasted on and off for two days; he must have lost altogether about two pints of blood. Under the influences of opium and gallic acid, with cold acid drinks, the haemorrhage ceased, and a good convalescence ensued. In the present campaign, so far as it has gone, I may safely say that we seldom if ever see a man in the early stages of enteric fever. Owing to the great *esprit de corps* and rivalry between the regiments to be first up at the front, a man really suffering from enteric fever, with only slight painless diarrhœa, goes on and on, sharing the labour and hardship, perhaps wet all day, and sleeping on the cold ground at night, eating salt beef and biscuits, with the other men in his boat or camel-troop, until he is so ill that he is simply prostrated; then he comes under medical treatment. I need scarcely say that his case cannot be looked upon very hopefully, however much we may admire the splendid spirit of pluck which keeps a man from giving in almost as a point of honour. Under conditions such as the above, we must, I fear, look for a high death-rate; and, in cases of recovery, a tardy and difficult convalescence. At all events, be the cause what it may, climate, field-service, or an unusually severe type of disease, from one or all combined, enteric fever will claim far more victims than the Madhi's bullets or spears. So far, the climate is all in our favour. There is a powerful sunshine, no doubt; but it is generally tempered by a cool northerly breeze by day. The temperature by day, as a rule, is over 90°; some mornings, the temperature falls close to 50°, in fact, the early mornings are bitterly cold, and the dryness of the atmosphere is extreme. To sum up, the hospitals are well supplied, the sick are well cared for, the most captious critic can find no fault; the medical staff corps are working like men; and whether at professional duty or hauling a boat, or in desert marching, in mending a hospital-bed, or in building a hospital kitchen, from morning to night, all day and every day, we are all hard at work, all honestly striving to help on the expedition. (*British Medical Journal* 1885;i:247.)

The concluding days of the Manchester Conference on Education under Healthy Conditions were taken up principally with a discussion on the subject of Physical Exercises. Mr Charles Roberts read a paper on the "Correlation of Mental and Physical Education." Miss M. A. Chrisman, of the Physical Training College, London, followed with a paper advocating the physical training of women. Mr. John Holm said the good average *physique* of the British race, due to our predilection for active sports, had a retarding influence on the introduction of gymnastics. At the same time, he condemned much of the apparatus now used in ordinary gymnasia, expressing the opinion that the parallel bars were most objectionable, sharing with clubs and dumb-bells the invidious distinction of producing the gymnastic stoop, combined with stiffness of the shoulders. His preference was for the Swedish system of gymnastics, which, if carried out in accordance with the teaching of Ling, was free from the blemishes of our system, while capable of fully developing the body. The discussion was taken part in by Dr. Shuttleworth (of the Royal Albert Asylum for Idiots), Miss Blyth (Edinburgh), Dr. Watts, and Mr. Broadfield. In reply to the President, Dr. Watts said he did not believe there was any falling off in the health and strength of school-children in consequence of the vigorous application of the system of compulsory attendance. He thought it was pretty generally known that infant mortality was decreasing, and that adult life was lengthening. At the close of the conference, Lord Aberdare expressed his belief that there was no serious foundation for the cry of overpressure, and nothing in the requirements of the Code too severe for the scholars. He considered that the report of Dr. Crichton Browne was unnecessarily extravagant. They ought for the present to be content with the changes which had been made in the Code, and not tinker it any further until it had had a longer trial. (*British Medical Journal* 1885;i:850.)

Practice Research

Universal claim form for items of service payments in general practice

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Abstract

A universal claim form was designed to replace 12 different forms currently in use by general practitioners in the National Health Service to claim payment for items of service. This form was evaluated over a period of three months in a group practice. It was acceptable to doctors, staff, and the staff of the family practitioner committee. Considerably more claims were made during the trial period than during the same period the previous year.

Introduction

Twelve different forms are used by general practitioners in the National Health Service to claim payment for items of service (FP81, FP19, FP1001, FP1002, FP1003, F106, FP32, FP82, FP23, FP74, F24, FP31). Three of these—FP19, FP1003, FP73—also serve as an encounter record because they record clinical data. Only the FP19 is of a size that will fit into the medical record envelope.

This paper reports the results of an evaluation of a universal claim form in a general practice over a period of three months.

Method

The universal claim form (fig 1) was designed by JRG to replace the existing 12 claim forms. It encompasses all the relevant data on the existing forms and complies with the relevant sections in the *Statement of Fees and Allowances Payable to General Medical Practitioners in England and Wales*. It was designed to fit into the traditional medical record envelope.

The thin front sheet is of "no carbon required" paper, hinged onto a card back piece. Hence, by using a ball point pen information entered on the top sheet is duplicated on the front of the card back piece (fig 2). After separation the front sheet is forwarded to the family practitioner committee as a claim. The reverse of the top sheet (fig 3) was designed to help the family practitioner committee to process claims. Clinical details may be recorded on the reverse of the card back piece (fig 4) and subsequently transferred to or filed in the patient's notes, be forwarded to the family practitioner committee (FP1003, FP106, FP32), or, in the case of vaccinations, be forwarded to the area health authority to be entered on their computer file.

Once the details about the patient are completed (fig 1) the patient ticks off and signs for the services rendered in this section. The bottom section is used by the doctor to claim for the services stated but not listed in the patient's section of the form—for example, night visits, emergency treatment, or second person for anaesthetic session. Maternity claims are made by using the existing maternity claim sticker (FP24A), which is attached to the back of the top sheet after the form is completed.

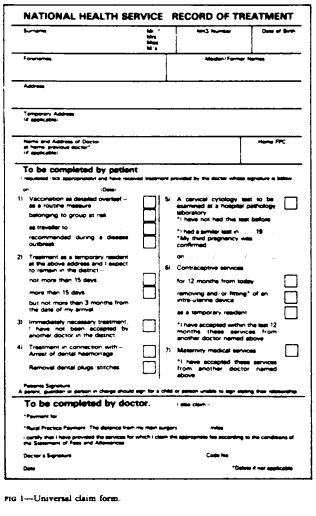

FIG 1—Universal claim form.

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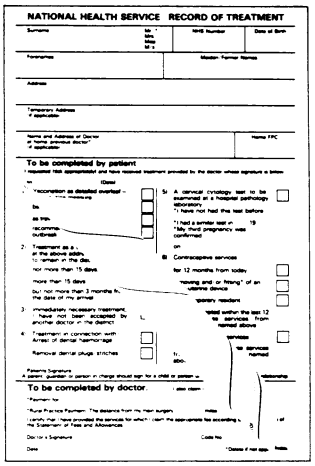

FIG 2—Universal claim form with the top sheet folded back to show duplication on back sheet.

EVALUATION

For the three months April to June 1981 all conventional forms were withdrawn from use in this department. The universal claim form was stocked in all consulting rooms, the treatment room, reception desks, and in the medical bags of eight principals and four trainee assistants. One week before starting the trial all the doctors and reception staff were instructed in the use of the form and provided with an instructional handout.

The completed forms were analysed for: (*a*) type of claim; (*b*) omissions and errors in completion; (*c*) validity by referring to the patient's records. The completed forms were then submitted to the family practitioner committee. These data were compared with similar data for the corresponding period 12 months earlier.

With the agreement of the Welsh Office the staff of the family practitioner committee agreed to process the form in two ways: (*a*) By sorting all the forms according to the category of the claim for processing by the relevant staff in each of the claims sections (the conventional method). (*b*) By arranging for a small group of the staff trained in dealing with the full range of claims to process all the forms without initial sorting. The time taken to process the claims was recorded together with the attitudes of the staff. A questionnaire was designed to measure the acceptability of the form by all the participating doctors and staff.

Results

Errors were noted in less than 2% of all forms completed. Omissions mainly concerned failure to record the data, the patient's date of birth, or failure of the patient and doctor to sign the form. Analysis of omissions showed a problem in design, which was a legacy from the existing form. It was thought that the declaration on contraceptive services should be reworded as a negative statement so that it was deleted only if services had been obtained elsewhere in the preceding 12 months.

There was a considerable increase in the overall number of claims completed during the trial period compared with the same period 12 months previously (table I). This increase was particularly in respect of claims for vaccination, contraception, cytology, and night visits. Retrospective analysis of the practice records showed that a similar number of these services had been performed but not claimed in the same period in the previous year. Using the 1981 rates of payment for both years, this showed an increase of nearly £100 per week during the trial period.

The universal claim form was used to record clinical details for all temporary residents and for immediately necessary and emergency treatment. It is customary in the practice for the patients' notes to be collected and taken on night visits so that most claim forms completed for night visits did not need clinical details (table II). The form was used to make multiple claims in roughly 5% of all claims: temporary resident and night visit, one; a course or more than one vaccination, four; contraceptive service plus cervical cytology, 10; and immediately necessary treatment plus vaccination, one.

The favourable comments received during the trial from both doctors and lay staff invalidated the questionnaire, which had been prepared for use at the end of the trial. No adverse comments were received, although two doctors initially complained that the size of the print used in the form was too small. A single form for all claims was unanimously welcomed, and the receptionists particularly commented on the speed and simplicity of completing their section and said that stock control was no longer a problem. The staff of the family practitioner committee were unable to time precisely the processing of the form in the two ways; nevertheless, they had no problem in processing the claims.

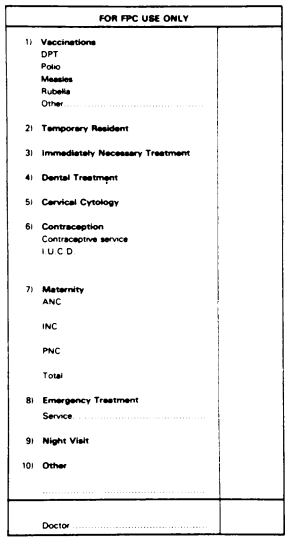

FIG 3—Universal claim form: reverse of top sheet used by family practitioner committee for payment.

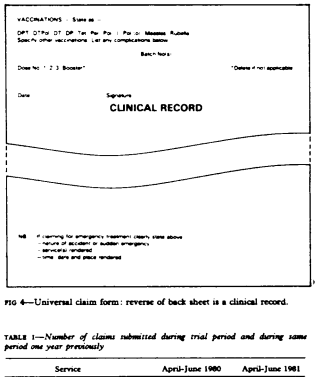

FIG 4—Universal claim form: reverse of back sheet is a clinical record.

TABLE I—*Number of claims submitted during trial period and during same period one year previously*

Service	April–June 1980	April–June 1981
Vaccinations		
Type A	0	5
Type B	0	25
Temporary resident		
Under 15 days	18	22
Over 15 days	22	21
Immediately necessary treatment	0	6
General contraceptive services	79	170
Intrauterine contraceptive services	0	3
Cytology	3	20
Emergency treatment	2	1
Night visits	16	56
Total	140	329

TABLE II—*Universal claim form used as a clinical record*

Type of use	No completed	No used as a record
Temporary resident	43	43
Emergency treatment	1	1
Immediately necessary treatment	6	6
Vaccinations	30	30
Night visit	56	17

Discussion

The results of this trial show that a universal claim form that replaces 12 existing claim forms is acceptable to both professional and lay staff in a general practice and is also acceptable to the staff of the family practitioner committee who are concerned with processing claims. The use of this form resulted in an appreciable increase in the number of claims. This observation, however, must be qualified by the well documented fact that a change of procedure often inherently produces changes that may or may not be permanent. Thus in this trial the number of claims made almost certainly reflects in part the interest that the trial generated.

An increase in the use of claims for items of service by general practitioners would lead to an appreciable increase in the cost of the health service. This would, however, reflect more accurately the actual workload and, in any case, needs to be balanced by the fact that it would be less costly to produce one form than 12 different forms and that processing the claim forms could be achieved by family practitioner committees with fewer staff. In South Glamorgan there is a complex staffing structure in which small groups of staff work in different sections and deal only with one or two categories of claim. The local union officials were quick to spot the implications of the universal claim form in this respect.

The form provides the capability for recording and passing on important clinical information that is not possible with the current forms. It thus serves the purpose not only of a claim form but also of a "clinical encounter sheet." In this respect the form might bridge the gap between conventional records and paperless consultations when medical records are computerised.[1,2] In the interim, before the development of complex recall systems, the stiff back sheet of the form might also be used to maintain a manually operated recall system: if it is arranged chronologically it may be used to recall patients for all contraceptive services and cervical cytology.

This paper summarises the project undertaken by J R Goves while a trainee in the department of general practice, University of Wales College of Medicine, and which received the first prize in the National Syntex Awards 1982. We thank the Welsh Office for allowing the South Glamorgan Family Practitioner Committee to process the universal claim form and the staff of the South Glamorgan FPC for their cooperation.

References

1 Royal College of General Practitioners. *Computers in primary care*. Occasional paper No 13. London: RCGP, 1980.
2 Bradshaw-Smith JH. A computer record system for general practice. *Br Med J* 1976;i:1395-7.

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100 YEARS AGO

One of the most revolting of the performances by which street-jugglers seek to attract the attention and the coppers of the idle, is that known as sword-swallowing. This may be an optical illusion, with a "trick" or telescopic sword, or the veritable passage into the gullet of a short blunt-edged weapon of solid iron. The latter, being the more realistic and disgusting method, is that generally practised, and is not more difficult of accomplishment than the introduction of the stomach-pump; but, the instrument being rigid and its direction unskilled, it is an extremely dangerous performance. Since its introduction or revival, about eight years ago, by a conjurer at the Westminster Aquarium, the trick has become a common one, and has been the cause of many accidents. Its most recent victim is a man named Henry Fry, aged 30, who was admitted to the Newington Infirmary on Saturday, January 17th. He stated that on the previous Thursday he was attempting to swallow a sword, a feat he had been in the habit of performing frequently, when he was seized with severe pain, and began to vomit blood. Difficulty of breathing and of swallowing followed, and he applied for admission to the infirmary, where he died last week. A very similar case is recorded in the eighth edition of Erichsen's *Science and Art of Surgery*, in which a juggler died, a few days after admission to University College Hospital, from perforation of the œsophagus, and injury to the pericardium. Tricks and exhibitions which entail abuse of the provisions of nature, and danger to health and life, are as degrading to the spectator as to the performer, and cannot too strongly be deprecated. It is not, unfortunately, in the gutter only that they are to be found; but it is to be hoped that culture and education will, ere long, exercise more influence in the music-hall and in the street, and will extinguish, amongst others, this objectionable class of so-called entertainment. (*British Medical Journal* 1885;i:242.)