THE KING'S FUND

ANNUAL REPORT 1993

KING EDWARD'S
HOSPITAL FUND
FOR LONDON

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ANNUAL REPORT 1993

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KING EDWARD'S HOSPITAL FUND
FOR LONDON

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ITS ORIGINS AND HISTORY

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

These words from the 1907 Act of Incorporation have been the guide to the Fund's practice for nearly a century. King Edward's Hospital Fund for London was founded in 1897 and was one of a number of ventures begun that year to commemorate Queen Victoria's Diamond Jubilee. The Prince of Wales gave it his wholehearted support, but there were many people who thought that he should not pursue it because it was too ambitious to succeed. Nevertheless his appeal to the people of London for a permanent fund to help the London hospitals elicited a good response from individuals, commerce and industry. A capital sum was built up and the interest from it forms a permanent endowment. The Fund took its name when the Prince succeeded to the throne. In 1907 it became an independent charity incorporated by Act of Parliament.

Although set up initially to make grants to hospitals, which it continues to do, the Fund's brief, as stated in the Act and printed at the head of this page, has allowed it to widen and diversify its activities as circumstances have changed over the years since its foundation. Today it seeks to stimulate good practice and innovation in all aspects of health care and management through service development, education, policy analysis and direct grants. As a matter of policy, however, it does not fund basic scientific or clinical research. It seeks to promote health as well as to support the provision of health services. London is still the focus of its concern, albeit within a national and international context.

The **King's Fund Centre**, which dates from 1963, is in purpose-built premises in Camden Town. Its aim is to support innovations in the NHS and related organisations, to learn from them, and to encourage the use of good new ideas and practices. The Centre also provides conference facilities, a library service and a bookshop for those interested in health care.

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

The **King's Fund Institute** was established at the beginning of 1986, and is currently located at 14 Palace Court W2. The Institute seeks to improve the quality of public debate about health policy through impartial analysis. It publishes *Health Care UK* and *London Monitor*, and a wide range of policy reports.

The **Organisational Audit Programme**, based at 10 Palace Court, is now working with about one quarter of all UK acute hospitals and carries out systematic reviews of their management arrangements. It has recently begun a similar programme in health centres, and is extending its work to purchasers and to mental health, learning difficulties and nursing homes.

Grantmaking ranges from sums of a few hundred pounds to major schemes costing more than £1m, such as the sustained drive to raise standards of care for people with learning difficulties in the 1970s, and in the 1980s, work on primary care in London, on which some £1.6 million was spent. Further substantial sums will be committed over the next few years, in partnership with Government and with Trusts, to primary care development. Other recent ventures concern the assessment and promotion of quality in health care and user involvement.

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CHIEF EXECUTIVE'S INTRODUCTION

In 1993 what were the key happenings in the health sector in the UK? I can think of several different answers, all valid in their way, for example:

- continuing the Government's structural changes in the National Health Service, two thirds of hospitals have by now become Trusts and a third of GPs have become fundholders. From April 1994, nearly all hospitals will be in Trust form. For the first time, people are beginning to invest seriously in the development of the commissioning side of the NHS.
- from the viewpoint of those who need continuing care and support, like elderly people and the disabled, the changes in community care are as important as anything happening in the NHS. These changes have gone surprisingly smoothly so far, but the intended improvements in the flexibility and responsiveness of services have yet to come.

- in London, this was the year of the Government's reaction (in February 1993) to the Tomlinson Report, followed by the specialist reviews of cancer, cardiac, plastics and burns, renal, neurosciences and children's services. The reviews were conducted with heroic speed. A long silence followed, while people awaited a Government response. Meanwhile, the London Implementation Group was negotiating day and night with hospitals all over London to try to shepherd the main institutions into the pens proposed for them by (among other things) the specialist reviews. The results – e.g. the planned closure of A&E at Bart's and a phased concentration of services on the Royal London site, a commitment to manage the market so that the UCL hospitals have a secure future – began to be announced by the end of the year. Substantial remedial investment in primary care was beginning. Hospital beds were nevertheless under great pressure, and the London health authorities could not afford to pay for the quantity of hospital care demanded. Waiting lists rose.
- the somewhat mysterious Functions and Manpower Review was meanwhile examining the role of Regional Health Authorities in England (the intermediate tier) and arriving at a compromise. The tier will stay, but the Authorities will go. Instead the 'centralised office' of the NHS will have a friendly, regional face – but in fewer places, with fewer staff and with different, more developmental roles.

Against this background, the work of the King's Fund has continued at full stretch. More important, so have the efforts of the NHS, the voluntary sector and (no doubt) private medicine, all trying – day in, day out – to care for the sick and to promote health.

The Report which follows describes what the King's Fund has been up to this year. It is, in my opinion, a creditable range of activity, of good quality. But that is for others to judge, because we are a privileged institution, with a mission of public service, which is publicly accountable. A lot of effort goes into this Report – perhaps sometimes to the detriment of what we are trying to achieve – but I do not for a moment grudge the effort if the Report enables people better to understand what we have been doing.

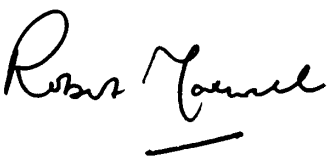
After the accounts of our activities there follows, as usual in recent years, discussion of a number of controversial issues (see pages 15–24) which we think important in the context of current events and future health policies.

Looking forward, my personal concerns are about morale among those who work in the health sector, about adequacy of funding and about public confidence. A rational person

would currently be pessimistic about all of these: morale is low, funding is inadequate and public confidence in the NHS is shaken. How can we, as a nation, turn this situation around? I do not know the answer, but many other countries are currently looking at the UK as an example of courageous experiment. If we in the UK have not found how best to provide excellent health care to the whole population and promote health, then nor, certainly, has anybody else.

Turning back for a moment to our domestic affairs, the King's Fund is moving house. From mid-1995, you will find us all on one site, if not actually under one roof, at Cavendish Square. A description of our new home appears on page 27. We are very lucky. The logic for the move is to try to serve the health sector better, by reducing overheads and by uniting the staff who have previously worked on different sites, several miles apart. I have no doubt that bringing us all together is right, and long overdue.

But the justification has to be external, not internal. Let none of us ever forget, in the King's Fund or outside it, that what matters in any nation is the quality of care that people receive when they truly need it, and the population's health.



Robert J Maxwell

KING'S FUND CENTRE

Our business at the King's Fund Centre is health services development. We identify needs, support innovations and encourage the development, application and evaluation of new ideas and practices. All our programmes aim to promote developments which are sensitive to the needs of users of health and social services, and we have a particular interest in health and race issues.

Service development activities based at the Centre include: grant funding for innovative projects; fieldwork and project support; development of networks and databases; organisation of workshops and conferences; policy analysis, research and evaluation; and publication and dissemination.

Primary Health Care

Following on from the work of the King's Fund London Commission, the primary care team has been working closely with practitioners and policy makers on development priorities to strengthen London's primary care services. A series of Capital Conferences was organised to discuss the scope for extending innovative services such as general practice resource centres or hospital-at-home schemes.

Hospital-at-home was the subject of a study tour to Holland organised for Chief Executives of Community Trusts. Participants were enthusiastic about the approach taken by their host, an independent Dutch development agency, to finding solutions to technical problems, thus enabling chronically ill patients to return to their homes.

Three workshops focusing on specific clinical topics helped to stimulate thinking about primary-care-led commissioning. Meanwhile the Community-Oriented Primary Care project team continued to support general practices, District Health Authorities and Family Health Service Authorities in Haringey, Sheffield, Wiltshire and Northumberland, all of whom are engaged in reviewing their services, and planning and implementing developments based on an assessment of local needs.

Clinical Change

Six conferences were organised during July to encourage public debate about the outcomes of the independent reviews of specialty services in London. The specialties under review included renal services, children's services, cancer, plastic surgery, neurosciences and cardiac services. A report on the issues raised, *Conflict and Change*, was published in October.

As part of its Information for Shared Decision Making project, the team has been encouraging the evaluation and use of interactive videos which provide patients with information about the risks and benefits of various treatment options for conditions such as benign prostate disease, mild hypertension, breast cancer and back pain.

We continue to support developments in medical education and provide assistance to medical schools interested in reviewing and reshaping their curricula to fit the changing demands for medical skills. Our project on Commissioning Health Care for Black Populations is now working with teams in Bradford, Newcastle, Tower Hamlets, Camden & Islington, Sandwell and Waltham Forest to encourage purchasers to take account of the health needs of people from black and minority ethnic groups.

Nursing Developments

The Centre's major nursing project is coordinating and supporting the work of 30 Nursing Development Units (NDUs). Based in hospitals and community units throughout the country and covering a wide range of clinical specialties, the NDUs are pilot sites where innovative approaches to nursing practice are tried and tested. Many are at the cutting edge of practice, for example developing new ways of supporting patients on discharge from psychiatric units, trying out nurse management of beds, encouraging self-medication by patients, and developing public health nursing in the poorest parts of inner cities.

The major priority now is to disseminate the results of this work in order to encourage

wider take-up of successful practice. The Nursing Developments Network has 500 members who share good practice ideas through workshops, training events and newsletters. Several reports have been published and many more are in the pipeline.

Community Care

The community care team aims to improve health and social care services for particular groups of people with long-term support needs, including people with mental health problems, people with learning difficulties, people with physical or sensory disabilities, carers of ill or disabled people, and black users and carers. Publications charting progress and problems in developing better services for these groups have included *Getting Results: unlocking community care in partnership with disabled people* and *Design and Development of Carers Support*.

Our fieldwork in support of projects such as Living Options, which aims to ensure that disabled people are involved in the design and evaluation of the services they use, provides us with a unique opportunity to monitor the effects of the new community care arrangements. We are coordinating a review of developments in community care, using our network of contacts to report the impact of the new policy as experienced by users, carers and professional staff 'on the ground'. Our first monitoring report, *All Change, No Change*, was published in November.

The NHS and Community Care Act 1990 emphasised the importance of health and local authorities working together to meet the health and social needs of their various customer groups. There is much enthusiasm for this policy, but positive experience of joint working is scarce. Our Joint Commissioning project is working with five development sites providing advice and assistance in using collaborative effort to unlock better services for older people.

Information Resources

Information about good practice provides an essential underpinning to all service development work. During 1993, we have strengthened our library and information services by developing electronic links with other information providers and establishing new databases, for example on innovations in health care purchasing.

Our medical and nursing audit information services organised a successful InfoMapping workshop in November designed to help those involved in audit to exchange experiences and gain an overview of audit activities. Staff of **Share**, our health and race information exchange, contributed to the joint NAHAT/King's Fund Centre working group considering ways of increasing recruitment of black people as non-executive directors of health authorities and NHS trusts. The working group's report, *Equality across the Board*, was launched by Baroness Cumberlege in October.

Baroness Cumberlege also presided over a major NHSME-sponsored conference held at the King's Fund Centre entitled 'Managing the knowledge base of health care'. The conference helped to strengthen the links between the Information Management Group and the R&D functions of the NHSME, and to promote closer cooperation and better management of information resources at local level.

Change of Director

In May, Barbara Stocking left us to become Regional General Manager for the Oxford Region of the NHS. She had led the Fund's health services development work for the past six years with great distinction, extending its range and impact. Through her earlier research background, she had an unusual understanding of development processes, and of how innovation happens or gets blocked in the NHS; this has been a major help in creating unity across the diversity of the Centre's programmes. Other Foundations, particularly Baring and Sainsbury, recognised her strength and have been generous in their support. We hope very much that these strong alliances will continue under the new Director, Angela Coulter, who brings a distinguished record of health services research in primary and secondary care, and also has experience of development work. Ironically, Angela Coulter comes to us from Oxford, while Barbara Stocking goes there. Both are appropriate career moves by people who have a big contribution to make to health care in this country. Sad as we were to see Barbara Stocking go, we are grateful for her achievements here and wish her well in her new role, whatever that may turn out to be, following the reform of Regions.

KING'S FUND COLLEGE

In September, Jo Ivey Boufford left her post as Director of the College to take up a senior post in the Clinton Administration in the USA with a key role in refining and implementing their health care reforms. We were very sorry to lose her, but delighted at her success. She said that her experience at the College and with the NHS had been one of the best learning experiences of her distinguished professional career. At the end of the year, Peter Griffiths was appointed both as the new Director of the College and Deputy Chief Executive of the Fund, and was welcomed into post in January 1994. His distinctive experience of change management is particularly valuable at this period of the College's development within a changing Fund.

Theoretically, 1993 should have been a year of sustained development for the NHS after the uncertainty of the election period in 1992 and the turbulence of the immediate post-reform period. In practice, the world of health service management and professional leadership has frequently been one of immense pressure and demand, where 'short-termism' has been hard to avoid. Senior people have often felt obliged to present a good face in public, while experiencing doubt, uncertainty, confusion and weariness in private. Significant organisational turbulence in the form of mergers and reconfigurations, and then the Functions and Manpower Review have had considerable impact on morale and energy. It has become clear that the aftermath of the Tomlinson Report is not only a major challenge to London, but will also profoundly affect thinking and practice elsewhere, particularly in major cities.

Health and the NHS have been very much in the media and the political arena throughout the year. Managers have frequently feared, and sometimes found themselves, being made scapegoats amid complex and competing demands. Public recognition of the genuine difficulties and complexities of their role and tasks has been rare. At the same time, serious debate has been developed about the nature of accountability and of corporate governance.

Like the NHS, the College experiences tensions between its role as part of the Fund, its need to be a viable business, and its desire to be professionally sound and distinctive. These are difficult tensions to reconcile and manage, but we believe that our own experience in addressing them will help to inform our work in the external world. The College Faculty now spend 70 per cent of their time in the field, offering on-site consultancy and bespoke developmental programmes. We continue to review and focus the open-access programmes offered at Palace Court.

Our work in 1993

A major NHSME project on Purchasing Innovations in conjunction with the King's Fund Centre, combining a database and learning network, has been a significant cornerstone of our work on commissioning. Also in collaboration with the King's Fund Centre we are working on a Gatsby Trust-funded project on joint commissioning for services for elderly people. We have developed a seminar series for members of Commissioning Boards and have consulted to a number of commissioning mergers and reconfigurations.

The College's approach to Trust Board development has been increasingly in demand and we have continued to work with a wide range of provider clients on aspects of strategy, team-building and clinical involvement in management, as well as the management of clinical activity.

Our well-established work on management development with doctors has continued and evolved, both at Palace Court and on site. It has broadened to include experimental programmes with doctors earlier in their careers. Similarly, our work with nurses in leadership roles has continued and has strengthened its base. We have begun to work more systematically with other NHS clinical professionals and increasingly we are welcoming clinical professionals into our generic programmes.

The NHSME Women's Unit has funded or subsidised a considerable range of activities to accelerate women's development as part of

Opportunity 2000. We are now drawing on our experience to inform our other work with both men and women.

Early in 1993, we successfully tendered for a major project, commissioned by the Scottish Management Development Group, to identify the management and organisational development needs of the Scottish NHS as it moves into reform implementation, and to make recommendations about appropriate interventions. This work and its follow-through, together with Purchasing Innovations development and our nursing leadership initiations, have greatly strengthened our understanding and contribution in Scotland.

In common with colleagues across the Fund, work in London, with the London Implementation Group and other major stakeholders, has been a strong focus during the year.

As we move into 1994, the College clearly recognises the need to help the NHS, its managers and professional leaders to respond to the big challenges still facing the Service. In England, this is within the new context being created in the implementation of the Government's report *Managing the New NHS*, and with a new Chief Executive about to take up post. Of particular concern are:

- the need to create space for reflection and thinking;
- the restoration of public, professional and staff confidence in NHS management, and managers' own confidence in themselves;
- movement to output and outcome performance measurement;
- finding ways of managing stepped change, as opposed to annual incrementalism;
- enabling those who practise management and leadership to cope with increasing personal stress and uncertainty within themselves and in their organisations.

The year ahead presents yet again a tough agenda for NHS management. The College will continue to provide support to individuals and organisations in their pursuit of greater management effectiveness, within the NHS in general and London in particular.

KING'S FUND INSTITUTE

The Institute continues to aim to produce accurate analyses of significant health policy issues and to contribute to the practical development of policies. The Institute is problem-focused and its main objective is to produce timely and authoritative reports. The principal methods employed include systematic reviews of relevant literature and secondary analyses of existing data sets, supplemented by a continuous process of intelligence gathering. However, the Institute's approach to policy analysis is not focused solely on the production of its own reports. It is continuously engaged in a wide range of other activities to stimulate debate and contribute to policy development.

During 1993, the main content of the Institute's activities focused on three key questions.

- What has been the impact of the NHS reforms, both in general terms and in specific areas of health care?
- How can inequalities in the health of disadvantaged groups and inequities in the allocation of health care resources best be tackled?
- How is the NHS in London reshaping itself to meet the needs of the population?

CHANGING THE NHS

The early 1990s have witnessed almost unparalleled change within the UK health care system. Part of the Institute's job has been to monitor and to evaluate critically the changes that have been taking place. During 1993, three significant pieces of work were completed. One examining the NHS reforms as a whole, and two looking at specific aspects of change – discharge from acute hospitals and community-based mental health care.

When the NHS reforms were announced, the then Secretary of State for Health, Kenneth Clarke, denied there was any need for formal monitoring and evaluation. In the belief that this view was mistaken, the King's Fund decided to make such evaluative work the focus of a major grants programme.

The King's Fund Institute has now published a book, *Evaluating the NHS Reforms*, summarising the results of the seven projects which were supported. The findings enable something to be said about the impact of the reforms, although the assessment is far from definitive. In the early years of the reforms, there was little actual change of any kind in meeting the key criteria of quality, efficiency, choice and responsiveness to the needs and wants of patients. One exception was that GP fundholders appeared to be obtaining quality improvements for their patients, although the extent to which this was the result of the fundholding scheme itself was unclear. Nonetheless, there appeared to be the potential for real gains in relation to the key criteria in some areas where hospitals faced greater than expected competition, and Trust managers looked for efficiency improvements. Finally, some of the early commentators' worries about the adverse consequences of the reforms for equity seemed unfounded, with no indication so far, for example, of 'cream-skimming' (selecting potentially cheaper patients) by GP fundholders.

During 1993, the Institute also completed two reports looking at specific aspects of change within the health and social system which have given rise to concern:

- *Seamless Care or Patchwork Quilt?* argues that pressure to speed up the implementation of the NHS reforms has exacerbated long-standing problems about arrangements for discharging patients from acute hospitals. The mirage of 'seamless' care is both a major source of tension between health and local authorities and a significant barrier to continuity of care for elderly patients in particular. The report indicates that discharge planning has been neglected in the UK far too long and must now become a priority for managers and policy-makers.
- *Reshaping Mental Health Services* suggests that the UK is relying on inadequate piecemeal solutions in developing mental health care in the community. Valuable

lessons could be learnt from initiatives and experience in the USA that would help transform the situation in the UK. The central problem in both countries has been the patchy, slow and uneven development of community services to take the place of the old mental hospitals. What is needed, according to the report, is a systems approach to the design of the new services and a well-structured stakeholder network to facilitate the process of developing the services and monitoring their effectiveness.

Inequalities

It is well known that there are substantial inequalities in the health of different social groups. For example, the latest evidence about infant mortality in England and Wales shows that children from manual classes are nearly twice as likely as those from professional and managerial groups to die in infancy. However, by far the worst mortality rate is experienced by the children of single mothers.

In September 1993, the Institute held a weekend seminar to identify appropriate policies to tackle inequalities in health. The seminar was chaired by Sir Donald Acheson, the former Chief Medical Officer for England, and participants included national policy-makers, senior managers from health and local authorities, academics and health care professionals. The outcome was a set of recommendations about the most important areas of social policy and health care provision which need to be developed if inequalities in health are to be reduced. A report will be published in April 1994.

Any serious attempt to tackle health inequalities requires not only radical changes to the health care system but also the introduction of new approaches to social policy. Nevertheless, NHS purchasing authorities could do more to use their own resources to tackle the health consequences of disadvantage. The new emphasis on health authorities purchasing services for resident populations and GP fundholders buying care for their patients, which stemmed from the NHS reforms, the availability of morbidity data in the 1991 Census, and the blurring of distinctions between primary and secondary care all require new approaches to the allocation of purchasing power.

The Department of Health began to review the allocation of hospital resources at the beginning of 1993. The Institute provided analyses and advice to assist this process, but a more radical agenda is emerging. Our view is that the further organisational changes planned for the NHS demand a *unified* approach to geographic allocations of all NHS funds which is based on an assessment of the *total* health care needs of a particular area. The Institute will continue its own programme of work to develop this case, while taking every opportunity to work with others who are concerned to promote equal access to health care.

London

During 1993, two substantial publications were produced: *Primary Health Care in London: Quantifying the Challenge*, and the first issue of the *London Monitor*.

Following on from its work on the provision of acute hospital services, the Institute turned its attention to the provision of primary health care. A careful analysis of comparative data led to the conclusion that more resources are required in order for London's GPs to provide an appropriate level of service. The report also showed that London is very short of residential care for elderly people and it underlined the continued need for carefully managed change in the capital's health services.

The first issue of the *London Monitor* included invited articles by leading health service managers and commentators on London issues, as well as detailed commentary on events affecting London's health services and a selection of fact and figures about London health and health care. It is hoped that the regular *London Monitor* will provide a forum for discussion of issues relating to the management of London's health services, and that it will be a source of continuing statistics for the purpose of analysing, monitoring and evaluating what actually happens, including the impact of the changes.

KING'S FUND ORGANISATIONAL AUDIT

In 1993, King's Fund Organisational Audit (KFOA) took its place alongside the College, Centre and Institute as a directorate of the King's Fund. The past year was a busy one for the unit: the demand for participation in the acute programme was such that our acute hospital activity will double from 35 surveys in 1993 to over 70 surveys in 1994. Preparation for these surveys got under way in 1993.

During 1993, we also put in place the first component of what will develop into a comprehensive primary and community health care audit programme. This key element, in the shape of the primary care audit for health centres and general practices, completed a two-year development phase in the summer and, following a successful evaluation, has evolved into a programme which will encompass some 50 units in 1994/5.

Following hard on the heels of our primary care work, two further projects were launched: the development of organisational audit for community hospitals and for nursing homes. Work in the field of mental health services is still at a very early planning stage, but we are confident that we now have the core elements of a 'pick and mix' package, which will enable community trusts to audit the organisational quality of their services along similar lines to those now familiar in acute care.

We have been very encouraged by the level of interest shown by commissioners in developing a process by which they too can assess, and demonstrate their concern with, the quality of their own organisations. In collaboration with colleagues from the College, we have developed *Guidelines for Commissioning Health – A Peer Review for Health Authorities*, using the survey method to measure performance along the seven dimensions for good purchasing identified by the Minister for Health, Dr Brian Mawhinney. We intend to roll out the programme substantially in 1994, both to further commissioning authorities and ultimately to GP fundholders. Less formal in its approach than organisational audit for providers, we hope that this initiative will result in a practical tool for commissioning devel-opment, as well as a broadly based network for sharing and building upon good practice.

During 1993, we have carried out a strategy initiative supported by market research, to tell us what both users and non-users think of the services that we currently offer, as well as those that they wish us to make available in the future. The results show that the majority of hospitals that have been through the audit process have a very positive response to it and have gained tangible internal and external benefits from their participation. The findings also confirm that we should focus upon the three categories of health service organisation already identified, namely (a) acute health care providers; (b) primary and community health care providers; and (c) commissioning organisations.

THE YEAR AHEAD

Besides extending our operations in these ways, there are two other major issues for 1994:

- the development of our information service to exploit on an anonymised basis the information arising from surveys and to meet clients' demands for comparative data;
- closely allied to this, the development of performance indicators. These will be drawn from our existing standards and will offer a means of measuring key aspects of an organisation's performance over time.

Our market research has also shown that users and non-users of our services favour the introduction of accreditation for acute hospitals and regard the King's Fund as a legitimate body to offer this service. It is our intention to introduce such a scheme in the spring of 1995. In order to achieve this, much of our energy during the year ahead will be absorbed in overhauling our own systems and processes, our standards and the training of our surveyors, to ensure that they meet the stringent demands that accreditation will place upon them. This report offers us an opportunity to thank all those hospitals and individuals who are already working so hard in helping us to achieve that goal.

KING'S FUND GRANTMAKING

Nineteen ninety-three saw the completion of the first stages of a major reorganisation of the Fund's grantmaking activities. In the context of unprecedented change in health care in London, the time had come to take stock of the Grants Committee's activities and to articulate the contribution which the grantmaking work of the Fund will seek to make to the improvement of health in the capital in the next few years.

A major policy review of grants throughout the latter stages of 1993 led, for the first time, to the Fund identifying five key priority themes (see Exhibit 1) on which to focus its grant-making resources over the next three years. The process of consultation produced lively discussion about the most appropriate priorities for the Fund, but a widespread approval of a more targeted approach and the attempt to establish a shared agenda with other areas of the Fund's activities. This drive to build complementary and collaborative programmes across the Fund prefigures the amalgamation of all the Fund's activities on one site, due in 1995.

Backing up this policy review, the management and administration of grants has been modernised. The installation of a database, originally developed for the use of charitable foundations in the USA has streamlined our administration procedures, while revol-utionising our capacity to analyse the nature of our grantmaking. We now have the means rapidly to assess our activity against our express priorities and to analyse the applications which come to us – types of organisations, health needs being addressed, ethnicity, user involvement and so on. Such overviews of our whole grants programme will help the Grants Committee to respond in an informed and flexible manner to the needs being presented in the capital.

As the restructuring of the NHS continues, the issue of developing primary care in the capital has grown ever more important in the Grants Committee's activities. Working with the primary health care programme at the King's Fund Centre, and in partnership with a number of other funders from central government, Trusts and the private sector, their Major Grants monies in 1993 (a total of £500,000) were allocated to a Primary Care Development Fund, bids for which will be invited in 1994. Recognising the crucial nature of this area of development, the Grants Committee has committed itself to maintaining this focus in future years. Within the main grants programme, individual grants also expressed this interest in the future of primary care services. Grants to the Marylebone Centre Trust and to St Mary's Hospital Medical School recognised the need to develop professional education appropriate to the emerging nature of primary care services in London. A grant to Bromley Health to examine the appropriate mix of primary, acute and community services in the borough, and support to a Triage Training package being developed at King's College, expressed the Fund's concern to focus on the difficult but vital area of the changes taking place *between* health sectors.

Throughout 1993, the Fund has continued its commitment to ensure that less privileged groups in London are helped to obtain good-quality health care. In part, this has been achieved through strengthening existing agencies – the funding of a post at the Medical Foundation for Victims of Torture, for example, will enable them to improve and coordinate

EXHIBIT 1
KING'S FUND GRANTMAKING:
PRIORITY THEMES 1994–7

Innovations in Primary and Community Care
Developing Quality in London's Acute Services
Inequities in Health Care
Strengthening the Voice of the User
Arts and Health
Open Category

Detailed guidelines will be available from the King's Fund in May 1994.

their clinical services for refugees. At the community level, an increasing degree of support is being offered to health projects among minority ethnic groups, tackling both a sense of isolation from mainstream services and developing models of more appropriate forms of health care. The Fund, too, is facing challenges about how to be a responsible funder of such groups, whose development needs can be substantial. Strengthening our practice in this area will continue to be a concern in the coming year.

As part of its emerging grants strategy, the Grants Committee has declared an interest in supporting new voluntary organisations addressing unmet needs among health service users. There have been good examples of this concern in 1993. In funding the establishment cost of 'Afterwards', a new organisation offering information and counselling to newly disabled people, the Grants Committee sought to address needs previously confirmed in a study funded by the Joseph Rowntree Foundation: an interesting example of the way in which Charitable Trusts can use their complementary approaches to progress a project to fruition. The Committee also gave its support this year to SENSE's London Advocacy Initiative which seeks to involve advocates in the lives of deaf-blind people in a number of long-stay hospitals in the London area. The Committee was keen to target support to this group of people, likely to be suffering very great disadvantage, and they endorsed SENSE's argument that advocacy support was most needed by people with profound communication difficulties.

The topic of Arts and Health has been slowly growing in importance in the Grants Committee's work in recent years, and 1993 saw a continuation of this trend. Support to the King's Fund Art in Hospitals Scheme continued, and a survey showed that almost half London hospitals now have artwork in their buildings and grounds, and that they perceive a major therapeutic benefit to both patients and staff. There is a growing acceptance of the importance of the environment to the healing process. With 19 London hospitals having building works in progress, or planned, there remains considerable scope for integrating artwork creatively in the development plans at an early stage. The King's Fund Hospital Design Awards continue this concern with the impact of good design and have secured support from the Grants Committee for a second year. Meanwhile the 'Prime Time' Elderly Arts project in Gateshead, funded in the 1992 Major Grants Programme, has continued to delight, with its highly innovative blend of community development, art therapy, holistic health, environmental regeneration and civic concern. As it approaches the end of its funding term, the project is looking to develop further work in primary care, and has been enabled to build bridges to the primary health care programme at the King's Fund Centre. Thus are links woven between the strands of our apparently diverse concerns.

Importantly, the Grants Committee, in seeking more focus for its activities in future years, has not lost sight of its vital role in supporting the unexpected, the quirky, the maverick. In 1993, it again supported the work of Community Hygiene Concern, convinced that this organisation, with its highly innovative community-based approach to parasitical infections (toxocara, head lice, and so on) has a unique contribution to make in identifying new solutions to intractable and often disregarded health problems. Women in Special Hospitals (WISH) also attracted continued support, in recognition of their very substantial achievements, in their first two years, in helping women patients find a voice in their relations with the authorities. A small grant to the National Funerals College, to encourage the development of better funeral practice nationally, reminded us that our definition of health care must be flexible enough to accommodate support to excellent ideas outside the mainstream. It is also a tribute to Michael Young, a remarkable innovator, responsible among many other things for the College of Health, whose work we have been glad to support.

Finally, this year we said a reluctant goodbye to John Penton, a Grants Committee member for the previous five years, whose informed and thoughtful contributions to Committee discussions had been highly valued. A new member joining this year was Chris Heginbotham, Chief Executive of the Riverside Mental Health Trust, and recently a Faculty member at the King's Fund College.

SELECTED ISSUES

STRENGTHENING THE KNOWLEDGE BASE OF CLINICAL PRACTICE

The appointment of Professor Michael Peckham in 1991 as the first NHS Director of Research and Development, signalled the beginning of an ambitious attempt to strengthen the knowledge base of health care in Britain. In a way that is probably unique among western countries, we now have a national strategy for health services research and an organisational framework, including regional directorates, to commission studies evaluating health care interventions and methods of service delivery. The aim is to ensure that only effective health care is provided. There is a very long way to go before this goal becomes a reality.

The majority of medical treatments in common use have never been rigorously evaluated. Some estimates have suggested that only about 15–20 per cent of medical interventions have been evaluated in clinical trials and shown to be effective. The others have simply been adopted and retained on the assumption that they are beneficial. Although there is a clear need for more studies, this alone will not be sufficient to ensure that the quality of health care improves. Even where studies of the outcomes of treatment have been carried out, they are often buried in esoteric journals rarely read by clinicians, let alone managers and policy-makers. Little effort has been made to gather together the findings from relevant studies and disseminate them to practitioners in a usable form.

The Cochrane Collaboration was launched in 1993 as a major international effort to address this problem. Building on the work of Dr Iain Chalmers and his colleagues at the Cochrane Centre in Oxford, which was established last year as part of the NHS R&D programme, the Cochrane Collaboration aims to review and synthesise the world literature (published and unpublished) of randomised controlled trials of health care. The output will include systematic reviews of the best scientific evidence on the risks and benefits of treatment options, available in electronic form to clinicians throughout the world.

However, it is not only clinicians who need information about health care outcomes – health care purchasers and patients need it too. As yet there are few signs that an 'evidence-based culture' has taken root in the NHS. Purchasing plans of health authorities and GP fundholders seldom demonstrate concern about anything other than volume and costs, and certain process measures such as waiting times. Effectiveness is not yet on the agenda. Most patients who are told by a doctor that they should have a particular treatment assume that this advice is based on a scientific assessment of their needs and a careful evaluation of the risks and benefits of intervention. Doctors are not very good at owning up to uncertainty: many people would be surprised to discover that if they had consulted a different doctor they might have been given entirely different advice.

If the R&D programme is to succeed, it will have to go beyond commissioning studies and disseminating the results, although both are crucial components of the programme. Even more important, though, will be the development of incentives to ensure that research findings are acted upon. Too much research effort gathers dust on the shelves of academic departments, ignored by those who have the power to improve services for patients. Everyone involved in commissioning, providing or using health care needs to be aware of the evidence about risks and benefits and the limits of current scientific knowledge. Evidence-based practice demands a critical approach to current methods and a commitment to change where necessary. It is time to shift the balance from research to implementation.

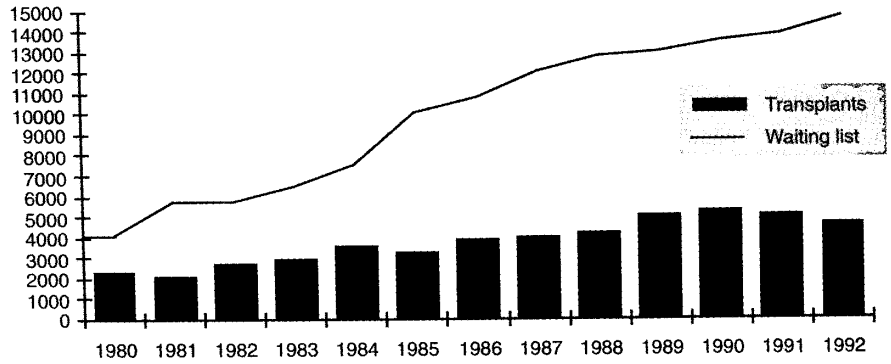
Improving the supply of donor organs for transplantation

Transplanting organs from one human to another is increasingly constrained by a shortage of donors. The world-wide rate of kidney and heart transplantation has now reached a plateau, while the number of those waiting shows no sign of levelling off. Figure 1 shows the widening gap between the total waiting list and kidney transplants carried out in six European countries during the 1980s and early 1990s. Although this phenomenon affects all the developed countries that utilise transplant technologies, there exist extremely wide variations between countries in the rate at which transplant activity takes place. Figure 2 shows cadaveric and live kidney transplant rates in 19 developed nations. These variations have been viewed by researchers as indicating that the UK could significantly improve its performance.

International comparisons need to be made with caution, however. One of the factors which constrain the supply of cadaveric donation is the number of individuals who die in 'appropriate' ways, from the viewpoint of transplantation. Cadaveric organ donors will typically have suffered some form of catastrophic intracranial trauma, either as a result of a road accident or internal haemorrhaging. These mortality rates vary from region to region and country to country, and there is evidence that relevant mortality rates are positively correlated with donation rates. At least some of the variation between countries is therefore beyond the influence of the transplant community. In this country, we have relatively low death rates from road accidents, which is good, but obviously affects organ supply.

Nevertheless, there is undoubtedly room for improvement in the UK. Our problems with organ supply are in part a consequence of the legal framework for donation in this country, colloquially known as an 'opting-in' system. This means effectively that the organs are not available unless the relatives consent at the time of death, which is obviously a time of great distress for them. They are likely to be helped if the person concerned had clearly signified their wish to donate, for example by carrying a donor card, and if that card is found. But, notwithstanding the donor card, evidence shows that 30 per cent of relatives refuse consent. Reducing this proportion is a key goal for improving the supply, and to this end some countries have adopted a different legal framework – 'opting-out' or 'presumed consent' – which allows the removal of organs without the explicit consent of relatives. The medical profession and transplant community in the UK, however, are split over the ethics and practicality of such a change. The Government is unlikely to allow a change, without a clear lead from professional and public opinion. Nevertheless, there are other reasons why potentially suitable donors may not donate organs. Lack of consent is the main barrier in

Figure 1 Total cadaveric kidney transplantation rates and waiting list figures in the UK and Eurotransplant region, 1980–1992



Notes: 1. Eurotransplant region includes: Austria, Belgium, Netherlands, Germany, Luxembourg
2. Figures exclude ex-DDR residents

Source: Eurotransplant Foundation and UK Transplant Support Service Authority

Intensive Care Units (ICUs). Other studies have found that many of those who die on general wards might also be suitable, but because they are not ventilated in an ICU, the relevant tests are not undertaken. Clinicians in Exeter have developed a protocol for 'electively ventilating' those patients who would otherwise have died on general wards, so that their organs become available.

An alternative source of kidneys is the live donor. In the UK, a very small proportion of kidney transplants are from living donors, amounting to 1.5 per million population. Norway, for example, undertakes ten times that number. The reasons for this relatively low level in the UK are manifold, but the outcome is that relatives are not routinely informed of the possibility of live donation and, indeed, there is no central guidance to clinicians on how this matter should be approached.

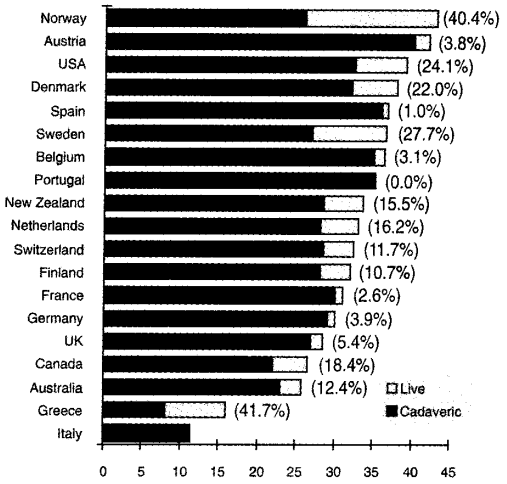
Recommendations

- Methods to reduce the rate of refusal of relatives by voluntary means do not offer scope for significant improvement in donation rates from their current levels.
- Presumed consent legislation may not be feasible in the short term due to a lack of consensus among the transplant community on the ethics and practicality of the policy, and reluctance by Government until there is a clear balance of public opinion in favour of such a change.
- Elective ventilation has provided initial evidence of making a potentially substantial impact on donation rates; implementation of this procedure is recommended if legal and ethical questions relating to the interests of the potential donor can be resolved.
- There is scope for improving kidney donation rates from live donors, but carefully formulated guidance will be essential if this opportunity is to be taken without falling into unethical practices.

Notwithstanding these initiatives, it is extremely unlikely that the supply of organs will ever be sufficient to eliminate waiting lists. Medical advance offers the prospect of animal organs replacing those of humans and, therefore, the real possibility one day of an end to the problem of supply. However, this is unlikely for at least 15 years and will present ethical problems of its own. In the meantime, available organs should be allocated fairly.

Improved data collection and more open discussion of allocation practices is necessary if organs are to be collected in a socially just manner.

Figure 2 Total kidney transplant rates (living plus cadaveric) (pmp) and the proportion (%) of live transplants, 1992



Note: Breakdown for Italy not available; data are for 1991

Source: Individual countries' organ data registries

Prison health services

The prison health service has been subject to a number of reports in recent years[1,2,3] that have suggested it provides a worse service than the NHS. There is general concern about the overall health status of prisoners, while the management of mentally ill offenders, the suicide rate, drug use and the increasing numbers of prisoners who are HIV positive all call for particular attention. A number of explanations have been put forward, including the following.

- The UK is the only western society where the prison system directly employs medical practitioners, who consequently tend to be isolated. There is no formal training for the specialty and it has a low status within the medical profession.

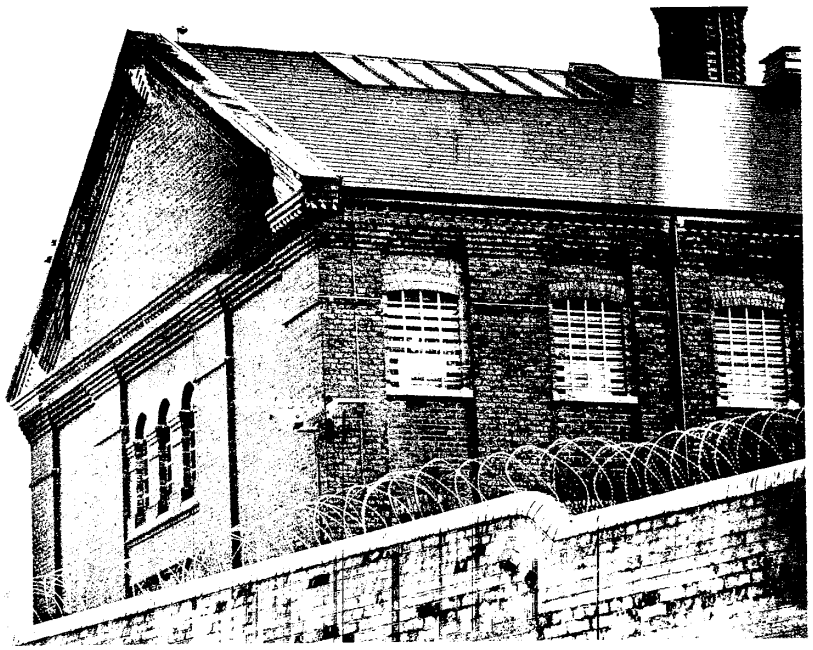


PHOTO: Joanne O'Brien – Format

Brixton Prison

- The inherent tension between providing care and maintaining security causes the authorities to focus on security as the 'safe' option.
- Prisoners command little influence and have little public support. As a result, their health has low government priority.
- Prisons themselves are overcrowded and are in a poor state of repair.

Like many other public sector organisations, the prison service has been subject to reforms. These have combined distancing the service from the Home Office by the establishment of an agency; devolving managerial responsibility; and privatisation. Many prison governors have responded by trying to introduce more liberal and imaginative opportunities for prisoners in a chronically under-capitalised system.

In 1991, while these changes were being implemented, a series of coincidences occurred that resulted in the formation of a learning network involving a number of the London prisons and the four Thames Regional Health Authorities. The membership varied but has included governors and medical staff from Brixton, Pentonville, Wandsworth, Holloway and Wormwood Scrubs, representatives from Regions, purchasers and providers, as well as a number of people from the health care directorate of the Home Office.

The learning network has met on five occasions. The wide-ranging formal agenda has included: the health needs of prisoners; medical ethics in prison; health promotion for prisoners; and extensive discussion of the issues surrounding prisoners with mental health problems, including the Reed report.[4]

Some of the outcomes have been very practical, as there is no other forum where this group of people has the opportunity to meet. In addition, some more seminal themes have emerged from the working of the learning network:

- The difficulties for two very different but very complex organisations in working together when their mutual understanding is imperfect. As one would expect, there is a tendency for unjustified, usually wrong assumptions to be made that interfere with both the planning and delivery of health services to prisoners. If progress is to be achieved, it is essential to spend time learning about each other's organisations, their different but overlapping priorities and their organisational cultures.

- The many similarities between the two worlds. For example, the tension between the field and the centre; the conflict between those who give priority to an individual as opposed to those who focus on the overall needs of a wider constituency; the differing perspectives of those who engage in dealing with day-to-day problems as opposed to those who focus on policy development; and the fact that the prison service and the NHS are both politically sensitive: each has to live with direct political involvement.
- The predictability from the initial sessions of the nature of the problems and the recognition that an objective and rational understanding does not of itself ensure that appropriate action is taken.
- The use of the prisoner's home address or place of arrest, rather than the prison, discourages many purchasing authorities from exercising an appropriate responsibility for their local prison population.

Finally, mentally disordered offenders and their complicated and resource-intensive needs remained a recurring issue. The continuing failure of both organisations to meet these needs was perceived as an indictment of both services; and the mutual frustration that is experienced is bound to undermine any broader efforts to work collaboratively.

Conclusion

One of the more insightful observations was made by an individual from the prison service who observed that dealing with the NHS was 'like landing in a foreign country with the wrong currency'. The value of this intervention was to enable sections of these two large bureaucracies to begin to understand their differences as a step towards action that is long overdue.

1. House of Commons Social Services Committee. Prison Medical Service. London: HMSO, 1986.
2. Her Majesty's Chief Inspector of Prisons. Report: January 1990 – March 1991. London: HMSO, 1991.
3. Prison Medical Scrutiny Team. Report on an Efficiency Scrutiny of the Prison Medical Service. London: HM Prison Service, PMS Directorate, 1990.
4. DoH and Home Office. Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services. London: HMSO, 1992.

The turbulence of health reform in Central and Eastern Europe

'An order based on freely accepted responsibility to and for the whole society ... takes years to develop and cultivate'

Vaclav Havel

The political events of 1989 shattered forever the frozen shape of Europe which had defined allegiances in the post-war world, offering at best the opportunity for a new order based on international collaboration and mutual respect. All too quickly, aspects of that dream have confronted a harsher reality, most cruelly expressed in the destruction of Yugoslavia and clearly present in the uncertain trajectories of countries in the former Soviet Union.

Between these extremes, the other countries of Central and Eastern Europe are all making significant strides in the most fundamental peaceful transformation of whole societies to have taken place in the modern era. As the quote from Vaclav Havel makes clear, the dissolution of previous totalitarian structures is relatively easy compared with the historic challenge of developing the new social contract among free citizens that is required to underpin the pluralist institutions characteristic of Western democracies.

In all of these countries, one small but significant part of social transformation is health sector reform: small, only in the sense that so much else is changing; significant, because collective decisions about health care are a crucial reflection of this social contract.

As part of its contribution to shaping the new Europe, the King's Fund College has since 1991 made support to Central and Eastern Europe the main focus of its international work. Faculty have been active in developing links with health sector leaders in seven countries and have undertaken two major projects:

- designing proposals for health sector reform in Romania (supported by the World Bank);
- developing managerial capacities to implement reform in the Czech and Slovak Republics (supported by the European Community).

PHOTO: Patrick Doherty - The Image Bank

Prague

It is sometimes argued that all developed countries are facing similar dilemmas as they seek to balance competing objectives in health care, relating to the comprehensiveness of provision, the extent of individual choice, control over costs and achieving equity. Responses to these dilemmas lead to further choices about the financing of health services, the design of provider systems, the balance of public and private inputs, and forms of regulation.

In Central and Eastern Europe, however, the context for these decisions is radically different from the West. The new governments have inherited very poor standards of population health, chronic inefficiency in the highly centralised state health services, professional dissatisfaction with the previous reward systems, and major fiscal crises. Moreover, health reform is being driven by the wider political agenda requiring destruction of previous totalitarian structures, introduction of market incentives and rapid implementation.

In all the countries where the College is working, this has led to fundamental reform programmes which involve introduction of new health financing systems (based upon compulsory insurance), denationalisation of facilities (including development of private medical practice) and growth in the influence of more autonomous, provider associations under medical leadership.

The boldness of these programmes is heroic. There is reason for concern, however, about the common preoccupation with new financing and ownership arrangements, to the relative neglect of real investment in defining performance outcomes and delivery arrangements. There are also significant problems in the reliance on legislative and market mechanisms to achieve change, in advance of investment in the management infrastructure required for successful implementation.

In its work in Romania, therefore, the College has promoted the importance of primary care reform, decentralisation in decision making and the development of performance incentives linked to outcome targets. In the Czech and Slovak Republics, work in three pilot districts has sought to demonstrate the new definition of management

that is required by a decentralised, pluralist health system and to draw lessons for national management development strategies.

The King's Fund has as much experience as any European health agency in addressing strategic change in complex environments. As expected, the turbulent situation in Central and Eastern Europe has proved at least an order of magnitude more difficult than any previous College initiative. The College approached this challenge in a spirit of open-mindedness and partnership, expecting to learn as much as to contribute. Inevitably, the experience has been both rewarding and disappointing. In Romania, the analytic contribution to the design of reforms has been well received, but the way subsequent proposals will be implemented remains to be seen. By contrast, the local work in the Czech and Slovak Republics demonstrated relevant approaches to management and organisation development despite the language barriers, but it has proved difficult to build on this experience at the national level.

In both projects, third-party funding, short project horizons and the need to sustain partnership with health ministries as 'clients', when the ministries themselves were in a continuing state of flux, added considerably to the tensions.

What we bring back to the UK is, first, a better sense of proportion about the difficulties here and a recognition that the NHS, for all its faults, has great strengths. Second, confirmation that changing the structures and financing systems is no substitute for building leadership and continuity at all levels. In the end, it is the people working in the system, their standards and their idealism, that matters.

For us and our new professional colleagues across Europe this has been an experience not to be missed. The journey will necessarily be long but (to quote Havel again) 'the only lost cause is one we give up on before we enter the struggle'.

The new NHS – back to management

The latest structural changes at the centre (or 'head office') of the NHS provide the opportunity for greater clarity about what the centre should be doing, for reducing unnecessary bureaucracy and for saving money. All of this is welcome. However, there is also a far greater opportunity for the new Chief Executive, the Management Executive and its Regional offices to focus on their real job of managing the NHS, not just rearranging it.

Tone, style and approach will be as important as substance. We should expect that the rearranged centre will have some or all of the following characteristics:

- innovation, evaluation and sensible risk-taking will be valued and encouraged;
- 'short-termism' and a new priority a week will diminish;
- reflection and relaxation will be promoted;
- greater accountability and performance based increasingly on outcomes will be expected.

The new management agenda

The debates around rationing and effectiveness within the NHS will remain central, both to its internal management agenda and to wider issues of public interest and confidence in the Service. We still need a revolution in the quality and accessibility of information available to politicians, professionals, managers and patients to help inform our judgements in these crucial areas of decision-making.

The credibility of managers and management has taken a battering in the eyes of the public, the professionals and staff working within the Service. There is a sense that 'doctor power' has been replaced by 'manager power' and that on balance the latter is even more objectionable than the former.

A reassertion that management in the NHS is about a capacity to explain and to inspire, and that promotion of teamwork at all levels is vital to re-establishing the confidence of public and employees alike. Inspirational leadership must be underpinned by practical strategies for improving management communication at every level. Finally, the remotivation and involvement of its one million plus employees must be put firmly at the centre of the management agenda.

The job of the Fund will be to provide whatever help and support it can to the management of the NHS in addressing these cardinal issues, particularly in London.

Improving acute hospital design

Concern within the Fund at the standard of hospital design in the UK has grown in recent years. The new, large acute hospitals opened in the late 1970s and early 1980s have frequently seemed to be unbeautiful as a whole and unwelcoming to patients. Furthermore, they often provide both the patients and the staff with a poor environment. More recent major acute hospital developments, often based on the Nucleus designs which have been researched and developed centrally, have been very economical in capital costs and functionally efficient; but on occasion they have failed to produce the high quality of personal space needed to support patients' dignity and individuality during their admissions or outpatient visits.

These failings may be imputed to a shortfall in vision by design teams and their under-valuing of the personal needs of people receiving professional care. The same problems used to be widespread in the non-acute services, but today the ordinary life initiatives, earlier sponsored by the Fund as well as by others, are beginning to show good results in many new or refurbished developments for people with mental illness, or learning difficulties, or terminal diseases, or AIDS. The same is not yet true in acute hospital care.

For these reasons, the Fund decided, as a first step, to try to understand the scale of the problem. First we commissioned Rawlinson, Kelly and Whittlestone to complete a review of what had been built in England and Wales over the last 25 years. Their report showed that whereas in the late 1960s nearly 85 per cent of schemes had been acute hospital developments, the proportion had begun to fall and by the late 1980s amounted to two-thirds. Many medium-sized schemes were designed by NHS-employed architects, but the biggest schemes, on the whole, were not.

Rawlinson and her colleagues found that consumer surveys in these new developments regularly reported:

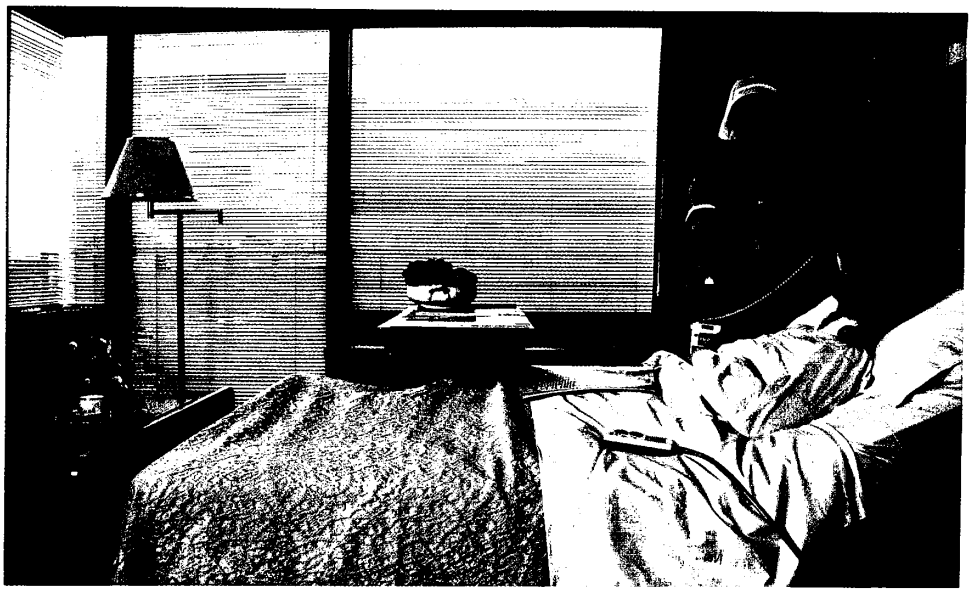
- inadequate privacy, signposting and car parking;
- too few bathrooms and WCs in wards and outpatients' departments;
- waiting areas that are too small and lack children's play areas;
- drabness in colour schemes.

The Fund also commissioned Keith Critchlow and Jon Allen of the Prince of Wales' Institute of Architecture to study excellence in hospital design. They suggested that certain architectural and aesthetic principles had been frequently neglected, and that the first impressions created by a hospital should inspire confidence, display proficiency and invoke beauty. They did some particularly compelling comparisons of good and bad hospital entrances.

The Fund's next step has been to mount a competition during 1993 to identify good examples of design of acute hospitals which were opened in Britain between 1980 and 1990. This decade was chosen, on the advice of the Royal Institute of British Architects, because it would allow sufficient time to have elapsed for design faults and successes to become apparent. The Fund let it be known that it was seeking hospitals which provide beautiful or attractive environments which contribute to excellent patient care. A panel of twelve judges was appointed, and shortlisted hospitals were all visited. At the same time, the views of patients and staff in these hospitals were obtained.

There is a separate illustrated report on the results of this competition which can be obtained from the Fund. But there were several recurrent areas of weakness identified by the judges:

- new hospital entrances are certainly often very unsatisfactory and far from being beautiful or even pleasing to the eye;
- ventilation is still inadequate in many day-rooms and in some Nucleus wards;
- some new hospitals are still smelly (e.g. food or lavatory smells) and this need not be the case;
- storage remains a severe problem; it is usually inadequate for ward staff and totally insufficient for patients;
- good landscape design and active art schemes can enormously improve hospitals, and please and reassure both patients and staff;



Good landscape design and active art schemes can enormously improve hospitals, and please and reassure both patients and staff

- window designs in ward and single-bed areas are frequently very poor (e.g. at the wrong height for patients).

It is the responsibility of those commissioning new hospitals to see that their designers pay sufficient attention to these points.

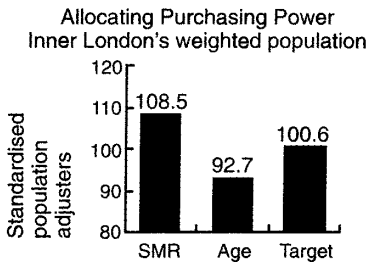
None of the hospitals considered by the panel of judges was good on all counts, but four were judged worthy of commendation and there was one King's Fund Award. The scheme will continue.

Inner London's share of NHS purchasing power

The Tomlinson report recommended radical changes to the provision of hospital care in the capital. It also expressed unease about whether the existing national system of resource allocation 'is always applied fairly to inner London districts'. In particular, it questioned whether the use of information about standardised mortality ratios (SMRs) is sufficient to capture critical aspects of health care needs in London.

Since the publication of Tomlinson, the Department of Health (DoH) has begun a major review of weighted capitation and the early signs are that the changes being mooted are likely to be beneficial to Inner London. To appreciate the anticipated direction of change, however, it is first necessary to understand the basis of the existing system of resource allocation.

Weighted populations which are the basis of financial allocations are obtained through two separate calculations. First, the population is adjusted to take account of national average variations in the use of hospital services by different age and sex groups. In addition, SMRs up to the age of 75 are also used to adjust crude populations. The impact of these factors on the five innermost London districts – City & East, SELHA, Camden & Islington, Kensington, Chelsea & Westminster and Wandsworth – is shown in the following diagram.



The existing target allocation for Inner London as a whole is expressed as a proportion of its actual population. This is calculated by adjusting the population to take account of the SMR and costs data which are also shown. It can be seen that Inner London has a higher than average SMR weighting (108.5) but a relatively young age structure (92.7), and the product of these two population adjusters yields the existing target of 100.6. In other words, Inner London's weighted population for resource allocation purposes is slightly higher than its actual population.

Both of the weighting factors are likely to be changed in any new system of resource allocation and in both cases they are likely to benefit Inner London. For example, new research suggests that the costs of hospital treatment for elderly people are less expensive than was previously supposed. This will work to the advantage of areas such as London which tend to have younger than average populations. For example, simply using the new age/sex costs weighting in place of the old would increase the weighted population of Inner London from 100.6 to 104.6.

There is also a strong possibility that the SMR weighting will in future be supplemented by additional data about morbidity and deprivation which would also benefit Inner London. This is a complex topic, however, and while the Fund welcomes the new approaches to weighted capitation being explored by the DoH, it is conscious of the need for vigilance to ensure that the health care needs of Londoners are properly considered. For example, there are concerns about the possible under-recording of certain sections of London's population. During 1994, therefore, the Fund proposes to launch a grants initiative to encourage researchers and analysts to review critically any new proposals which do emerge.

SPECIAL ITEMS

US HEALTH CARE REFORM: LESSONS FROM THE UK

by

Dr Jo Ivey Boufford

Deputy Assistant Secretary for Health
Washington
and (until September 1993)
Director of the King's Fund College

PHOTO: Andrew Wiard

After four years observing health care change in the UK and four months now back in the Clinton Administration observing the beginnings of the change process in the USA, it is clear that the biggest differences lie in the starting point for the change. The UK reform has sought to increase the potential for local autonomy and responsibility by introducing market forces. The USA is seeking to develop a national framework to bring some order to its highly market-driven, extremely heterogeneous and decentralised system. It appears that it will be much easier to 'let go' than to develop the consensus necessary to bring the pieces back together.

As we begin what are likely to be extended negotiations between the executive and legislative branches over the next several months, there are a few key lessons to be learned from the UK experience.

First, a successful system must be one that provides financial access to health care for all its citizens. The most dramatic difference between the USA and UK has historically been in the strong cultural value placed, in the UK, on social equity – universal financial access to the health care delivery system. This is contrasted with the values conflict between equity and individuality that has been the stronger force in US culture in general and in health care culture in particular. America's health care system has guaranteed the individual's right to consume as much health care as he or she can afford, even if it means some will be denied access except in cases of extreme need. This is now changing for two reasons: the costs of care are exceeding the ability of the middle class to pay, and provider institutions, especially the powerful, urban hospitals, are suffering serious financial losses from care provided to the uninsured. For the first time, there may be an opportunity to have a health care system in which every American has a stake.

Second, a globally budgeted health care system appears to be the most certain route to cost containment. This is barely palatable to US health policy makers. While the President's reform sets a defined rate of increase for health care costs tied to the annual increase in GDP, there is an escape clause built into the legislation that will permit Congressional action to increase the amount appropriated, if it appears inadequate. The USA now spends in excess of 14 per cent of GDP in the health care sector, and it is unlikely that a system used to open-ended financing will be able to change its culture without a clear message about limits.

Key to the ability to realise projected savings will be the ability to build an effective system for primary care as part of the reform. A clear lesson from the UK experience is the success of the General Practice system in dramatically lowering the percentage of expensive (and according to US data, often unnecessary) care. Such care is common in a fee-for-service system where patients self-refer anywhere in the system and financial incentives

reward high utilisation. Restructuring the financial incentives in the USA to promote capitated, managed care systems as the major provider mechanism will provide the US equivalent of the GP gatekeeper. There will also be a need to develop the kind of integrated, community-based health and social care models that have been the hallmark of the UK arrangements at their best.

Another feature of the UK system, that of central physician manpower controls determining the numbers and types of specialists that will be produced, is also proposed to be part of the Clinton reform. This will be critical to moving from the current *laissez-faire* system that has resulted in less than 30 per cent generalist physicians to the target of 55 per cent primary care physicians over an 8–10 years' period. Without this mechanism, achieving the primary care practice goals will be very difficult.

It is becoming increasingly apparent that our ability to construct a cost-effective health care delivery system will be dependent on our ability to strengthen our traditional public health infrastructure. Public health and medical professionals have historically been separated in the USA and there are clear lessons to be learnt from the increasing integration of the concerns and expertise of both groups in working together to improve the health status of the population, a key feature of the UK reform.

Health care makes only a modest contribution to health status, but we must make sure that the services provided are those with demonstrated effective outcomes, on both an individual and population basis. Our ability to address traditional public health needs of assuring water quality, food safety, population-based education and prevention programmes, and links to other sectors of government in order to improve housing, education and economic development, will be critical to avoiding excess costs in the health care system. A section of the President's proposal addresses a series of investments to 'reinvent public health' in a reformed US system. The role of public health in the UK reform can be very instructive in developing US capacity in this area.

Ultimately, change of the magnitude that has occurred in the UK health care system, and that is proposed for the USA, results from a confluence of culture, perception of crisis, leadership and political consensus. The first three factors have been integral to change initiation in both countries, but a Parliamentary system makes the political consensus much easier to achieve. This is what will be sought through the debates of the next several months in the USA.

THE FUND IS MOVING TO CAVENDISH SQUARE

Depending upon its date, the next General Council meeting could be held in the Fund's new home at 11–13 Cavendish Square. This major upheaval is to improve cooperative work between the different parts of the Fund. In a small way, there will also be some long-term financial benefits.

The scheduled buildings facing Cavendish Square are two pairs of houses in a five-bay, Palladian-style façade built by G.F. Tufnell, a speculative builder, between 1769 and 1772.

There is an archway by Louis Osman between the houses above Dean's Mews constructed in 1951–3 partly to strengthen the houses which had been bomb-damaged. The arch supports a large sculpture of the Madonna and Child by Jacob Epstein, erected in 1953. Acquiring the Epstein seems a fitting piece of good fortune for the Fund in the light of our long-term commitment to the encouragement of art in hospitals.

The majority of the Fund's accommodation will be new and found a few yards back from the Square in Dean's Mews. Although the façade of this building will be much as now, inside the Fund's new front door there will be purpose-built accommodation designed by the architect Derek Latham. The Fund's library, conference and seminar rooms, exhibition space and dining rooms will be here as will most of the fellows, the project directors and their key support staff.

One of the pleasures to which we look forward will be the new proximity of many of the Fund's colleagues. Across the Square is the Royal College of Nursing, nearby can be found the Royal Society of Medicine and the London Medical Society, and there are many others close by. As we approach the Fund's centenary, we believe that this move will afford better opportunities for joint activities than ever before.

FINANCIAL REVIEW

The following pages (29 and 30) contain abridged financial statements extracted from the full accounts of the King's Fund which are available on request.

At 31 December 1993 the valuation of the Fund's net assets was £131.0m, an increase of £21.3m over the year. This increase was attributable to the significant improvement in stock markets worldwide and an upward revaluation of the Fund's property holdings.

The overall value of securities was £99.2m at the year end, an increase of £14.4m over 1992. Net current assets, which include bank balances, declined by £1.6m to £1.9m, reflecting the investment of excess liquidity. The value of the Fund's holdings in property, including the Fund's own premises, increased by £8.5m to £29.9m. This increase comprised a significant upward revaluation upon planned disposal of a major investment property and the purchase of a site in Cavendish Square, London W1 to be developed as a unified site for the Fund's operations.

Total income for the year amounted to £12.7m, of which £5.7m was investment and other income and £7.0m was received by way of grants from other bodies or was generated as fees for services provided by the Fund. This compares with a total income of £12.0m in 1992, of which £5.5m represented investment and other income. Total expenditure of the Fund was £13.0m (1992 £12.4m), including grants allocated of £1.8m (1992 £1.5m). The overall deficit for the year of £243,000 was in line with budget and was met from General Fund.

Against a background of high total return but relatively low interest rates, it has been agreed for the immediate future that the Fund's annual expenditure will be based on a percentage of net worth and not solely investment income. This will ensure financial stability for the Fund's ongoing operations and provide sufficient finance for the move to the unified site.

The average number of staff employed by the Fund during the year was 252 (1992: 256), of whom 74 (1992: 85) were funded by grants from other bodies.

The Treasurer gratefully acknowledges all contributions received by the Fund during the past year. New sources of finance will always be welcome and the Fund remains a very suitable object for donations and charitable legacies, to support the advancement of health care and help the hospitals of London.

BANKERS:

Bank of England
Baring Brothers & Co Ltd
Midland Bank plc

AUDITORS:

Coopers & Lybrand

SOLICITORS:

Turner Kenneth Brown

ABRIDGED STATEMENT OF ASSETS AND LIABILITIES

AS AT 31 DECEMBER 1993

MARKET VALUATION

	1993 £000	1992 £000
CAPITAL FUND	43,801	36,066
GENERAL FUND	87,201	73,638
SPECIAL FUNDS	24	23
	131,026	109,727
Represented by:		
CAPITAL FUND		
Portfolio investments	43,121	39,920
Net current assets/(liabilities)	680	(3,854)
	43,801	36,066
GENERAL FUND		
King's Fund premises	13,621	8,785
Computer equipment	472	526
Portfolio investments (incl. Investment Property)	72,349	57,567
Net current assets	759	6,760
	87,201	73,638
SPECIAL FUNDS		
Portfolio investments	–	23
Current assets	24	–
Net Assets	131,026	109,727

In our opinion the abridged financial statements on pages 29 and 30 are consistent with the annual accounts of the King Edward's Hospital Fund for London for the year ended 31 December 1993 and comply with the King Edward's Hospital Fund for London Act 1907.

Coopers & Lybrand
Chartered Accountants and Registered Auditors
April 1994

ABRIDGED INCOME AND EXPENDITURE ACCOUNT

FOR THE YEAR ENDED 31 DECEMBER 1993

	INCOME £000		EXPENDITURE £000	1993 NET £000	1992 NET £000
INVESTMENT AND OTHER INCOME AND RECEIPTS					
Securities and cash assets		4,881	176	4,705	4,522
Properties		830	288	542	593
Donations		8	-	8	11
Available to service the operations of the Fund		5,719	464	5,255	5,126
OPERATIONS OF THE FUND	£000				
King's Fund Centre		3,009	3,890	(881)	(912)
Contribution from DoH	*649*				
Conference fees etc.	*551*				
Grants from other bodies	*1,809*				
King's Fund College		2,846	4,019	(1,173)	(1,318)
Fees and service charges	*2,846*				
King's Fund Institute		69	616	(547)	(486)
Fees and publications	*69*				
King's Fund Organisational Audit		739	867	(128)	
Fees for services	*585*				
Grants from other bodies	*154*				
King's Fund Other Projects		328	369	(41)	(412)
Grants from other bodies	*328*				
Grants allocated		47	1,880	(1,833)	(1,524)
Grants lapsed	*47*				
		7,038	11,641		
NET COST OF OPERATIONS				(4,603)	(4,652)
ADMINISTRATIVE COSTS					
Head Office staff			479	(479)	(422)
Head Office other			161	(161)	(175)
Professional fees			214	(214)	(196)
Maintenance of premises			41	(41)	(80)
Total administrative costs			895	(895)	(873)
Total net expenditure				(5,498)	(5,525)
TOTALS OF INCOME AND EXPENDITURE		12,757	13,000		
EXCESS OF EXPENDITURE OVER INCOME				(243)	(399)

CONTRIBUTORS IN 1993

Her Majesty The Queen
Her Majesty Queen Elizabeth The Queen Mother
HRH The Duke of Gloucester

D & W Backhouse

CASPE
AH Chester
NH Clutton
Coopers & Lybrand

V Dodson
K Drobig

Donald Forrester Charitable Trust

SM Gray

Lord Hayter KCVO CBE

Roger Klein

RJ Maxwell
Merchant Taylors' Hall
Morgan Grenfell Group plc

G Pampiglione

Albert Reckitt Charitable Trust

Sussman Charitable Trust

The Wernher Charitable Trust
D & KL Welbourne

GRANTS MADE IN 1993

GRANTS COMMITTEE

promotes the better delivery and management of health care in the statutory and voluntary sectors. Grants are awarded mainly in the Greater London area, although projects of national relevance are also considered when they have a bearing on London.

£

PRIMARY CARE INNOVATION IN LONDON 500,000

MAIN GRANTS PROGRAMME

AFTERWARDS 44,000
towards the costs of establishing a support line for newly disabled people, and to develop a direct counselling service, training, discussion and the dissemination of information

ASSOCIATION FOR THE VICTIMS OF MEDICAL ACCIDENTS 32,000
for funding for a coordinator to develop and service a network of support groups for patients who have experienced a medical accident

BROMLEY HEALTH 29,000
towards a study of the appropriate mix of primary, community and acute services in the Borough of Bromley

BULLETIN OF MEDICAL ETHICS 25,300
towards the costs of supplying the Bulletin free of charge to Research Ethics Committees

CEDC 30,000
towards promoting the use of community education approaches in involving disadvantaged families in the planning and delivery of services

CITY & HACKNEY CHC 30,000
to provide advocacy to 150 long-term care elderly residents in hospital who are to be transferred to nursing homes

£

COMMUNITY HYGIENE CONCERN 10,000
towards the direct costs over two years of producing the *Primary Health Care Guide to Common Parasites*

DISABLED LIVING CENTRES COUNCIL 10,000
towards establishing a Training and Communications Officer to work with the 30 Disabled Living Centres nationally

EAST LONDON SCHOOLS FUND 30,000
towards funding school/home support workers from the Somali community to tackle mental health problems experienced by the Somali refugee community

HARINGEY WOMEN & HEALTH 39,965
towards the costs of a counsellor to work with black women with alcohol problems

KING'S COLLEGE 20,000
for funding of the final stage of refining, testing and publishing a Triage Training Package for A&E nurses

KING'S FUND ART IN HOSPITALS PROGRAMME 25,000
£8,000 – to Public Art Development Trust
£3,500 – 'Artist in Residence' scheme
£4,000 – to use the Artist in Residence scheme to help hospitals
£7,000 – King's Fund Forum
£2,500 – administrative support for the scheme

KING'S FUND HOSPITAL DESIGN AWARDS 24,000
funding for the 1993 awards which aim to recognise outstanding hospital design

MARYLEBONE CENTRE TRUST 20,000
towards the costs of establishing an MA Programme in Primary Care

MEDICAL FOUNDATION FOR VICTIMS OF TORTURE 40,000
towards the cost of establishing a Clinical Director post over three years

£

NATIONAL ASSOCIATION OF LEAGUES OF HOSPITAL FRIENDS 15,000
towards the costs of a development officer for Greater London, to identify where needs exist for the work of the League as it applies to long-term elderly, mentally disturbed people and inform people moving out of long-term hospital care

NIGEL CLARE NETWORK TRUST 44,000
for funding for two years towards a co-ordinator's salary for the Network One project

NORTH MIDDLESEX HOSPITAL 10,000
Evaluation of North Middlesex Hospital A&E Community Nursing Scheme

PARTNERSHIP TRUST 20,000
funding of the King's Fund prizes for innovation and development in Medical Education and in Nursing Education

PHOENIX HOUSE 20,000
towards clinical equipment in a residential rehabilitation service for 36 AIDS symptomatic drug users

PROVIDENCE ROW 20,000
towards the cost of equipping a medical room at a new centre – the Gunthorpe Street Project – for homeless people in the City and East End

RE-SOLV 11,107
for a third year's funding towards a Liaison Officer post and the establishment of a Parent Support project

BRENDA ROBBINS 30,700
towards researching the need for information and education for disabled women and those working with them as regards their sexuality

ROYAL COLLEGE OF GENERAL PRACTITIONERS 20,000
towards the cost of networking among the Prince of Wales' Fellowship holders over a three-year period

RCN NURSING UPDATE PROGRAMME 10,000
for funding of a unit of the RCN Nursing Update Programme

£

ST MARY'S/IMPERIAL COLLEGE COMMUNITY HEALTH SCIENCES CENTRE 50,000
towards the cost of establishing a new centre combining St Mary's departments of general practice, primary health policy and public health

SCOSAC 24,000
to provide a free, focused counselling service to women who were sexually abused as girls and to evaluate this in a controlled practice setting

SENSE 29,519
funding for a part-time advocacy worker to develop and coordinate partnerships with deaf-blind people in long-stay mental hospitals

WALTHAM FOREST FAMILY SERVICE UNIT 26,500
towards the cost of providing training to Asian women in counselling skills

WOMEN IN SPECIAL HOSPITALS 20,000
towards the costs of an administrator post

Small Grants

ARTS FOR HEALTH 2,500
towards the cost of a research project concerning the design of health care buildings

BEDGROVE HEALTH CENTRE 500
towards the stock costs of establishing a patients' library

BLACKFRIARS WORK CENTRE 500
towards the cost of a course on healthy eating for people with mental health problems

BRITISH HEALTH CARE ARTS 500
towards the cost of a one-day workshop on the effective use of the arts in hospitals

BUCKINGHAMSHIRE HEALTH AUTHORITY 4,000
to fund a full report of a conference on 'Letting Consumers Know about Outcomes' to be disseminated to all purchasers, regions, FHSAs and CHCs

CARILA LATIN AMERICAN WELFARE GROUP 2,000
towards the cost of a bi-lingual health advocate project

£

CHILD ACCIDENT PREVENTION TRUST 6,000
towards the costs of the first phase of a study exploring the role of the primary health care team in contributing to child accident prevention

CONTAGIOUS PERFORMANCE COMPANY 5,000
towards reviewing and updating the theatre group's work in health promotion

DEMAND 3,000
towards the cost of the design and prototype of a walking frame

FACILITATED COMMUNICATION SUPPORT GROUP 2,500
towards the costs of bringing Rosemary Crossley to Britain for a national conference and workshops

GAD 2,500
towards the cost of a user conference

GOOD PRACTICES IN MENTAL HEALTH 2,500
towards the cost of two workshops run by the self-advocacy team

GREATER LONDON ASSOCIATION OF COMMUNITY HEALTH COUNCILS 5,000
towards core funding

GUILDFORD SCHOOL OF ACTING 1,379
towards an overspend on a Management Committee grant for a video for health service staff regarding quality in hospitals

HEALTH RIGHTS 500
towards the costs of republishing a 1989 study, *Pictures of Health*, of a local community consultation in Clapham

HEALTH SERVICE JOURNAL 6,000
to sponsor the health management award scheme

HEALTHY EASTENDERS 3,269
towards six-month extension of grant aid

INPUT 2,000
towards the cost of a feasibility study of the INPUT pain management programme

£

KING'S FUND CENTRE/ NUFFIELD INSTITUTE FOR HEALTH 9,700
towards the cost of the first year of a two-year survey to monitor services changes resulting from community care, and their impact on elderly and disabled people and their carers

KING'S FUND COLLEGE/ EHMA 3,000
towards the costs of a publication from a pan-European conference co-ordinated by the KF College on management development for doctors

KURDISH ASSOCIATION 1,000
towards the administration costs of the Medical Committee

THE LIFE ANEW TRUST 1,100
towards the development of the library and training room

LONDON LESBIANS IN HEALTH CARE 3,000
towards the cost of an educational video and associated teaching pack

MACINTYRE 7,500
towards development of a gymnasium for people with sensory or mental disabilities

MANOR GARDENS CENTRE 2,500
towards the cost of providing two weekly health workshops for Bengali and Kurdish Turkish women

THE MATTHEW TRUST 2,000
towards the cost of publishing a report from a forum on Press and Patient Confidentiality

MISSION CARE 1,000
towards the cost of nursing equipment

NATIONAL AIDS TRUST 536
towards a meeting on AIDS and Sexuality at Leeds Castle

NATIONAL ASSOCIATION FOR THE EDUCATION OF SICK CHILDREN 10,000
towards the start-up costs of the Association. They plan a national survey to establish an accurate picture of the provision of education for sick children

£

NATIONAL BLACK MENTAL HEALTH ASSOCIATION 10,000
to enable the Association to continue its activities

NATIONAL COUNCIL FOR ONE-PARENT FAMILIES 2,500
towards the costs of updating the health section of their *Information Manual*

NATIONAL FUNERALS COLLEGE 5,000
towards the costs of the College, an initiative to improve funeral practice

OAKLEIGH SCHOOL 500
towards the shortfall for a school for parents of children with disabilities

PARLIAMENTARY FOOD AND HEALTH FORUM 1,000
administrative costs of the Forum

PARTNERSHIP TRUST 668
towards the costs of the King's Fund judging expenses

PERSONAL EMPOWERMENT PROGRAMME 9,000
towards the cost of a part-time National Director for six months who aims to promote and develop their work in rehabilitating addicts in prison

DR GORDON PETERS 1,000
towards the cost of attending and presenting a paper at The Universal Health Conference in Russia

POD 2,000
towards the costs of funding shows for children in London hospitals

RCGP INITIATIVE ON GP MORALE 375
towards costs of funding Annabel Ferriman's work with Dr Mollie McBride

REACH OUT 1,000
towards the costs of the first year of operation of the Wellington Approach Befriending Project

REFUGE 2,253
a top-up grant to cover shortfall on budget due to reshaping of original proposal, arising from Grants Committee's comments

£

THE ROYAL BOTANIC GARDENS, EDINBURGH 2,500
towards the cost of a guide to fungi for paediatricians

ROYAL COLLEGE OF SURGEONS 2,500
towards the cost of a project about graduated patient care

ROYAL STAR & GARTER HOME 6,000
towards the costs of materials, training and study packs for a new Open Learning Resource Centre for night-shift, temporary and part-time care staff at this residential centre for disabled service personnel

SELCA 6,000
towards the cost of an evaluation officer for the community needs assessment project

SELF IMAGES 5,000
towards the establishment of an art therapy service for young women in Southwark

SHANTI WOMEN'S COUNSELLING SERVICE 8,965
towards the costs of drafting a book on the experience gained from the five years of Shanti's existence

STRATHCONA THEATRE COMPANY 1,000
towards training programmes on the promotion of positive attitudes to disability

TOURETTE SYNDROME (UK) ASSOCIATION 480
towards the costs of information packs produced for GPs and schools in London

TOWARDS CO-ORDINATED PRACTICE 2,000
towards the establishment of a mechanism of discussion and collaboration for clinicians to identify areas of ineffectiveness and achieve changes in services

TRANSCULTURAL PSYCHIATRY SOCIETY 5,000
for funding towards a conference on Mental Health, Race and Culture in Europe

UK HEALTH FOR ALL 1,450
towards the costs of sending two members of UK Health for All Network to an international conference on Healthy Communities and Cities in San Francisco

£

UNITED WESTMINSTER ALMSHOUSES GROUP OF CHARITIES 500
towards cost of purchasing a Pegasus Mattress for a London-based residential home

UNIVERSITY COLLEGE MIDDLESEX SCHOOL OF MEDICINE 5,000
to extend Dr Graham Scambler's study to include research on male prostitutes

VICTIMS' HELP LINE 1,000
towards training counsellors in deaf awareness, training deaf volunteer counsellors and using sign-language interpreters in counselling sessions

WEST INDIAN SELF-EFFORT 5,600
towards the costs of an education programme on sickle cell anaemia, Alzheimer's disease and other health topics for the senior citizen project

WOMEN'S EAST/ WEST HEALTH CARE FORUM 1,000
towards the cost of a seminar for women, eminent in health care fields in the UK and Eastern Europe

YORKSHIRE REGIONAL GENETICS SERVICE 3,500
towards the costs of presenting a workshop, in theatrical form, to the British Medical Genetics Conference

TOTAL GRANTS MADE BY GRANTS COMMITTEE £1,443,866

MANAGEMENT COMMITTEE

£

College Travel Fund 11,000

Educational Bursaries for Nurses and Others to continue the scheme for a further year 45,000

Travelling Fellowships for Doctors to continue the scheme for a further year 30,000

TOTAL GRANTS MADE IN 1993 £1,529,866

CENTRE COMMITTEE

£

PURCHASING FOR BLACK POPULATIONS 125,000
the three main objectives for this work are:

(i) to create mechanisms encouraging the involvement of users in the development of purchasing plans and contracts;
(ii) to identify specific requirements to be included in contracts and service agreements with providers;
(iii) to involve users in the creation of outcome measures and assessing whether these have been achieved.

Each project site was awarded £25,000:
Newcastle Health Authority
Sandwell Health Authority
Waltham Forest Health Authority
Bloomsbury & Islington Health Authority
Tower Hamlets Health Authority
(an additional site in Bradford Health Authority was funded from an earlier grant)

LIVING OPTIONS PARTNERSHIP (PHYSICAL DISABILITY) 144,000
to continue to support ways of building a partnership between agencies and users in order to increase disabled people's involvement in the planning, delivery and monitoring of services. Grants were allocated in order to:

(i) extend the number of localities where disabled people and service agencies are working together to promote service development;
(ii) stimulate service development with black disabled people;
(iii) promote links between purchasers and providers of user-controlled services;
(iv) encourage disabled people's involvement in policy and practice in community care.

Partnership steering groups comprising representatives from health, social services and local disability organisations have been formed in the following areas:

	£
Tower Hamlets	17,750
Southampton	16,000
Wiltshire	16,500
Kirklees	18,500
Hammersmith & Fulham	14,000
Shropshire	15,000
Also, grants were given to:	
British Council of Organisations of Disabled People	1,250
Small Grants Living Options Network	15,000
Regional Network in the Wirral	30,000

MENTAL HEALTH 'SANCTUARIES' 66,000

to continue support for better services for people with mental health problems from black populations and in particular to look at how 'sanctuaries' in the community could be developed.

The main aim of the sanctuary will be to develop an alternative to hospitals in the community for black people. The model projects will strive to involve people who have experienced a mental health problem in the planning, staffing and management of the initiatives. The project proposes to develop a range of therapies and complementary action/treatments to enhance and stabilise as well as develop an individual's life.

West Lambeth District	13,000 (additional to 1992 grant)
Hackney Sanctuary Project	48,059
Small Grants Sanctuary Projects	4,941

Small Grants (less than £1,000) £15,000

	£
The Royal Free Hospital Medical School – A study of stress in medical students	1,000
Kent Information Federation – a contribution towards the launch of this Federation	1,000
Lambeth Advocacy Project – a contribution towards publicity material	500
Healthy East Enders Project – 'Beating heart disease: giving appropriate advice to Bangladeshi, Afro-Caribbean and Chinese patients	500
African and Caribbean Elders – a contribution towards an information and education project	500
ADFAM (the families and friends of drug users) – contribution towards a conference 'Partnership in care'	1,000
Afro-Caribbean Mental Health Project – contribution towards the cost of producing the final report	1,000
Brixton Community Sanctuary – information pamphlets	890
Confederation of Indian Organisation – to update directory of organisations which provide mental health services for the Asian community	1,000
Southwark Community Care Forum – research into contract management model	350
ARTSLINE – Asian project to set up a mobile library of videos and talking books in major Asian languages for blind, deaf and disabled people	1,000
Carers Support Network – support for transition period from being serviced by the King's Fund to becoming an independent body	1,000
Black Carers Conference, March 1994 (first national conference) – contribution towards paying for carers to attend the conference (i.e. travel expenses and sitting costs for replacement carers)	1,000
South London Users Consultancy Services – research into the use of major tranquillisers	660
Black User Group – Lambo Centre	600
Development of user participation in Tower Hamlets	1,000
College of Health – financial contribution towards disseminating the findings of a study re. the health needs of refugees and political asylum-seekers in the London Borough of Newham	1,000
Statham Grove Surgery, Hackney – to translate into Turkish a *Good health education package* following a study which looked at iron deficiency in children	1,000

TOTAL GRANTS MADE BY CENTRE COMMITTEE IN 1993 £350,000

GENERAL COUNCIL AND COMMITTEE MEMBERS

GENERAL COUNCIL

President
HRH The Prince of Wales KG KT PC GCB

Honorary Member
HRH Princess Alexandra, The Hon Lady Ogilvy GCVO

The Lord Chancellor
The Speaker of the House of Commons
The Bishop of London
His Eminence The Cardinal Archbishop of Westminster
The General Secretary of the Free Church Federal Council
The Chief Rabbi
The Rt Hon The Lord Mayor of London
The Governor of the Bank of England
The President of the Royal College of Physicians
The President of the Royal College of Surgeons
The President of the Royal College of Obstetricians and Gynaecologists
The President of the Royal College of General Practitioners
The President of the Royal College of Pathologists
The President of the Royal College of Psychiatrists
The President of the Royal College of Radiologists
The President of the Royal College of Anaesthetists
The President of the Royal College of Ophthalmologists
The President of the Royal College of Nursing
The President of the Royal College of Midwives
The President of the Institute of Health Services Management
The Chairman of each of the four Thames Regional Health Authorities
Professor Brian Abel-Smith MA PhD
Sir Donald Acheson KBE DM DSc FRCP FFCM FFOM
D Adu MD FRCP
Valerie Amos
The Hon Hugh Astor JP
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Brendan Devlin MD FRCS
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Lord McColl MS FRCS
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L W H Paine OBE MA AHSM
Professor J R Pattison
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Sir Maurice Shock MA
Richard P H Thompson DM FRCP
Professor Sir Bryan Thwaites MA PhD FIMA
Lord Walton
Lord Wardington
Professor Jenifer Wilson-Barnett PhD SRN FRCN
Sir Henry Yellowlees KCB FRCP FFCM

Management Committee

S M Gray FCA **Chair**
William Backhouse **(Treasurer)**
Baroness Blackstone PhD
Anthony Bryceson MD FRCP
Brendan Devlin MD FRCS
Sir William Doughty MA CBIM
Miss Christine Hancock BSc (Econ) RGN
M J Hussey
Professor Brian Jarman
Sir Duncan Nichol CBE MA AHSM
Professor J R Pattison
Professor Lesley Rees
Richard P H Thompson DM FRCP

Finance Committee

William Backhouse **Chair**
The Governor of the Bank of England
Sir Richard Baker Wilbraham Bt
Lord Catto
Sir Michael Colman Bt
V P Fleming
Lord Rayne

Estates Committee

William Backhouse **Chair**
Sir Richard Baker Wilbraham Bt
J R G Bradfield PhD MA
J P A Cooper
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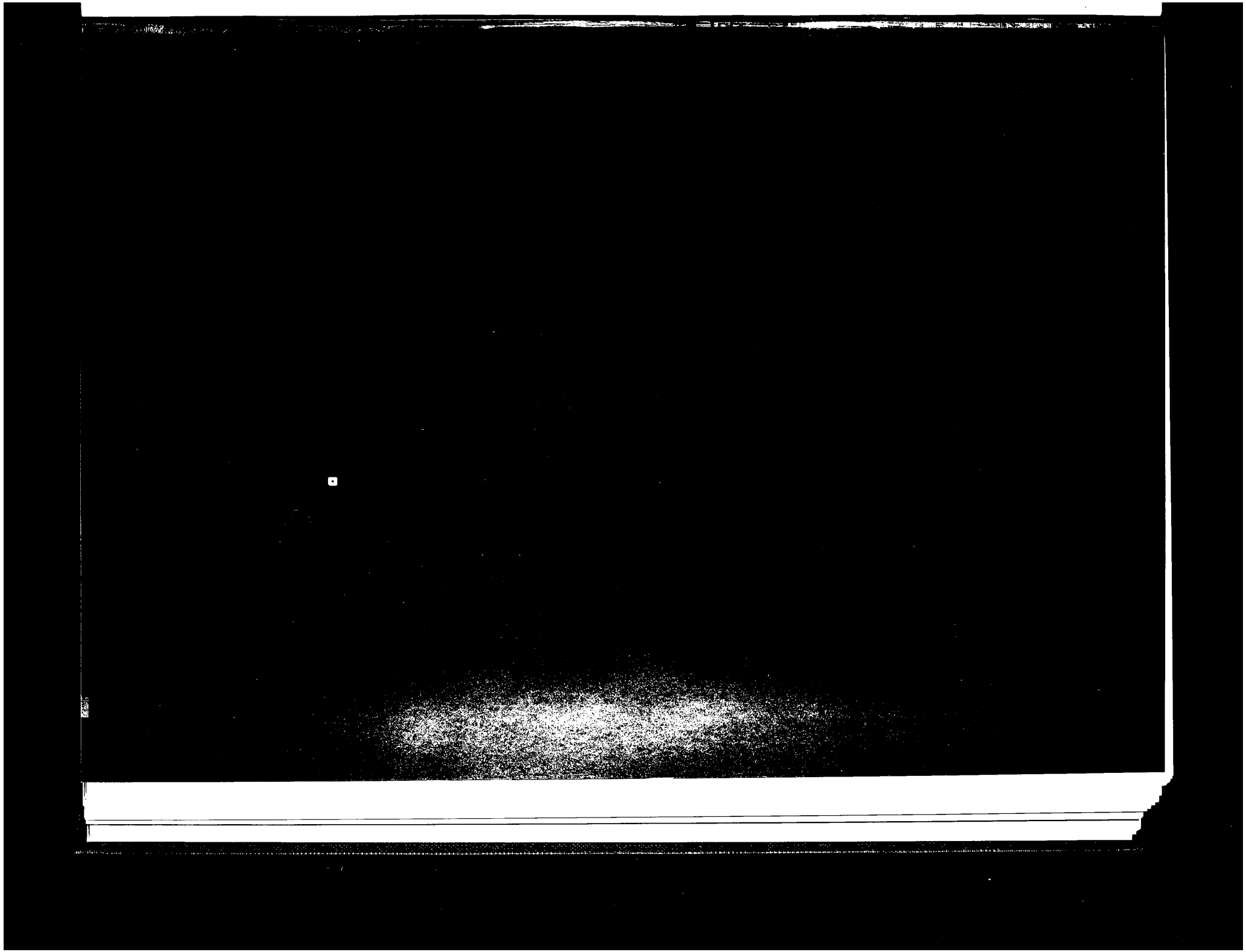


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