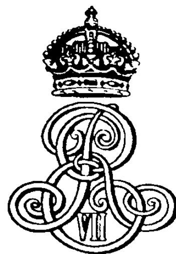
What next for London's health care

Robert J Maxwell



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EXECUTIVE SUMMARY

Robert J Maxwell

Roughly two years after the report of the King's Fund Commission on London and the Tomlinson Report, and three years prior to the next general election, it is time to take stock. Policies shaping the NHS in London have become increasingly controversial. Against this background there are (at the extremes) two policy options: to back off major changes on the grounds that they are too difficult, or to carry on doggedly regardless of criticism.

Both options should be resisted. This paper argues that, despite growing resistance to the Government's policies for the NHS in London, the case for changes in the balance of services remains overwhelming. Primary care (in its broadest aspects, including nursing homes and community-based health services) needs strengthening and adaptation in the particular context of the capital. Specialist care should, in many cases, be concentrated in a smaller number of units. Research and education should be aligned with fewer, stronger university-based centres.

Nevertheless, there is every reason to listen to the mounting concern generated by these policies and to think again, particularly about the pace of change and its leadership. As Professor Jarman has demonstrated, London has been losing acute beds fast, and there is now every reason to believe that London as a whole is coming into line with the rest of the country. Meanwhile there are grave problems in London's hospitals about admitting emergency patients, long waits on trolleys, and rising waiting-lists for elective patients.

It is essential to re-establish trust and a shared vision of the pattern of services that London is seeking to create, and the strategy for getting there. Proposed elements of such a strategy include the following.

- No more acute bed reductions overall, and great care about A&E departments, while the pressures on both remain as intense as they are now.

- Continue to develop primary care, very broadly defined to include nursing homes and community-based health services.

- Restate the long-term objectives for London and the vision of what pattern of services we collectively intend to create. Be clear about timing and implementation questions (the 'when' and 'how' questions as well as the 'what').

- Maintain transition funding for London for the next three years, in return for explicit agreements from each health authority and the principal institutions about the changed balance of services that together they are committed to creating.

While there have been some real achievements in London in the last two years, particularly in primary care and in acceptance of the proposed university-based regroupings of some of the leading institutions, there are also major problems that must not be ignored. There is intense pressure on acute beds and on A&E departments, a serious loss of morale and a sense that deals are being done behind closed doors which are not communicated to those (patients and staff) principally affected by them.

It is essential not to abandon the task of changing the balance of services in London. It is equally essential to take on board the lessons of the last two years. We now need rather less attention to the private negotiation of 'right' answers and a lot more to managing the present situation and the processes of constructive change.

August 1994

What next for London's health care?

Robert J Maxwell

Two years after the publication of the report of the King's Fund Commission on London,[1] and somewhat shorter periods after the Tomlinson report[2] and the Government's published response,[3] it is time to take stock.

With up to three years to go until the next general election, there are (at the extremes) two obvious policy options. One is to back away from change in London, on the grounds that it is all too difficult and too unpopular. The other is to continue doggedly with current policies, regardless of opposition and criticism.

Both these options must be resisted. The first, because the need for changes to the balance of health care services in London remains overwhelming for anyone who will look at the evidence with an open mind. The second, because what has happened (and some of what has *not* happened) over the past two years underlines the difficulties of making changes on the scale proposed. In London, there is widespread concern that the changes under way are putting patients at risk and that some of London's most famous hospitals have been pushed into a downward spiral of decline. At a minimum, there is a need to re-establish confidence, revise time-scales and review the management of the transition.

This paper will, first, re-examine the evidence that the balance of services in London must be changed, not precipitately but over a period of years. Second, it will review the reasons for the mounting alarm and growing opposition to the policies prescribed by Tomlinson. Finally, it will consider what ought to be done next.

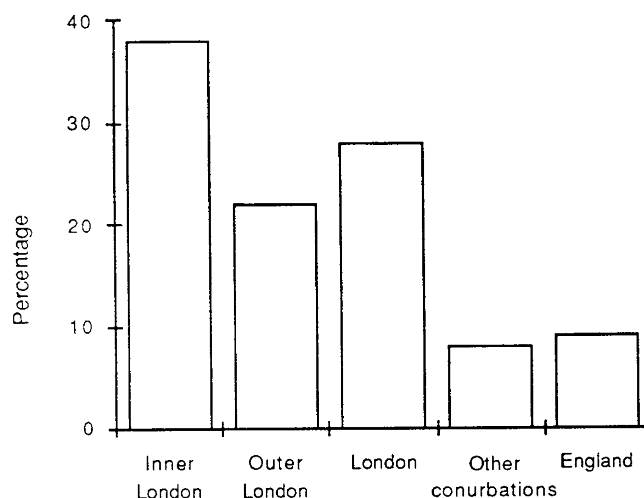
The need for long-term charge

Primary Care

By international standards, one of the greatest strengths of the National Health Service (NHS) is general practice, which provides a flexible and relatively inexpensive first- contact level of medical care and (emergencies apart) acts as gatekeeper and pathfinder to the use of specialist resources. In Inner London, however, and in other similar inner cities, these arrangements are patchy, with both some some outstanding examples and some that fall short of an acceptable level. For example, in 1991/2 a far higher proportion of GP premises were below minimum standard (see Fig. 1). Nor is it just a matter of premises. Other indicators also suggest that, by conventional

measures, Inner London general practice is more fragile and less well-developed than elsewhere (see Fig. 2).

Fig. 1 Proportion of GP premises below minimum standards 1991/92



Source: King's Fund Institute Analysis of DoH's Health Service Indicators (1993)

Over the past two years, the £125 million allocated for investment in the London Initiative Zone is supporting a wide variety of local projects which are beginning to change this situation. Improving premises will be the relatively easy part. Establishing strong teams will be more difficult. Moreover, it is likely that the family oriented-model of British general practice simply will not work for some of the groups who make up the varied and mobile population of London – homeless people, for example, and also commuters, tourists and mobile young people who still think of their family base as elsewhere. For them, the model needs to be adapted into new forms, appropriate to the conditions of a large city.

Everyone agrees that strengthening this level of first-contact medical care in Inner London is profoundly worth doing. Some may question whether it will take a load off the acute hospitals, or indeed whether it can be done in an inner-city setting. Ironically, there can be a degree of unconscious collusion between GPs, hospital doctors and the local population that can make it particularly difficult for general practice to flourish in the shadow of a major teaching hospital. These, however, are not arguments against a sustained, systematic, evaluated programme of primary care development in Inner London, using a combination of conventional general practice and other approaches, including some that span the old boundaries between primary, chronic and acute.

Fig. 2 The structure of GP service provision

(ratios standardised to England value)

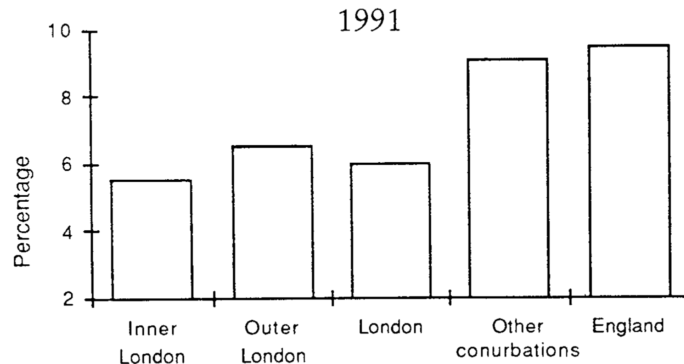
	GP premises below minimum standards	Single-handed GPs	GPs older than 65	GPs meeting either high or low cervical cytology targets	GPs on minor surgery list
Inner London	452	183	311	58	38
Outer London	277	179	222	90	66
London	348	180	249	82	58
Other conurbations	82	127	139	103	85
England	100	100	100	100	100
Value for England	8.0%	11.4%	1.9%	92.6%	73.2%

Source: King's Fund Institute Analysis of DoH's Health Service Indicators Dataset (1993)

The scope of this programme actually has to be considerably broader than general practice. This can be demonstrated most obviously in the case of elderly Londoners. As life expectancy has increased, so have the years of recurrent ill health, loneliness and partial disability. We need strong community-based health and social services, in their broadest sense, to help individuals cope with the illnesses and impairments with which they have to live. When there are acute episodes, it is particularly elderly people for whom it is hard to negotiate acute hospital admission.[4,5] This is partly because hospital doctors know by experience that this group may be difficult to discharge when the acute phase of treatment is complete. There is a dramatic deficit of non-acute provision (hospital, nursing home, residential care) in London, which is reflected in the low proportion of elderly people in medical and care establishments (see Fig. 3).

Paradoxically, the pressure to curtail expenditure in the London hospitals in the past 20 years has resulted in the virtual eradication of the smaller, weaker institutions, which were often precisely those most able to offer a local, sub-acute service to elderly people. It is not obvious how best to fill this gap, although the Lambeth Community Care Centre provides one good model. A range of approaches ought to be tried, including strong and imaginative home-based care and hospital discharge arrangements. Without doubt, this involves crossing the medical/social care divide, since this boundary is virtually meaningless for anyone with long-term illness or disability.

Fig. 3 Proportion of elderly people (75+) in medical and care establishments 1991



Source: King's Fund Institute Analysis of 1991 Census, OPCS
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Specialist care

A need for change of a different kind is presented by the fragmentation of many tertiary referral services in London. The problem is of long standing and was highlighted by the London Health Planning Consortium nearly 20 years ago (see Box 1). In 1993, the Secretary of State established six groups to review the main specialties concerned. Each was led by a medical expert from outside London along with a London purchaser. The work was done to an extremely – some would say dangerously – tight timetable, and some of the assumptions and conclusions have been criticised.[6] Nevertheless, the broad thrust of the changes recommended by the reviews (see Box 2) is undoubtedly correct – that London needs substantially fewer, stronger centres in most of these specialties, if it is to be taken seriously as a national (let alone an international) centre of excellence in the 21st century.

The King's Fund Commission's report, supported by Tomlinson, also recommended regrouping London's medical schools and postgraduate institutes into four main clusters, based on: Imperial College, University College, King's College and Queen Mary College/Westfield, with St George's as an outlier. While there have been reservations about timing and degree, few have argued against the logic of creating in London a small number of major clusters of medical institutions, each including strong basic science. As Box 3 indicates, substantial progress has been made since Tomlinson at the level of intent, although large amounts of capital will be needed to move from intention to reality.

Finally, in Inner London there is a high concentration of hospital doctors not only relative to resident population, but relative to workload (see Fig. 4). As a result, there is a high cost per episode of hospital care (see Fig. 5) and a larger difference than anywhere else in the country between the costs of teaching and other hospitals. Are these figures justified by the exceptional deprivation of many Inner London communities, or by teaching and research, or by the national and international referral role? (While there is no doubt about the high cost of providing *any* service in Central London, this is not by itself a sufficient justification for high NHS expenditures unless the service matches exceptional local need or is a good bargain in terms of referral, teaching and research.) It is at least equally plausible that the high concentration of hospital human resources in Central London is explained more by history than by today's needs or the uniform pre-eminence of London medicine. Of course, one cannot prudently change the balances overnight (between London and non-London; between Inner and Outer London; between the tertiary specialties and more flexible, generalist hospital and primary medical services), but that does not gainsay the arguments for such shifts in the long term.

Fig. 4 WTE staff per 10,000 episode, all acute specialties group, 1989–90

Area category	Consultant M&D	Non-consultant M&D	Acute nurses
LONDON			
Inner deprived	17	43	155
Urban	12	28	148
High-status	12	29	139
Total	15	36	149
NON-LONDON COMPARATORS			
Inner deprived	14	33	156
Urban	12	26	141
High-status	12	27	132
Total	13	30	146
England	12	27	147

Source: Boyle S, Smaje C. Acute Health Services in London: An Analysis. London: King's Fund Institute, 1992.

Some people maintain that the fact that Inner London is so out of line on medical human resources does not mean London is wrong. Redistribution, they say, should be a matter of levelling up, not levelling down. While I agree with their insistence that quality of care is a crucial variable, on which there is all too little information, what information we do have does not support the idea that London can be complacent about quality. The rest of the country has done considerable catching up and in some instances now sets the pace, at lower cost levels than Inner London. The questions about how to nurture centres of excellence for the 21st century are important, but they are national and not simply about defending the status quo in London.

Fig. 5 Average cost per episode by status category, all acute specialties group, 1989–90

Area category	London	Non-London comparators
	£	£
Inner deprived	790	630
Urban	628	532
High-status	565	509
Total	693	576
England	546	

Source: Boyle S, Smaje C. Acute Health Services in London: An Analysis. London: King's Fund Institute, 1992.

The problems of implementation

The Government's response to Tomlinson was published in February 1993 and the London Implementation Group (LIG) was set up at that time, headed by Sir Tim Chessells and Bob Nicholls. LIG has no line authority but, working directly to ministers, has considerable influence within and outside the Department of Health. Its role has been to make things happen in primary care development, acute sector rationalisation, education and research.

Predictably, strengthening primary care is a long, hard road. However, the start has been relatively uncontroversial and unproblematic: £40 million was committed in 1993/4 within the London Initiative Zone of the inner city for a wide range of projects, and a further £85 million has been allocated for the current year. Within this Zone, the detailed general practice rule-book is to be applied flexibly, by agreement with the British Medical Association, so that initiatives can be unconstrained by bureaucratic regulation. At times, the flexibility has been slow coming, to the frustration of those trying to use it. Inevitably, given the short time-scale for selecting projects in the first year, most of what has so far been funded is not outstandingly innovative. They are proposals that were already on somebody's shelf, which could be dusted down and submitted. Collectively, however, the scale and scope of these changes are large enough to produce tangible differences on the ground from this autumn onwards, particularly in terms of premises and primary health care teams. Of the £85 million to be invested in primary care services in Inner London this year, £10 million will be used to support mental health projects. A further £7.5 million has been made available over three years to

support initiatives in the voluntary sector. Just beginning is the London Health Partnership, a joint venture between trusts, Government and business, which will be chaired by Liam Strong of Sears plc and managed by the King's Fund, to work at the more innovative end of primary care development, focusing on care for elderly people.

Thus on the primary care side a considerable amount has happened in the past 18 months, though it is much too early to gauge its success. Those who have argued that primary care must be developed first, before changes can safely be made to reduce hospital provision, will say that it is still far too soon to tamper with the hospitals. The initiative on primary care will need to be sustained for a much longer period – at least five years and maybe ten – to overcome the obvious shortcomings of Inner London primary care.

It is also crucial to recognise that this is not simply a matter of improving general practice, important as that is. There is also the deficit in residential and nursing home care for elderly people, the lack of an urban equivalent of the community hospital and substantial difficulties in providing strong enough community nursing services in or near people's homes. While it would be absurd to continue to rely for the long term on acute hospitals, which are an expensive and inappropriate way of providing sub-acute care, we have to put something else in what is currently a vacuum.

If progress on the primary care side has at least been uncontroversial (though inevitably slow), the epithet 'uncontroversial' certainly does not apply on the acute side. In its response to Tomlinson, the Government anticipated reductions of about £50 million a year in contract income in London hospitals, and a reduction of 2000–2500 acute beds over 4–5 years, amounting to 15–20 per cent of the bed stock.[7] The Government also said that hospital services would be better provided from fewer sites. Subject to consultation, it proposed the closure of A&E Departments at Charing Cross, Bart's and Guy's or St Thomas', and examination of a number of mergers in all parts of London, involving the Special Health Authority postgraduate hospitals as well as the undergraduate teaching hospitals. It also set up the six specialty reviews (see Box 2).

Fierce campaigns for survival and for their patients have been fought by the threatened hospitals, both in private and in public. Bart's, the Royal Marsden and Guy's have fought the most public ones. During a year of turbulence and controversy, fortunes have fluctuated (see, for example, Box 4 which summarises the roller-coaster of life at Guy's/St Thomas' and Charing Cross during this period).

The effect within institutions has often been devastating. While bricks and mortar are not everything, they enshrine institutional tradition and identity. To maintain morale while moving and amalgamating teams is as difficult in a hospital as in any other setting (the merger of regiments, for example). It is sad to see some clinicians and researchers of real distinction leaving London[8] and to hear able young people avoiding London as a career choice. Not surprisingly, the effect on public confidence has also been severe. Patients have a confidence in their nurses and their doctors that they do not have in the managers and the politicians. With tense negotiations continuing behind

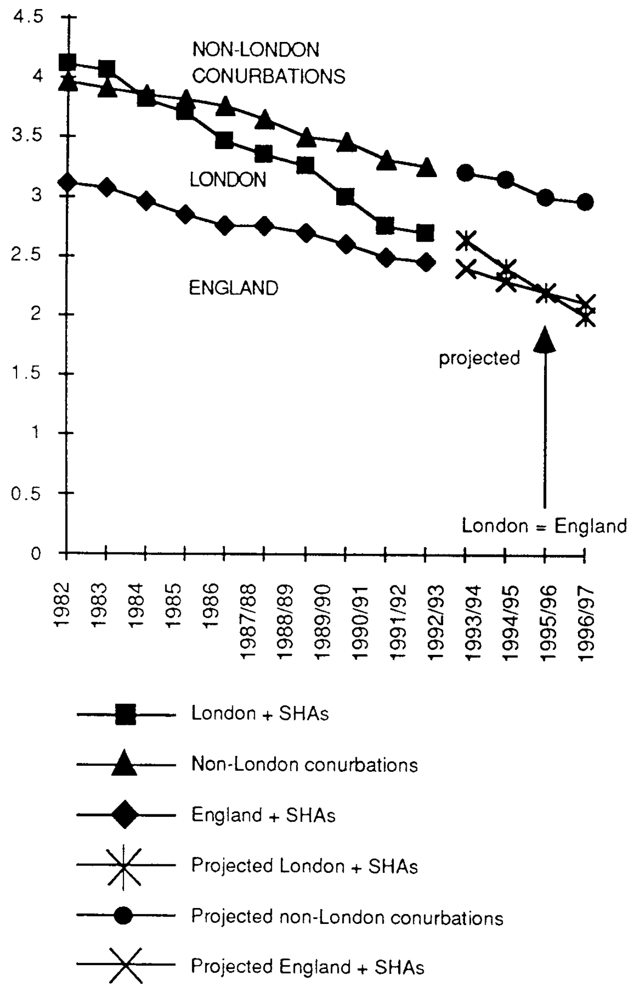
closed doors, most staff simply did not know where they stood. As nursing and medical morale has fallen in London, public confidence has plummeted. Most Londoners simply do not accept the argument for closing hospital beds, let alone for threatening whole hospitals which have a reputation for excellent service. Undoubtedly, there are arguments for rationalising facilities to keep pace with medical advances, reduce overheads and enhance quality, but these are not easy messages to put across. It is difficult for the public to accept a need for major changes at well-loved institutions like Bart's or the Marsden.

Meanwhile, there appears to have been a widespread rise in emergency admissions, not only in London. Quite why this should be so, and its extent, are still unclear.

Increasing attention has been paid to Professor Brian Jarman's claim that London is not overbedded.[9,10] He has consistently maintained that any excess of beds in Inner London is offset by deficits in Outer London, and that geriatric and acute beds should be taken together. On this basis, he says, London has no surplus of acute beds, although he acknowledges that the balance needs to be shifted over time between Inner and Outer London, and between high-tech and lower-tech medical care. He points to the rate of closure of acute hospital beds in London since 1982 (see Fig. 6), which is rapidly bringing London's beds into line with the average for England, and to the pressure on the Emergency Bed Service (EBS), as reflected in the number of applications for admission to London hospitals that have to be medically refereed before a bed can be found (see Fig. 7). His analysis suggests that London has already lost the 2500 beds referred to in the Government's response to Tomlinson, and this before any major hospital closure occurs.

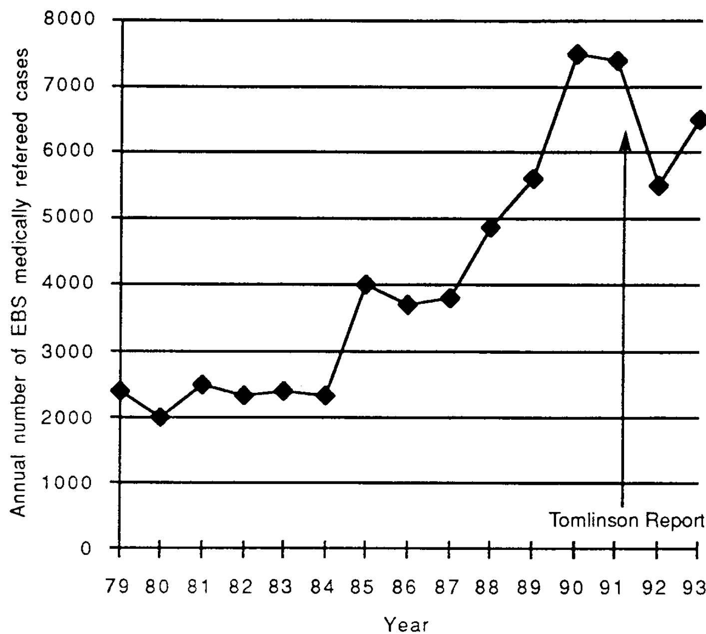
Not only are Professor Jarman's remarks powerful in the ears of those who are opposed to Government policies, they also coincide with anecdotal evidence and experience in many London hospital A&E departments. Whatever the arguments why beds are an outdated currency for defining hospital services in the longer term, common sense says that patients should not have to wait for long periods on trolleys for a bed to become empty. In the absence of alternative ways of caring, closing more beds can only make this situation worse.

Fig. 6 Acute beds/1000 resident population including SHAs



Source: Jarman B. The Crisis in London Medicine; How Many Hospital Beds Does the Capital Need? Special University Lecture, University of London, 5 July 1994.

Fig. 7 Number of EBS medically refereed cases



Source: Emergency Bed Service. Caseload Report. 1992 & 1994.

What next?

When the King's Fund Commission published its report on London, in June 1992, it received considerable cross-party support. Even within London, there was relatively little dissent from the main conclusions and recommendations. The climate of opinion now is very different, at least as far as reductions in acute hospital beds are concerned. It seems essential to take that message on board, without losing sight of the reasons why, in the long term, the case for changes in the balance of health services in London remains overwhelming.

A highly sensitive issue currently is the financial allocation for the NHS in London.[11] For almost 20 years the assumption, based on the formula initially devised by the Resource Allocation Working Party in 1976,[12] has been that London is overfunded, even taking account of deprivation, London's high costs and other factors. The King's Fund's London Commission operated on that assumption, although we emphasised that it was important to check that London receives its fair share of NHS resources. What seems crucial, however, whatever the outcome on the formula, is that any increase that there may be in funding for London is not used as an excuse to evade the need for change. By all means let us use it to smooth what is bound to be a difficult path – by investing in nursing homes and community hospitals, for

example, and by bringing about the powerful new acute hospital groupings that are needed – but let us use it to change balances, not to preserve the status quo.

It seems to me that a sensible strategy for the next stage of development in London should include the following:

- *No more acute bed reductions overall, and great care about A&E departments, while the pressures on both remain as intense as they are now.* It is important to recognise that the closures to date are not centrally planned but piecemeal, as a result of the funding pressures on providers. With centrally dictated closures, the situation will get even worse, unless measures are taken in advance to offset their impact. Everyone concerned needs to put their heads together both to contain the situation and to use the available resources to best effect. Closing beds by itself simply restricts services with relatively little saving and a disproportionate effect on service levels. This is precisely the opposite of an intelligent response, but one that is often forced on the providers, unless they and the health authorities put their heads together in advance to deliver other options. The evidence suggests that some parts of London are coping better than others in equally constrained circumstances. Whatever the financial pressures, there is an absolute responsibility to ensure that in each locality the NHS can provide good care to all those who need it.

- *Continue to develop primary care, very broadly defined.* To date, this has mainly been about addressing basic deficits in general practice, for example in premises. We need to go far beyond that, also addressing the deficits in nursing and residential homes, and strengthening community-based health services. Some groups in London may also need less conventional solutions, such as 24-hour primary care centres or community hospitals that are working alliances between the community, general practice and what we have traditionally defined as hospital medicine. What is going on needs to be recorded, communicated and assessed so that we can see, from a wide range of initiatives, what works and what it costs. Both the public and those working in the NHS, including the GPs, need reassurance that what is happening is not simply a dumping of work and patients from hospital to overstretched general practice.

- *Restate the long-term objectives for London, the vision of what pattern of services we collectively intend to create.* This must cover teaching and research, as well as clinical services. Quality is as important as quantity. The message has to be non-polemical and non-political, but clearly and carefully argued, taking on board all the evidence, including people's misgivings. It must address questions of timing and implementation (the 'when' and 'how' questions, as well as the 'what'). Much continuing effort will need to go into explaining the vision, listening to reactions and examining new evidence as it becomes available. It should not be a fixed blueprint, but a commitment to a direction of movement. The Government should be

forthright about the fixed points in its policy, for example which major institutions are to merge, and specific about the capital funds available to help create new patterns of service.

- *Maintain transition funding for London for the next three years, in return for explicit agreements from each health authority about the changed balance of services that they and their providers are to bring about.* In several areas of London, the financial situation is one that continually threatens to go out of control and to drive damaging cutbacks in service. At times, this threat can be used as an excuse for inaction. Equally, however, it often represents a situation in which even the most committed become helpless. The scale of change called for in London is such, and the risks so high, that it is imperative to pace it and to engage the combined efforts of all the stakeholders.

Bringing about change of the scale required in London's health services was never going to be easy. The experience of the past 18 months has underlined that fact. There have been gains, for example in primary care and in acceptance of the proposed university-based regroupings. There have also been weaknesses, with a deterioration in many London hospitals, a decline in public confidence and a lack of communication of what is actually happening.

We now need rather less attention to the private negotiation of 'right' answers and a lot more to managing the present situation and the processes of constructive change.

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Appendix

BOX 1

THE LONDON HEALTH PLANNING CONSORTIUM

The London Health Planning Consortium (LHPC) was set up in 1977 to:

identify planning issues relating to health services and clinical teaching in London as a whole; to decide how, by whom and with what priority they should be studied; to evaluate planning options and make recommendations to other bodies as appropriate; and to recommend means of co-ordinating planning by health and academic authorities in London.

(LHPC, 1980b)

RADIOTHERAPY

What the LHPC proposed

There were 16 radiotherapy units in London in 1980. The LHPC proposed that one unit, Oldchurch, should close; another, Mount Vernon, be transferred to Luton; and 12 other units should merge to become joint units with radiotherapy on one site. The proposed units were:

- Hammersmith/Charing Cross Hospitals
- London/St Bartholomew's Hospitals
- Middlesex/St Mary's/University College Hospitals
- St Thomas'/Westminster Hospitals
- North Middlesex/Royal Free Hospitals
- Guy's and King's College Hospitals.

What happened

The units in the Middlesex and University College Hospitals merged and the unit at St Mary's Hospital closed.

(CONT.)

BOX 1 CONTINUED

CARDIOLOGY AND CARDIOTHORACIC SURGERY

What the LHPC proposed

In 1978, there were 17 centres, excluding postgraduate hospitals. Some, such as Northwick Park, undertook major cardiac investigations only. It recommended the closure of units at Harefield, St Mary's, Westminster and Brook Green Hospitals. It also recommended the closure of the London Chest Hospital (a part of the National Heart and Chest Hospitals Special Health Authority (SHA)) and transfer of the service to the Royal Free Hospital, which was then a small unit.

What happened

Units in Northwick Park, North Middlesex and Westminster Hospitals closed.

NEUROSCIENCES

What the LHPC proposed

Neurosurgery was provided in 11 centres, excluding postgraduate hospitals. Neurology was also provided in nine other centres, six of which were in Inner London, three in Outer London.

The LHPC supported the policy that both neurologists and neurosurgeons should work from specialist centres, serving a population of 1.5 million. It recommended that Westminster, King's College, Central Middlesex and Oldchurch Hospitals stop undertaking neurosurgery.

What happened

Units in Central Middlesex and Westminster Hospitals closed. The unit at King's College Hospital was transferred to a joint unit with Guy's Hospital at the Maudsley and Royal Bethlem SHA. There has been little change in the number of centres providing neurology without neurosurgery.

(Sources: LHPC, 1979, 1980a, 1980c)

BOX 2
THE LONDON SPECIALTY REVIEWS

Six reviews of specialist (tertiary) services were carried out in the early part of 1993 as part of the Government's response to the Tomlinson inquiry. The services reviewed were: cancer; cardiac; children's; plastic surgery and burns; neurosciences; and renal. Their reports offered recommendations for the future organisation and provision of these services.

COMPOSITION AND TERMS OF REFERENCE

Each review was chaired by a leading clinician from outside London who worked closely with a senior London purchaser. Membership of the group included specialists (medical, nursing, and therapeutic), public health doctors, general practitioners and representatives from voluntary organisations.

The timetable was tight at a little over three months.

Ten common factors were identified for the framework of the reviews and customised to the individual services. These factors covered a range of activities and issues, including the design of appropriate models of care for patients, service specifications for tertiary centres and an analysis of services currently available in London.

Recommendations

The review groups presented a set of proposals for the delivery of care in June 1993.

The simplified chart overleaf indicates that the review recommendations, if implemented, would virtually halve the number of specialist units in London.

The recommendations related to individual units were made on the basis of dividing London into five segments. In each segment, one or two existing hospitals emerged as the site for most of the proposed reorganised specialties. Thus, UCH/Middlesex, Guy's/St Thomas', St George's, Charing Cross/Hammersmith, the Royal London/Bart's, would potentially become mega centres of specialist expertise. The rationale for these proposals was the need to link centres with the colleges of London University and have services provided at sites accessible to London's main transport arteries.

(CONT.)

BOX 2 CONTINUED

The reviews themselves, however, offered much more than numbers. They presented models of care for the future and opened up for debate some important issues about the outcomes, organisation and resourcing of specialist services in London. Their recommendations included:

- the need to reorganise specialist services to make them more effective and more accessible to patients;
- that specialist centres should be linked to district general hospitals through to primary and community care services and to people's homes;
- the need for better data to inform decisions particularly on quality and outcomes;
- the need to link services with research and teaching.

Existing Specialist Units	Recommendations
Cancer – 15 existing units	Reduce to 3 with 1 further site to be considered
Cardiac – 14 existing units	Reduce to 8 with 1 further site to be considered and 1 new unit outside London
Plastic and Burns – 12 existing units (excluding 2 outside London)	Reduce to 6
Neurosciences – 11 existing units	Reduce to 4 with 2 further sites to be considered
Renal – 12 existing units	Reduce to 5 with 3 further sites to be considered
Total 64	Total 31 plus 7 further options

Children's services are excluded from the above because existing provision (at 18 sites) is substantially at secondary level. The recommendations refer to 2 or 3 tertiary centres created by better links between Great Ormond Street and the Royal Free, and/or the Whittington, and Guy's or St Thomas'. One of the major recommendations of this review was that children should be treated as close to home as possible.

BOX 3
MEDICAL EDUCATION AND RESEARCH – UPDATE (MID-1994)

Imperial College – agreement in principle to merge with Imperial/St Mary's by Charing Cross and Westminster Medical School; clear intention to associate by National Heart and Lung Institute and by the Royal Postgraduate Medical School; no clear intention yet by Institute of Cancer Research.

University College London – close relationship intended to lead to merger with Royal Free Hospital Medical School; and good progress in discussions with the Institute of Child Health, Institute of Neurology and Institute of Opthalmology.

Queen Mary and Westfield College – commitment to merge by St Bartholomew's Hospital Medical College and the London Hospital Medical School, with agreement on the constitutional framework; and good progress made on association followed by merger with the Institute of Dental Surgery.

King's College London – agreement in principle to merge with United Medical and Dental School but progress currently dependent on decisions on the Guy's and St Thomas' sites; and agreement for association, leading to merger with the Institute of Psychiatry.

BOX 4

THE UNCERTAINTY OF CHANGE IN LONDON

The last two years have been a period of considerable uncertainty for the London hospitals. This is reflected in the chronology laid out below.

In the case of Charing Cross, there was a firm recommendation to close from Tomlinson. After some further analysis by the North West Thames RHA and LIG, this proposal changed to one of combining with the Chelsea & Westminster, followed by the current option where it is first to be a major partner in the Hammersmith Trust configuration.

In the case of Guy's and St Thomas', from a position of flagship first-wave trust, Guy's seems now unlikely to function as either a general or specialist hospital with all major services transferring on to the single site at St Thomas', although this has not stopped speculation regarding the extent to which any services will remain on the Guy's site.

This simple exposition masks the considerable quantity of analysis and negotiation behind these decisions, and does not capture the substantial uncertainty which the process of change has induced.

GUY'S/ST THOMAS'

23 October 1992
The Tomlinson report recommended a single management structure with the task of rationalising on to one site within two years. The choice of site was finely balanced. The immediate implication was the Guy's/Lewisham Trust to be split.

16 February 1993
The Secretary of State publishes *Making London Better.* Consultation has been initiated on the merger of Guy's and St Thomas' management, and a decision will be taken in March on the proposed trust structure with the new Board to bring forward the proposal for the consolidation within six months.

1 March 1993
Tim Matthews (from St Thomas') is appointed Chief Executive of the new Guy's and St Thomas' Trust (which takes effect on 1 April 1993). The Secretary of State approves trust status on 16 March.

23 June 1993
The reports of the six independent specialty reviews are published. These tend to favour Guy's if, as anticipated, there is a closure of either the Guy's or St Thomas' site.

(CONT.)

BOX 4 CONTINUED

28 September 1993
Guy's and St Thomas' Trust announces plan to reduce staff by 30 per cent over the next five years.

5 November 1993
Board of Guy's and St Thomas' recommends that both sites should remain open, with Guy's losing A&E and becoming a smaller specialist hospital.

10 February 1994
The Secretary of State announces proposal to concentrate acute hospital and specialist services on the St Thomas' site and the establishment of a group to agree a development plan for the future of the Guy's site, which will become an academic campus for King's College with some day surgery and outpatient facilities.

CHARING CROSS

23 October 1992
The Tomlinson report recommended that the site no longer be used for general district services, with a proposed relocation of Royal Brompton and Royal Marsden to the site, or failing this, disposal of site.

7 December 1992
A report commissioned by Royal Marsden/Royal Brompton suggests that Tomlinson financial analysis is flawed and costs of closure of these hospitals have been underestimated.

16 February 1993
The Secretary of State publishes *Making London Better.* Case for relocating Royal Marsden/Royal Brompton to Charing Cross is rejected and the two SHAs are asked to submit joint trust application. LIG to work with North West Thames RHA and local purchasers to develop detailed proposals for future of Charing Cross by the autumn.

23 March 1993
Consultation begins on closure of Charing Cross's A&E unit.

23 June 1993
Reports of the six independent specialty reviews are published. Review groups were aware of ongoing review of future of Charing Cross. Specialty services for cancer, neurosciences and plastic surgery compared favourably with other centres in London, and clinically Charing Cross was the preferred option.

(CONT.)

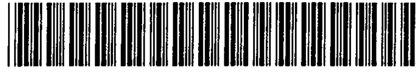
BOX 4 CONTINUED

7 October 1993
The Secretary of State defers decisions on a number of London trust applications including all SHA hospitals and Riverside hospitals (Charing Cross and Chelsea & Westminster).

15 November 1993
Riverside hospitals group announces shortfall of nearly £900,000 in first half of 1993/4. Cuts in services are planned at Charing Cross.
A recommendation on the joint fate of Hammersmith and Charing Cross Hospitals is expected by the end of 1993.

27 January 1994
Riverside Acute Hospitals Trust application is withdrawn. Hammersmith, Charing Cross, Queen Charlotte's and Acton Hospitals to develop a joint trust proposal by March.

21 March 1994
Hammersmith Hospitals NHS Trust, incorporating the four hospitals mentioned above, is accepted by the Secretary of State to take effect from 1 April 1994. This is the favoured option of the hospitals and medical schools following a review by LIG and North West Thames RHA. The Trust will operate from its main sites for the foreseeable future.

King's Fund

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