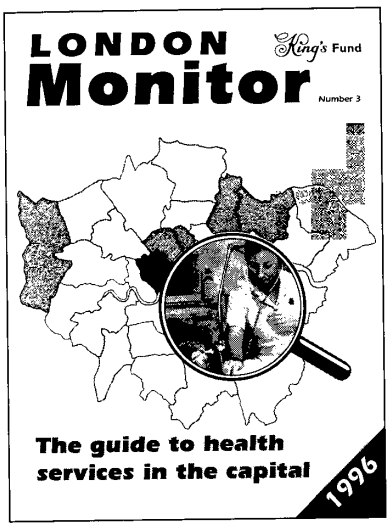
LONDON Monitor

King's Fund

Number 3

The guide to health services in the capital

1996



LONDON Monitor

Number 3

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Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

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First published 1996

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ISBN 1 85717 104 7

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD
Tel: 0800 262260
Fax: 0800 262266

Designed and printed in Great Britain by Intertype

Cover photograph by Alison Forbes

Foreword

The aim of *London Monitor* in this third annual edition remains essentially the same as in previous years: to provide an overview of what is happening in London's health services, to comment on these developments in an informed and even-handed way, and to supply a forum for responsible discussion. As last year, there are three parts. The first part is in two sections: a calendar of events, as they entered the public domain, and the Editor's commentary on health service developments in the capital. Second is an analysis of facts and figures. Finally, the third part comprises commissioned contributions to debate: in this instance on psychiatric emergencies (by Duffett & Lelliott); the London Ambulance Service (by Kathy Jones); the Emergency Bed Service (by Francis Dickinson); the development of a primary care resource centre (by Darkins & Sibson); and an analysis of trends in emergency admissions to hospital in London (by Chris Garrett).

What stands out from this material taken as a whole is a complex picture, justifying both optimism and pessimism. The pessimists may question whether change is needed in London at all (as opposed to just more money) or – if it is needed – what progress has actually been made. The optimists will be less gloomy. Thus, for example, the concept of five sectors, three north of the Thames and two south, provides an important framework both for academic development and for the rationalisation of hospital services in all parts of London. One of London's long-standing problems is the fragmentation of specialist services (cardiothoracic, neurosciences, and the others examined in the 1993 Specialty Reviews). The five sectors provide a sound rationale for determining the numbers of centres undertaking any one such supra-district service, and for working out the 'hub and spoke' relationships between it and the other hospitals in its sector. Of course some aspects of the NHS have to be considered across London (and even the nation) as a whole, but for many purposes that is simply too large a canvas to be manageable, whereas the five sectors are the right scale to develop service networks and relationships that will provide good care at an affordable price.

Meanwhile London's hospitals continue to be under great pressure, and yet its health authorities are faced with the need to cut expenditure. Substantial investment (£210 million to date) has been made in primary care development but, not surprisingly, the impact of this will take time to show. Nor can it necessarily be assumed that stronger primary care will automatically relieve pressure on the hospitals. Among the interlocking problems in London there continues to be the deficit in residential care for older people and a sluggishness in the processes of assessing people for community care, so that typically in any London acute hospital there will be patients who cannot be discharged for social, rather than medical, reasons. This is not good for their care, quite apart from the back-up effect throughout the hospital, resulting in admission problems and trolley waits that are totally unacceptable. This situation has to change, but will not be resolved easily. Equally there are, of course, obvious problems around the admission and discharge of people who are seriously mentally ill, as the paper in this edition of *London Monitor* by Duffett & Lelliott (particularly the vignettes in it) dramatically illustrates.

It is now some three years from the Government's acceptance of Professor Tomlinson's recommendations for London, and three and a half years from our own London Commission Report. The decisions around the main academic centres represent substantial progress, provided that the money is forthcoming to implement them, and they also provide the basis, in the five sectors, for developing hospital services for London. A start

has been made on strengthening primary care. These initiatives have a long way to go, but they are heading in the right direction.

While the King's Fund will continue to emphasise the need to take great care with the pace and handling of implementation, we support the broad strategy for change. We do, however, also judge it timely to take another hard look at the issues in terms of the next chapter of development for London's health services, concentrating in particular on the needs of people who are mentally ill and on older people, who typically have a complex combination of medical and social needs. In June 1995 we therefore reconvened the King's Fund London Commission, which is now working on a research programme with the objective of reporting inside 18 months from now. Research reports to the Commission will, we hope, be issued as they become available between now and then, as contributions to people's understanding of the complexity of London's health and health care.

That is also the purpose of *London Monitor:* not to put forward a partisan view of London's health services, but to inform the debate. We hope that everyone, whatever their opinions and allegiances, will find it of value.

Robert Maxwell
Secretary and Chief Executive
King's Fund
January 1996

Acknowledgements

I would like to acknowledge the support of a number of people who have made this issue of the *London Monitor* possible.

First, I would like to thank Richard Hamblin for his major contribution. I would also like to thank my colleague, Anthony Harrison, who, usually at very short notice, has given valuable comments on the text.

I wish to acknowledge the support of the King's Fund library staff who have provided material for the calendar of events in London. I would also like to thank colleagues in the Department of Health for providing data, and those London purchasers and Trusts who have been a constant source of information on events in London.

Profound thanks are due to the King's Fund Communications Unit – to Alison Forbes, Minuche Mazumdar, Lyndsey Unwin, and Ian Wylie, and in particular to Giovanna Ceroni, who has been responsible for the substantial design changes to this year's *Monitor*. I should mention also Martyn Partridge and his colleagues at Intertype who have made a reality of the final product.

I would like to thank the contributors to the Analysis and Debate section of the *Monitor* for producing – to deadline – a series of stimulating articles which I believe will add to the knowledge and understanding of issues surrounding the provision of emergency health care in London.

Finally, I wish to thank Robert Maxwell, Secretary and Chief Executive of the King's Fund, for once again giving me the opportunity to produce a monitor of health and health care in London.

I would like to end by taking this opportunity to encourage readers to contact me with comments on this issue or ideas for future *London Monitors.* As ever, any errors of fact or interpretation remain my responsibility.

Seán Boyle
Editor

Part 1
The last 12 months

Calendar of Events

This calendar attempts to capture the flavour of events as they entered the public domain, and has thus drawn from several sources. It includes items which were widely reported in the newspapers of the day, as well as in health service and medical journals. It has been checked against Department of Health press releases, for accuracy and authoritativeness, and also against material which has been made available to the editor by London purchasers and Trusts. Finally, a number of original published reports have been used as a source. It should be read in conjunction with the Commentary which follows on page 22.

January 1995

4 **A report** by the Department of Regional Planning at Cardiff University claims that GPs in deprived areas of London are underfunded by £2.5 million because the Government bases payments on the 1981 rather than the 1991 Census.

9 **Baroness Cumberlege,** Parliamentary Under-Secretary of State for Health, announces £425,000 worth of funding for projects in London concerned with promoting good practice in treating patients from minority ethnic groups.

9 **Fiona Wise,** Chief Executive of the Enfield Community Care Trust, announces that 40 Trust beds are permanently blocked, attributing the problem to the lack of funds for local authorities and the inappropriate provision of social care in hospital beds.

10 **A report** of the inquiry into the London Ambulance Service (LAS) led by William Wells, Chairman of South Thames Regional Health Authority (RHA), while acknowledging progress since the collapse of the computer-aided dispatch system in October 1992, highlights high rates of absenteeism, inadequate technology, weak management and misuse by the public as contributing to the service's difficulties. The inquiry, which followed the death of an 11-year-old girl in east London, recommends an extra £3 million a year funding. Virginia Bottomley, Secretary of State for Health, welcomes the report and announces that the LAS should prepare for Trust status in April 1996 but leaves decisions about future funding of the service to North and South Thames RHAs.

11 **Two leaked reports** commissioned by inner London health authority chief executives, *Hospital Services for London* and *Is There a Crisis in London's Healthcare?*, argue that the rapid reduction in London's hospital beds, exacerbated by a lack of suitable residential care, has led to considerable pressure on London's acute services which could *'assume the proportions of a crisis if there was a bad winter'.*

13 **St Bartholomew's Hospital** (Bart's) ceases to take emergencies from 999 ambulances as part of the run-up to the closure of its A&E department.

18 **Gerald Malone,** Minister for Health, in a meeting with delegates from the London Boroughs Association and the Association of London Authorities, rules out a change in the NHS funding formula and the creation of a single NHS management office for London.

19 **Baroness Cumberlege,** Parliamentary Under-Secretary of State for Health, announces funding for a £100,000 project evaluating new midwifery practices at Chelsea and Westminster Hospital and King's College Hospital as part of the 'Changing Childbirth' programme.

23 **David Bennett,** Head of Intensive Care (ITU) at St George's Hospital, Tooting, warns that emergency beds in London are under such pressure that London's hospitals may not have the resources to cope with a major disaster inside the M25.

24 **Homerton Hospital** in Hackney, which was expected to take more emergency cases following the closure of Bart's A&E to 'blue light' ambulances on 13 January, has on occasion been overwhelmed by the increase in A&E attenders, which has at times caused temporary closure of its casualty department.

26 **Consultants at Bart's** deliver a vote of no confidence in Sir Derek Boorman and Gerry Green, Chairman and Chief Executive of the Royal Hospitals Trust. However, Sir Derek, pointing out that the consultants at Bart's are not a majority of the total consultant staff of the Trust, announces that he has no intention of resigning.

27 **Following months of protest,** the A&E department at Bart's finally closes. It will be replaced by a minor injuries unit.

31 **Robert Creighton,** former Principal Private Secretary to the Secretary of State for Health, is appointed chief executive of the Great Ormond Street Hospital for Sick Children.

February 1995

2 **Howard Baderman,** Clinical Director of A&E at University College Hospital, in evidence to the House of Commons Health Committee, suggests London's helicopter ambulance service is inappropriately used, hazardous to operate and guilty of taking patients to the wrong hospital. He suggests its £2 million funding could be more appropriately used.

5 **The problem of inappropriate referrals** to London A&E departments is highlighted when a GP refuses to treat Gerald Malone, Minister for Health, suggesting instead that he attends the local casualty department.

6 **A report** by inner London health authority chief executives, *Hospital Services for London,* while confirming the broad strategic direction of change in acute services, concludes that improved provision for the care of older people is needed if there are to be further cuts in London's acute beds. It notes that until very recently London had poorer access to nursing home and residential care than the rest of the country. It also notes that bed occupancy in London, commonly at 90–95 per cent, is too high to deal with significant numbers of emergency referrals.

7 **Tom Sackville,** Parliamentary Under-Secretary of State for Health, orders a review by health authorities of intensive care facilities following the publication of two research reports, one by Dr David Bennett of St George's Hospital, Tooting, the other commissioned by the Department of Health from the London School of Hygiene and Tropical Medicine.

9 **Demonstrations** to support Guy's and Bart's hospitals are held in London. Over one million signatures supporting the 'Save Guy's' campaign are handed in at Parliament. Meanwhile, pensioners gather in Trafalgar Square to show solidarity with Bart's.

9 **Shaw Edwards** is appointed chief executive of North Middlesex Hospital Trust, a position he has held on secondment from accountants, Ernst and Young, since 1994. Patricia McCann is appointed chief executive at St Mary's Trust.

14 **Homerton Hospital** asks the LAS to take emergencies elsewhere until further notice, as it is unable to deal with them. The hospital claims this is not related to the closure of Bart's A&E department but is due to the annual peak in respiratory infections and the number of older people too frail to send home.

16 **A Labour Party report,** *A Tale of Two Services,* compares the performance of the LAS unfavourably with the London Fire Brigade which is controlled by local government, claiming only two-thirds of ambulances reach their destination inside 14 minutes: over 90 per cent of fire engines arrive within five minutes.

17 **Consultation** on the future of Guy's Hospital ends. The 'Save Guy's' campaign tries to extend the consultation period, claiming that the failure of Guy's and St Thomas' NHS Trust to publish a full business case invalidates the process.

19 **London Health Emergency,** the health care pressure group, claims that NHS waiting lists in London have risen by 5 per cent in the previous year.

22 **Announcing the intention to establish** a second King's Fund London Commission, Robert Maxwell, Chief Executive of the King's Fund, an independent health care charity, criticises the pace and process of change in London's health services. The new Commission will look more closely at mental health in London and the process of change as distinct from the changes themselves.

23 **A Labour Party motion** in the Commons calling for a moratorium on bed closures in London is defeated. During the debate the Secretary of State for Health announces an extra £85 million for primary care in the capital.

28 **The period of public consultation** on Hillingon Health Agency's *Proposals to Change Services at Mount Vernon and Watford Hospitals NHS Trust* ends. The document proposes the replacement of the A&E department at Mount Vernon Hospital in north west London with a minor injuries unit.

March 1995

1 **A report** by the York Health Economics Consortium for the Medical Council of St Bartholomew's Hospital, *An Evaluation of the Consultation Document 'Health Services for the Future'*, finds the business case put forward for closing Bart's unconvincing. In a detailed critique it argues that: the process of generating options has not met the requirements of the NHS Executive *Business Case Guide;* a number of other options should have been considered; and sufficient uncertainty exists around estimates of net revenue savings to call into question the recommendation for a single-site option at the Royal London's Whitechapel site. Bart's Medical Council strongly opposes this option.

3 **Lambeth, Southwark and Lewisham Health Commission,** following a three-month public consultation, recommends inpatient services are eventually brought together on St Thomas' site, but that Guy's A&E department should stay open until at least 1999.

7 **A 30-year-old** Sidcup man dies from brain injuries after a 200-mile flight to find a bed. The man was taken to Queen Mary's Hospital, Sidcup, but needed specialist neurology care, and eventually was taken by helicopter to Leeds General Infirmary when it proved impossible to find a specialist bed nearer to London.

8 **A spokesman** for King's College Hospital confirms that in the previous two months there were five occasions when patients had been forced to wait for long periods in temporary wards in the middle of the casualty department. The hospital is investing £10 million in a new A&E department.

8 **A 48-year-old** cancer patient dies after spending nine hours on a trolley at Northwick Park Hospital. Speaking a month later, Mike Cole, Chief Executive, commented, *'I am very concerned to hear of this; I have asked the Director of Nursing and the Director of Operations to investigate this as a matter of urgency'.*

9 **Sue Osborn and Susan Williams** are appointed joint chief executive of Barking and Havering Health Authority.

10 **The Department of Health** announces an investigation into the death of a patient on 7 March following a 200-mile flight to Leeds in search of a specialist bed. The investigation will focus on procedures used to locate a suitable hospital.

11 **'Intensive Care in the Ailing UK Health System',** a letter published in the *Lancet* by three ITU consultants at St George's Hospital, Tooting, warns that the hospital's ITU beds are almost always full and have no spare capacity.

11 **Sir Montague Levine,** Southwark coroner, rules that there was *'carelessness in some points'* after a patient's body was found in the boiler room of St Thomas' Hospital, a month after he went missing from a ward.

13 **Following public consultation,** East London and the City Health Authority recommends that acute services are centred at the Royal London Hospital, effectively consigning Bart's Hospital to closure.

28 **The National Hospital for Neurology and Neurosurgery** is rumoured to be the latest specialist institution in London to face merger.

30 **A Department of Health** inquiry into the death of a Sidcup man on 7 March who was flown to Leeds in search of a specialist bed claims that a bed was available in the London area at the time. The inquiry recommended: written procedures covering contact between referring hospitals and specialist centres; setting out clearly roles and responsibilities; a register of ITU availability in the Thames regions; ITU bed management procedures and a co-ordinated approach to bed usage between specialist neuroscience centres to help anticipate and manage demand.

30 **Some London NHS hospitals** earn large sums from treating private patients. Guy's and St Thomas' NHS Trust generated £8.4 million, and the Royal Free Hampstead, St Mary's, King's Healthcare and Harefield Hospital Trusts were in the top ten nationally.

31 **City of London** businesses and councillors draw up plans to recreate Bart's Hospital as a community hospital providing health facilities for businesses in the City. The aim is to have medical staff in any office in the City within four minutes in the event of a medical emergency.

April 1995

4 **The Secretary of State for Health** provokes protest from her own backbenchers when she releases news of the eventual closure of Bart's Hospital via a written response to a Parliamentary Question. Denouncing her for a lack of *'moral courage'*, backbenchers with constituencies close to threatened hospitals warn that they will not support the Government in any debate about health policy in London. She also announces: the closure of the London Chest Hospital and transfer of services to the Royal London site; the concentration of Guy's and St Thomas' NHS Trust inpatient services at St Thomas'; the transfer of acute services at the Brook and Greenwich hospitals to the Queen Elizabeth Military Hospital site; the transfer of inpatient services from Edgware Hospital to Barnet General; the strengthening of neurosurgery and neurosciences at King's College Hospital to replace services currently at the Brook Hospital; further development of the Homerton Hospital and of A&E services at King's College and Lewisham hospitals.

5 **Peter Brooke,** Conservative MP for the City of London constituency which contains Bart's Hospital, forces the Secretary of State for Health to defend closures of London hospitals in the Commons. Attacked by both the opposition and her own backbenchers, she defends the proposed changes, arguing that they have *'widespread support in the clinical and academic worlds'.*

6 **The Labour Party** claims that the number of operations cancelled at the last minute in London has risen by 14 per cent since 1992.

8 **Sir Bernard Tomlinson,** chairman of the 1992 inquiry into London's health services, recognises that public reaction to his report has been negative but nonetheless continues to argue the need to shift resources from acute to primary care.

10 **A Parliamentary Question** reveals that 50,000 Londoners have lost their NHS dentist since 1992. The British Dental Association blames the fact that many dentists will take only private patients on the low payments they receive for NHS work.

12 **The 16 London health authorities** agree to fund an extra 300 LAS staff.

13 **A first-wave GP fundholding practice,** the Taylor Practice in Islington, has withdrawn from the scheme denouncing it as *'dangerous and indefensible'* and claiming that, since joining the scheme, doctor-patient relations have deteriorated.

18 **National Audit Office** investigates the construction of Philip Harris House at Guy's Hospital which is two years behind schedule and where costs have risen from £61.5 million to £152 million.

19 **John Bowis,** Parliamentary Under-Secretary of State for Health, announces the publication of *Mental Health Task Force London Project: Follow-up report* claiming that *'London health authorities are tackling issues systematically and are making progress ... it is unrealistic to expect dramatic changes in six months but many improvements have been made'*. However, a Royal College of Psychiatrists survey, *Monitoring Inner London Mental Illness Services,* reveals that, of patients requiring admission on the survey day, over half were sent to distant hospitals. Bed occupancy on psychiatric wards in the capital was over 120 per cent. Dr Paul Lelliott, director of the College's research unit, argues, *'London's psychiatric admission units face serious problems of bed occupancy and violence'*.

20 **Northwick Park and St Mark's Trust** is to review its nursing levels after an inquiry found that on 8 March a dying cancer patient waited nine hours on a hospital trolley because casualty staff were under *'exceptional pressure'*.

21 **Gerald Malone,** Minister for Health, praises Haringey's new £2.3 million Canning Crescent Centre, declaring, *'The Centre forms an integral part of a visionary, comprehensive mental health care service for the people of Haringey'*.

24 **Camden and Islington Health Authority** issues for consultation *Getting Better Together,* which proposes that the University College London Hospitals Trust brings together services currently based at several sites – the Middlesex at Mortimer Street, the Elizabeth Garrett Anderson/Soho Hospital for Women at Euston and the Hospital for Tropical Diseases at St Pancras – on one site at the current University College Hospital in Gower Street.

27 **Camden and Islington Health Authority** pays substantial damages to Chris Johnstone, a junior doctor who had first taken action in 1989 claiming that *'intolerable hours'* led to stress and clinical depression.

28 **Claims** by the Royal College of Nursing that nurses are leaving the profession are supported by figures released by the Labour Party which show that 11 per cent of nurses in London and the South East left the NHS between 1990 and 1993.

28 **Tom Sackville,** Parliamentary Under-Secretary of State for Health, thanks West Ham United Football Club after they print in their match programme details of the NHS Organ Donor Register, together with a coupon for potential donors to use.

May 1995

1 **The Western Eye Hospital,** part of St Mary's Trust, launches its new digital imaging system 'Imagenet'. Gerald Malone, Minister for Health, declares that it represents a major improvement in the care and treatment of ophthalmology patients.

1 **LAS staff** vote 2–1 against changes in shift patterns and reorganisation of station staffing levels. The LAS management intends to implement the changes anyway, claiming that a 65 per cent turnout means that the majority of staff are *'not antagonistic'* to the changes.

3 **London Health Emergency,** the health care pressure group, releases waiting list figures for London showing an increase of 1 per cent between April 1994 and January 1995 to 180,000 patients waiting. John Lister of London Health Emergency claims that this *'nails the lie that London is "over-provided" with health care'*. A Department of Health spokesperson responds that the length of wait, which has fallen recently, is more important than the actual numbers waiting.

4 **An Independent Panel of Inquiry report** into the circumstances surrounding the deaths of Ellen and Alan Boland, delivered to Kensington, Chelsea and Westminster Health Authority, North West London Mental Health Trust and Westminster Council, and concerning a psychiatric patient who hanged himself in Wandsworth Prison while on remand for the alleged murder of his mother, concludes that Mr Boland would *'probably have slipped through the net of provision recently put in place which is designed to concentrate on people suffering from very severe mental illness'.*

8 **The A&E department** at Homerton Hospital in Hackney is closed again for 39 hours due to insufficient beds to deal with a sudden surge in admissions.

9 **Government figures** show that the number of GPs per 1,000 London residents has remained largely unchanged between 1991 and 1994.

10 **A Labour Party motion** condemning the Government's London health care policy is defeated by 320 to 308 votes. Conservative MPs Peter Brooke and Sir John Gorst vote with the opposition and three others abstain. In the debate, Virginia Bottomley, Secretary of State for Health, issues a seven-point pledge including the promise not to close hospitals until an alternative and better service is in place.

11 **Virginia Bottomley,** Secretary of State for Health, faces a second inquisition inside 24 hours over plans to close London hospitals, this time by the House of Commons Health Committee. She argues that no beds have been lost in east London as a result of the closure of Bart's A&E but agrees that *'if somebody is stuck on a trolley then that hospital is not providing a good enough service'.*

11 **Freemasons** serve a High Court Writ against the Grand Secretary of their controlling body in an effort to prevent the closure of the Royal Masonic Hospital in west London.

15 ***Health in the East End,*** a report from East London and the City Health Authority, claims the healthier suburbs of London are gaining NHS resources at the expense of the poorest parts of the East End. East End residents face a *'triple jeopardy'* of poverty, bad housing and high levels of unemployment.

15 **Opening a new paramedic training centre** at Fulham Ambulance Station, Tom Sackville, Parliamentary Under-Secretary of State for Health, hails the centre as *'very good news for London's emergency services'.* The centre will provide places for 240 paramedics to be trained each year.

17 **The South Thames Neuroscience Review Group** formally announces that the second regional centre for specialist neuroscience services should be based at St George's Hospital, Tooting. The centre will cater for south-west London, Surrey and West Sussex. The creation of the centre will require the transfer of services from Atkinson Morley's Hospital, part of St George's Healthcare Trust. A public consultation concerning this will be held later in the year by Merton, Sutton and Wandsworth Health Authority.

22 **An elderly man** dies of heart failure at St Thomas' Hospital two hours after being trapped in a lift there for 30 minutes. A hospital spokesperson says it is impossible to tell if the incident contributed to his death.

25 **Great Ormond Street Hospital for Sick Children** considers offering staff 'bounties' to bring in new recruits because there is such a shortage of adequately trained staff. Speaking in *Personnel Today* magazine, Deputy Personnel Director, Jessica Wood, reveals, *'We are considering "golden hellos" ... we have between 100 and 120 staff vacancies at any one time'.*

25 **The LAS and health union, Unison,** agree a compensation package over shift changes, thereby averting the threat of industrial action.

26 **Sir Montague Levine,** Southwark coroner, expresses concern at the death of a depressed schizophrenic who could not be seen because of staff shortages.

26 **Medical researchers** at St Thomas' Hospital have developed a blood test for identifying people genetically at risk of osteoporosis. Doctors believe that by identifying those at risk treatment can start early to keep the disease under control.

June 1995

1 **A second King's Fund London Commission** is convened under the chairmanship of Marmaduke Hussey. The first Commission is widely seen as having influenced Government plans for the reorganisation of London's health care. Robert Maxwell, Chief Executive of the King's Fund, emphasises that the Commission envisaged a much longer time frame for change than was advocated by the Tomlinson Report or the Government's *Making London Better.*

1 **John Browett,** the orthopaedic surgeon at Bart's Hospital noted for treating the footballer Paul Gascoigne, announces that he is to quit the NHS, declaring, *'What they have done to Bart's is an absolute tragedy, and act of vandalism'.*

7 **Speaking at a conference** on primary care in Lambeth, Southwark and Lewisham Health Authority, Gerald Malone, Minister for Health, claims that the new NHS is giving Londoners a more flexible and responsive service. He points to developments in primary care in the health authority area which include improvements to 12 premises, 83 more staff in local GP practices and the computerisation of 31 practices.

8 **A pilot study** by the King's Fund and King's College Hospital, *Evaluating a Nursing-Led In-patient Service,* suggests that patients cared for on a ward entirely run by nurses can recover more quickly than those cared for on a traditional ward.

14 **Dr Tony Stanton,** Secretary of the London Local Medical Committees, claims that GP services in London face a recruitment crisis as young GPs are put off applying for posts in the capital because of the problems facing health services. These include difficulties in getting patients admitted, inability to refer patients to a specialist of choice, problems with the LAS, and overwork.

17 **Dr Barbara Ghodse,** Service Contracts Manager with St George's Healthcare Trust, argues that the cost of handling GP fundholder and extra-contractual referral invoices is up to £25 a time. In an article in the *British Medical Journal,* 'ECRs: safety valve or administrative paperchase', Dr Ghodse maintains, *'The vast majority of invoices are for single outpatient appointments worth an average of £50'.*

21 **The Health Committee of the House of Commons** produces a critical report into the LAS. Key problems cited include: poor management which led to industrial relations problems; archaic working practice; reliance on outdated technology; and a lack of political will to address problems that had existed for years. Marion Roe, Conservative chairman of the committee, declares that the LAS is *'spectacularly worse'* than any other ambulance service in the country. Tom Sackville, Parliamentary Under-Secretary of State for Health, comments that the report *'gives insufficient credit for the much-improved performance over the last year'.*

July 1995

3 **Chief executives** from 12 inner-city mental health Trusts across the country, including some from London, have requested £50 million over three years to fund a number of pilot schemes which offer a mix of community and hospital care for people with schizophrenia and other severe mental illnesses.

5 **The second annual hospital league tables** released by the Department of Health show the Royal Hospitals Trust and Guy's and St Thomas' NHS Trust among the poorest performers. Concerns about the validity of the tables among London doctors are summed up by Duncan Cymond, cardiologist at Bart's Hospital, who explains, *'The popular doctors have more referrals, and therefore longer waiting lists. Teaching hospitals tend to attract the most difficult cases, but these tables take no account of that casemix'.*

7 **Stephen Dorrell,** the new Secretary of State for Health, refuses to reverse his predecessor's controversial hospital closures in London declaring, *'I am not in the business of reopening decisions which have already been taken'.*

13 **The Health Ombudsman,** William Reid, criticises a number of hospitals, including several in London, for poor communication with their patients.

13 **North Thames RHA** assembles a 'project team' to oversee developments in health services in the Edgware area, led by Nigel Beverley, director of the region's Trust Unit. The move coincides with the announcement that Wellhouse Trust Chief Executive, Martin Havelock, will leave in September.

13 **Baroness Cumberlege,** Parliamentary Under-Secretary of State for Health, launches a £10 million women's and children's unit at Lewisham Hospital. The unit will contain two children's theatres, four paediatric beds, a parent suite, an ante-natal clinic, a labour suite and a gynaecology ward.

14 **Public consultation** ends on Camden and Islington Health Authority's proposal for the University College London Hospitals Trust to bring together services currently based at several sites – the Middlesex at Mortimer Street, the Elizabeth Garrett Anderson/Soho Hospital for Women at Euston and the Hospital for Tropical Diseases at St Pancras – on one site at the current University College Hospital in Gower Street.

16 **An 18-month trial** at Queen Charlotte's Hospital reveals that old-fashioned midwifery, with the same nurse caring for the expectant mother throughout her pregnancy and the delivery, leads to fewer complications and faster discharge after delivery. Lesley Page, professor of midwifery, says, *'It is back to the old days of the midwife who is out in the community and is part of the community'.*

18 **Doubts** are raised by the *Evening Standard* about the timely completion of hospital building schemes such as the £65 million new site at St Thomas' Hospital, the £239 million reconstruction of the Royal London Hospital and the £69 million Wellhouse Trust project, which will need to seek private capital under the Private Finance Initiative before they can gain access to public funds.

19 **Stephen Dorrell,** Secretary of State for Health, in evidence to the Health Committee of the House of Commons, guarantees that *'no changes will be introduced into the health care available in London until* [he is] *satisfied that the changed provision will be an improvement on the provision that is there now'.* He does not intend to revisit fundamental decisions that have been made, and acknowledges *'the traditions of the great teaching hospitals in London as being important but those institutions need to change in order to respond to the needs of today's and tomorrow's patients'.*

20 **The merged medical school** of the National Heart and Lung Institute, St Mary's, Charing Cross and Westminster and the Royal Postgraduate Medical School at Hammersmith Hospital is to be housed in a new £61 million biomedical sciences building at Imperial College in west London.

24 **Dr Paul Knapman,** Westminster coroner, orders an investigation into the operation of the London helicopter ambulance service after the death in May of a 79-year-old woman in Chelsea who waited 30 minutes for an air ambulance. A report by Sheffield University, *Effect of London Helicopter Emergency Medical Service on Survival After Trauma,* found *'no evidence at all that the London helicopter emergency medical service was improving the chances of survival for the whole group of patients with trauma that it attends'.*

31 **Monica Willan,** 81, a regular patient at Bart's Hospital who lives in sheltered housing nearby, wins the right to mount a legal challenge to the closure of the hospital. Mr Justice Sedley ruled that her claim that the consultation process leading up to the decision to close Bart's was flawed ought to be argued in court.

August 1995

1 **Stephen Dorrell,** Secretary of State for Health, opens a £500,000 minimal access surgery unit at St Mary's Trust in west London, saying, *'The unit will mean London and Londoners continue to have access to the highest standards of modern medicine'.*

1 **Dr Paul Knapman,** Westminster coroner, at an inquest into the death of a 79-year-old woman in Chelsea who waited 30 minutes for an air ambulance, expresses his concern at the *'undercurrents of dissatisfaction'* about the way the service operated. At the inquest Dr Jeremy Booth, A&E consultant at the Chelsea and Westminster Hospital, described the decision to send for the air ambulance as *'incomprehensible and quite wrong'.*

7 **Stephen Dorrell,** Secretary of State for Health, visiting a Clapham GP practice, praises its planned developments as the first fruits of an investment of £210 million over three years, saying, *'Developing primary care is a talisman for improving London's health care'.*

9 **David Carr,** plastic surgery nurse at the University College London Hospitals Trust, is sacked for alleged gross misconduct after he is accused of arguing *'aggressively'*, a charge which is denied by eye-witnesses. Health union, Unison, claims Mr Carr is being victimised for his opposition to the Trust's plans for multi-skilling.

9 **In an interview** with *The Times,* the Secretary of State for Health, Stephen Dorrell, argues that controversial decisions to close Bart's and Guy's hospitals would only go ahead if they were accompanied by parallel measures producing an overall improvement in the quality of the capital's health services.

10 **Professor Harrison Spencer** is appointed Dean of the London School of Hygiene and Tropical Medicine.

16 **Age Concern,** the pressure group for older people, is anxious over the possibility of Acton Hospital being redeveloped as a nursing home with local authorities buying space. Age Concern believes that older patients could be forced to pay for their treatment there.

18 **The Public Accounts Committee** criticises North East Thames RHA and the Department of Health over the case of Dr Bridget O'Connell, a consultant paediatrician, who was suspended on full pay for 12 years between 1982 and 1994 at the cost of £600,000. Ken Jarrold, Director of Human Resources for the NHS Executive, said that the case was *'regrettable'* but that the NHS was now better prepared to deal with other cases.

19 **Dr Humphrey Needham-Bennett,** psychiatrist at Belmarsh Prison in south London, writing in the *British Medical Journal,* reveals that the health centre at the prison is full of mentally ill prisoners because there are no beds for them in secure hospitals. He comments that *'it is not unusual to wait three months for placement to a secure unit even for an acute psychotic prisoner who is refusing treatment'.*

24 **A proposed development** of a new clinic at the Royal Brompton Hospital, funded by private capital, is put on hold until at least January 1996 in the wake of continuing uncertainty about the future pattern of service provision in west London.

25 **Dr Ian Smith,** head of the lung unit of the Royal Marsden Hospital, condemns the practice of withholding chemotherapy from patients older than 70 or 75. His own studies at the Royal Marsden reveal that older patients benefit just as much from the treatment.

28 **Figures** released by Labour health spokesperson, Tessa Jowell, show that only 42 per cent of under 18's in the Lambeth, Southwark and Lewisham Health Authority area are registered with a dentist, the lowest level in the country.

30 **The Local Government Ombudsman,** Edward Osmotherly, censures Lewisham social services department for causing acute distress to a severely disabled woman by trying to remove her from the carer who had looked after her for the best part of 12 years, saying the woman was done a *'great disservice'* and that her wishes should have been paramount.

30 **The third survey** of 12 inner London mental hospitals by The Royal College of Psychiatrists finds that they are still very overcrowded. On 12 July 1995 there were 122 patients needing care for every 100 beds and 96 patients had been placed in distant psychiatric hospitals – two-thirds of them in private hospitals because NHS hospitals were full. Dr Paul Lelliott, director of the College's Research Unit, comments, *'There are still unacceptable pressures on London's psychiatric services. There are serious problems of over-occupancy and violence'.*

September 1995

4 **An internal inquiry** into the death of a 39-year-old woman at St George's Hospital, Tooting, criticises the post-operative care she received, but blames no individuals. The woman's widower denounces the report, saying, *'No one has been blamed for her death and no one has apologised'.*

14 **Dr Mark McCarthy,** Director of Public Health at Camden and Islington Health Authority, calls for a review of expenditure on HIV / AIDS services. Commenting on the £25 million allocated this year by the health authority to these services, he says, *'I would prefer to see money allocated to other areas for prevention rather than concentrate it within our authority for treatment ... this may mean that our own HIV/ AIDS budget will be reduced in the future'.*

14 **The Association of London Government** announces a three-stage inquiry into London's health care to examine community care, acute hospitals and NHS management.

17 **David Carr,** the plastic surgery nurse sacked by University College Hospital, is re-instated on the eve of a strike to support him.

20 **The Labour Party** reveals figures showing there were a total of 135 temporary closures of A&E departments in London and the South East in the last year. Homerton Hospital had the highest number of closures with 19, including six in May 1995 alone.

21 **Statistics released by the Department of Health** show that 25 per cent of GP premises in London fall below minimum acceptable standards.

22 **A report,** *The Care Gap: hospital services in the London Borough of Barnet,* from pressure group London Health Emergency, for Barnet Local Authority, claims plans to close the A&E department and acute beds at Edgware General Hospital would reduce capacity at the Wellhouse Trust as a whole by 37 per cent, and concludes, *'The Barnet Health Agency plans remain seriously flawed; the danger is that a care gap will be opened up, forcing local people to travel out of the borough for hospital treatment'.*

25 **A report** by Newham Council and East London and the City Health Authority into the stabbing of a fellow voluntary patient at Worlands Day Centre by Stephen Laudat, a known schizophrenic, concludes that a combination of individual error, poor communications and chronic underfunding was responsible for the tragedy. However, the policy of community care *per se* was not criticised.

October 1995

1 **Further concerns** with the quality of mental health care are raised when it is revealed that a mental hospital inpatient who gouged out the eye of a nurse was the next day discharged by a psychiatrist who ruled that his mental state had improved. The patient was later arrested by police and remanded to Belmarsh Prison, in south London.

5 **The annual accounts** of the Royal National Orthopaedic Hospital reveal that £3.5 million has been written off following an abortive scheme to develop an incinerator with a private sector partner. Robin Field, who takes over as chairman, comments, *'I don't think there is any question that the Trust has acted outside its legal powers'.*

5 **Baroness Cumberlege,** Parliamentary Under-Secretary of State for Health, opens a £3 million purpose-built health centre on the site of the old Prince of Wales's Hospital, Tottenham.

9 **The 'Save Guy's' campaign,** Southwark Community Health Council and Simon Hughes, Liberal Democrat MP for Bermondsey and Southwark, file an application to bring a judicial review of the decision to transfer services to St Thomas' Hospital. Their case is based on refusal of access to the business case prepared by the Guy's and St Thomas' NHS Trust which outlined the financial reasons for the reorganisation.

11 **A league table of management spending** at hospital Trusts, based on Audit Commission definitions, reveals that London has the biggest and smallest spenders. The Royal London Homeopathic Hospital spends more than 10 per cent of its budget on management, but the Chelsea and Westminster Hospital spends only 2.1 per cent.

13 **The foundation stone** is laid for the first stage of the £62 million new merged medical school for St Bartholomew's and the London Hospital medical colleges.

17 **Higher than expected use** of intensive care facilities and a slowdown in payments from health authorities have led to a cash flow crisis at Harefield Hospital, which has had to postpone payment of £500,000 worth of bills. Finance Director, Phil Harding, comments, *'This is a temporary hiccup, we expect to be back to normal within two months'.*

18 **The application** made by the 'Save Guy's' campaign, Southwark Community Health Council and Simon Hughes MP, for judicial review of the decision to centralise services at St Thomas', is rejected.

19 **Harriet Harman,** Labour MP for Peckham, becomes Shadow Secretary of State for Health.

20 **Camden and Islington Health Authority** are forced to send psychiatric patients to private clinics as far away as Wales because there are not enough secure beds in the capital. Dr Mark McCarthy, Director of Public Health, comments, *'We are still having to send half the patients who need to be in secure units out of the area'.*

20 **Public consultation** over the proposed merger of the management of the Royal National Throat, Nose and Ear Hospital, King's Cross, and Royal Free Hospital, Hampstead, ends. The proposal aims to achieve management and administration cost savings with no change planned to provision of services at either site.

27 **The cost of structural changes** such as merging Bart's and the Royal London hospitals, the introduction of local special health authority hospitals into the funding equation, together with increasing health needs of a deprived community, have left East London and the City Health Authority with an overspend requiring a reduction in annual expenditure of £7 million. The Department of Health's revised funding formula is widely regarded as not taking enough account of needs of deprived populations, and Janet Richardson, Chief Officer of City and Hackney Community Health Council, declares, *'We are going to see services cut in both the hospital and the community. It is disgraceful'.*

31 **Merton, Sutton and Wandsworth Health Authority** begins a public consultation into the transfer of neurological and neurosurgery services from Atkinson Morley's Hospital to St George's Hospital, Tooting.

November 1995

1 **BBC television programme,** *Here and Now,* reveals that a London fertility clinic has been exploiting a legal loophole to 'buy' human eggs at £1,000 a batch. Professor Ian Craft, head of the London Gynaecology and Fertility Centre, defends the practice, saying, *'Donors and patients are consenting adults and what goes on between them is a matter for them'.* Professor Robert Winston of the Infertility Unit at Hammersmith Hospital declares himself *'genuinely shocked'* by the practice.

2 **The LAS** confirms that the first steps towards a computer-aided dispatch system will be in place by Christmas.

2 **Gerald Malone,** Minister for Health, announces a £35 million package of initiatives, over two years, to attract high-quality GPs to London.

6 **A report** by the Association of London Government, *The Cost of Care,* argues that the Government's funding formula discriminates against London by failing to take sufficient account of the high levels of deprivation in the capital. Also not taken into account, it claims, is that London subsidises medical training for the rest of the country, treats more commuters and has more patients with HIV/AIDS. The report suggests that London receives only 15 per cent of NHS funding as opposed to 21 per cent of local authority social services funding.

8 **Bart's Medical College** is formally merged with the London Hospital Medical College and Queen Mary and Westfield Colleges (QMW). Queen Mary and Westfield Principal, Professor Graham Zellick, describes the merger as *'the beginning of a new chapter for Bart's, the London and QMW'.* The 'Save Bart's' campaign condemns the move.

8 **The new Lord Mayor of London,** John Chalstrey, a former consultant surgeon at Bart's, announces that smoking will be discouraged at official dinners at the Guildhall and Mansion House.

8 **A pioneering screening test** that can identify expectant mothers at most risk of going into premature labour is being introduced at Guy's and St Thomas' hospitals. The new test has been devised by Professor Lucilla Poston, Professor of Fetal Health at St Thomas' Hospital.

10 **A report** by Carey Oppenheim from the South Bank University indicates all 12 of the inner London local authority boroughs are among the 20 most deprived boroughs in England. Within London there are enormous differences with some wards, for example, having unemployment rates eight times as high as others.

15 **Redbridge and Waltham Forest Health Authority** collaborates with the King's Fund, in a scheme to provide information concerning local services for Asian women with mental health problems.

16 **Simon Hughes,** MP for Bermondsey and Southwark, is appointed Liberal Democrat Health spokesperson.

17 **There are further reports** of bed shortages in London with patients being sent to other hospitals or waiting on trolleys. Chris Everrett, the General Manager at St George's Hospital, Tooting, comments, *'We have been very, very busy. We filled up completely at least once this week and are reaching that point again now'.*

23 **A candlelight vigil** to mark the closure of the Brook Hospital is held at Shooters Hill.

30 **Nigel Beverley** is appointed chief executive of Wellhouse Trust and will take up his appointment in January 1996.

30 **Consultants** at Queen Charlotte's Hospital in west London have started to provide remote diagnoses and counselling to expectant mothers on the Isle of Wight. Prototype equipment and a high-speed communications link allow ultrasound images taken on the island to be analysed in London. The same link allows the two medical teams and the patient to see and talk to each other.

December 1995

4 **The second King's Fund London Commission** announces its main areas of research. These will include: mental health, care for older people, systems of delivering care and the management of changes in health services.

6 **Consultation** begins on Ealing, Hammersmith & Hounslow Health Authority's *Proposals to Relocate Queen Charlotte's and Chelsea Hospital,* which recommends closure of Queen Charlotte's and the transfer of services to a new purpose-built maternity unit on the Hammersmith Hospital site in Du Cane Road at an estimated cost of £9 million, which would be realised from the sale of the old site.

7 **In the midst of the latest concerns** about links between 'mad cow' disease and its human equivalent, Creutzfeldt-Jacob disease, Wandsworth Local Authority bans beef and beef products from its schools and nurseries.

7 **Barnet Health Agency** commences a period of public consultation regarding the future of Edgware Community Hospital, which would see the transfer of services from Colindale Hospital and the Northgate Clinics to the Edgware Hospital site, as well as the development of an expanded rehabilitation service, a dedicated 'one-stop' children's treatment and therapy centre, and a low-risk birth unit.

12 **Dr Anthony Inwald,** a GP in Archway, north London, is stabbed twice by a patient in his surgery. He is recovering in Whittington Hospital. His colleague, Dr Ivor Robinson, comments, *'There has always been a feeling that we are vulnerable ... but it is more difficult now because the care in the community programme is discharging people in a way that does not give them adequate support'.*

14 **A research report** commissioned by the King's Fund, proposes a future for Bart's Hospital as a charitable foundation with a combination of state, charitable and private funding, suggesting this as a model for collaboration between the NHS and the independent sector.

15 **Bill Bain,** Chief Executive of the Royal Brompton Hospital Trust, resigns to become vice-president of a health insurance group in his native Canada. Mr Bain speaks of his frustration at a £20 million Private Finance Initiative scheme to provide a new clinic being put on hold, *'I would be less than honest if I said the continuing delays and vacillations ... were not a factor'.*

15 **Public consultation** concerning the merger of the management of the Eastman Dental Hospital and the National Hospital for Neurology and Neurosurgery with University College London Hospitals Trust ends. A decision by the Secretary of State for Health is expected early in 1996.

19 **A report** by the Greater London Association of Community Health Councils, *Diagnosis: crisis,* warns that a rise in emergency admissions combined with the closure of A&E departments is putting unbearable pressure on the NHS in London. The report suggests that lengths of wait in casualty departments were often at variance with official figures, as patients could be seen within five minutes by a nurse to comply with *Patient's Charter* standards, but then have to wait hours to receive treatment.

20 **Harriet Harman,** Shadow Secretary of State for Health, claims that a third of the capital's A&E departments have had to close because of bed shortages over the course of the previous month. A Department of Health spokeswoman is unable to comment on the figures but notes, *'Anyone in inner London is within a three-mile radius of an A&E department'.*

21 **A survey of GPs** in south-west London carried out by London Liberal Democrats reveals that 92 per cent of those questioned had less job satisfaction following the 1991 NHS reforms, and that nearly 40 per cent were considering leaving the profession.

22 **The public consultation period** ends for East London and the City Health Authority's *Developing Hospital Services in Newham,* which proposes the transfer of services from St Andrew's Hospital to Newham General Hospital.

Commentary

This commentary examines six key issues relating to London's health services and concludes by considering what 1996 will hold for the health and health care available to London's residents. These issues are summarised briefly in the box opposite.

Acute hospital developments

At the end of 1994 a number of issues remained unresolved as the consultation process surrounding the reconfiguration of London's acute hospital sector continued. At the same time doubts were raised about the ability of the capital's health care system to cope with an apparent ever-growing demand, involving substantial increases in some areas in the level of emergency admissions, and about the ability of health and local authorities to ensure an effective interface between their responsibilities for community care. This latter issue manifested itself in the difficulties faced by many London hospitals in discharging older people, even though other forms of care were generally agreed to reflect better practice.

Changes in London have been described in previous *London Monitors* in terms of five sectors based loosely on the configuration of London services around five medical education groupings – the east, north-central, north-west, south-east and south. These sectors have gained some acceptance as a means of organising discussion of the capital's services. However, decisions within one sector may have implications across others. The responsibility for overall co-ordination is discussed briefly and potential difficulties are indicated.

East London

The major grouping of acute services in east London remains the Royal Hospitals Trust consisting of services on three sites, the Royal London Hospital at Whitechapel, the London Chest Hospital and St Bartholomew's (Bart's) at Smithfield. Contention has focused on the decision to close Bart's.

At the end of January 1995 the A&E department at Bart's was closed. It was replaced immediately with a minor injuries unit which was projected to treat 250 people a week. Consultation ended in late February on the proposal from East London and the City Health Authority to close two of the three sites, with services transferred to the Royal London site at Whitechapel. In early March the authority confirmed this recommendation. Further controversy was provoked by the manner in which the Secretary of State for Health, Virginia Bottomley, announced Bart's eventual closure – in a written response to a Parliamentary Question on 4 April. Such outrage ensued that she was forced to appear in the Commons the following day to defend her decision.

Nevertheless, the centralisation of services on the Royal London site continues apace. Some doubts about the speed and feasibility of change are raised by the requirement that private sector capital should be sought, under the Government's Private Finance Initiative (PFI). The future use of the Bart's site was also explored by a consultant's report commissioned by the King's Fund. This revisited the case for a single site suggesting the possibility of some public and private sector collaboration to ensure the continued use of the Smithfield site for medical purposes. The final chapter in Bart's history has yet to be written.

Developments have continued in other parts of east London. Sporadic difficulties with high levels

KEY ISSUES

Acute hospitals

In early 1995 the completion of a series of key consultations throughout London about the future shape of hospital services meant that patterns of rationalisation were emerging with some clarity in most of the capital, the exception being the north-west where substantial issues remain, e.g. the location of services between the Charing Cross and the Hammersmith sites. Insistence that all major capital expenditure proposals must be tested by the Private Finance Initiative (PFI) may impose further delays in what is already a rather long drawn-out and difficult process.

At the same time the development of the medical education sites around colleges of the University of London has also required the commitment of substantial capital resources. These have been sought from a variety of sources, including the Higher Education Funding Council for England (HEFCE), which set aside £80 million for capital projects to implement the mergers, as well as the NHS and the private sector.

Primary care

Over 1,000 projects have been initiated, originally under the auspices of the London Implementation Group, but there is little to show yet in terms of improvements in a number of key indicators, as is shown in the Facts and Figures section of this *Monitor*. This may reflect the long timescale required for major change, or it may require some fundamental reshaping of the primary care strategy. Evidence is urgently needed either way.

Mental health services

Problems remain in the area of mental health care. Again there have been a number of reports showing clearly that London is not coping well with current levels of demand. Duffett and Lelliott report on the latest MILMIS (Monitoring Inner London Mental Illness Services) study in the *Monitor's* Analysis and Debate section, illustrating their arguments with accounts of actual cases.

The London Ambulance Service

The London Ambulance Service (LAS) has come in for severe criticism, first from a South Thames Regional Health Authority inquiry, producing the Wells Report, and then from the Health Committee of the House of Commons. However, as the second article in the *Monitor's* Analysis and Debate section argues, there are signs of improvement in 1995. The successful delivery of emergency response services requires a complex management process and equally complex measures of performance.

Conflict between short-term and long-term delivery of services

The programme of change in London is intended to improve the health services available to local residents. However, there is an undercurrent of discontent reflected in the writings, in 1995, of several commentators and patient pressure groups, with some evidence supporting their concerns. Problems have been apparent again at either end of the hospital process: with increased demands being made on the hospital system through emergency admissions resulting in temporary closures of A&E departments and trolley waits for patients; and the other side of the coin, the inability to move people through the system and out of hospital as quickly as is thought appropriate and possible, causing pressures on beds, cancellations of operations and increased waiting times. How real these difficulties are is considered.

Fair shares for London

The issues raised here must be set within the context of a fundamental debate about appropriate levels of funding for London health services. In 1995 there was a deterioration in the financial position of London health authorities at a time when the new formula adopted by the Department of Health for allocating resources to health care would have moved resources in the direction of the capital. This contrary result has come about through numerous other service changes which have brought funds from other sources under the budgets allocated by this formula. Such changes may be logical but have caused difficulties for most London purchasers.

of emergency admissions at the Homerton Hospital are well documented throughout the year. A firm rebuttal of the suggestion of any link between these and the closure of Bart's A&E came from Ron Kerr, Regional Director of North Thames RHA, when questioned by the Health Committee of the House of Commons in May 1995. He acknowledged then that the Homerton had a problem in coping with peaks in emergency demand, but said, '*The problem does not result from the closure of Bart's A&E. It is a problem the Homerton has. We acknowledge that and we are improving bed numbers at Homerton'.*

It had already been planned to open 28 beds at the Homerton. This was brought forward to June 1995 partly to deal with these pressures. It is difficult to be certain about the extent to which any of the increased pressure on A&E facilities at the Homerton has resulted from the closure of Bart's. The consultation process, referred to above, recognised that there would be some increased demand at surrounding hospitals, and therefore possible pressure on beds; hence another 28-bed admission ward had already opened at the Royal London. The question is whether increases in bed stock should have been put in place at the Homerton before the closure of Bart's A&E. In the first three months after the closure there were 10 per cent more A&E attendances at the Homerton, which was greater than had been anticipated, but perhaps more significant, the substantial rise (nearly 20 per cent) in admissions via A&E would seem to have been impossible to predict.

There has been some success in terms of the merger of medical schools in this sector, which is reflected in this year's Calendar. St Bartholomew's and the London Hospital medical schools have agreed to merge on the Whitechapel site in association with Queen Mary & Westfield College. The Smithfield site is intended to continue to be used for research purposes.

North-central London

This was the location of one of the major consultations of the year on the future configuration of services provided by the University College London Hospitals (UCLH) Trust. Provoking considerably less controversy than that of its famous neighbours, the local purchaser, Camden & Islington Health Authority, issued *Getting Better Together* for public consultation in late April 1995. The proposal was for the UCLH Trust to bring together services currently based at several sites – the Middlesex at Mortimer Street, the Elizabeth Garrett Anderson/Soho Hospital for Women at Euston and the Hospital for Tropical Diseases at St Pancras – on one site at the current University College Hospital in Gower Street. Consultation ended in July. There were no objections to the proposal, which was confirmed by the new Secretary of State for Health, Stephen Dorrell, in August 1995. The Trust is in the process of developing a full business case based on the outcome of the consultation.

A second stage of consultation closed in December 1995. This proposed that UCLH, the Eastman Dental Hospital and the National Hospital for Neurology and Neurosurgery form a single Trust from April 1996. Essentially, this would combine the management of the former special health authority (SHA) hospitals with UCLH, with no declared intention to rationalise provision across sites. Savings are to be achieved through management and administrative rationalisation. A decision on this proposal will be announced in 1996.

Almost unnoticed has been the decision, following consultation in the summer of 1995, to bring the management of the Royal National Throat, Nose and Ear Hospital, at King's Cross, under that of the Royal Free in Hampstead. Again, there is no intention to change the current location of services. As with the plans for the Eastman and the National, the rationale is estimated savings from management costs. This is to be achieved at the expense of the independence of smaller specialist units. The question is whether the quality of these services will be affected as they come under the umbrella of a larger management structure.

There has been an emerging consensus among medical schools in this sector. Thus, the medical schools of University College and the Royal Free have agreed to merge, and the first joint undergraduate intake is expected to occur from the beginning of the 1996–97 academic year. At the same time the postgraduate institutes which were associated with single-specialty sites have agreed to merge or affiliate. These include the Institute of Child Health (associated with Great Ormond Street Hospital for Sick Children), the Institute of Neurology (associated with the National Hospital),

the Institute of Ophthalmology (associated with Moorfields Eye Hospital) and the Dental Institute (associated with the Eastman). In many cases these changes reflect organisational re-alignments in the provision of services which were discussed above.

North-west London

Events in west London in 1995 produced less clarity about what the future configuration of services would be. The Hammersmith Hospitals Trust – comprising Hammersmith Hospital, Queen Charlotte's and Chelsea Hospital, Acton Hospital and Charing Cross – is one of the more significant acute providers in the area, but the close proximity of several other acute providers – St Mary's Hospital Trust and the Chelsea & Westminster Hospital Trust – and other single-specialty sites of long-standing tradition – the Royal Marsden and the Royal Brompton – has made the decision process drawn out and difficult.

It seems clear that some rationalisation across these acute sites is inevitable. A number of reviews of particular services, for example cancer and children, have been undertaken by local purchasers and Trusts, but there have been no significant public consultations as a result. Nevertheless, significant shifts in the location of provision may eventually emerge. While clarity about the direction of change is awaited, decisions are being made elsewhere in London which may prove, in the long run, at least as important an arbiter of where services in west London are eventually located. One example of the cross-sectoral impact of decision making is the effect of developments at UCLH or the Royal Free on the preferred configuration of services in west London. The competitive position of a Trust such as St Mary's may be more affected than one more distant from the centre of London. There are many other such examples.

Meanwhile, a number of 'smaller' changes are emerging. Thus, although for most of the year no significant public consultation was undertaken, in December 1995, Ealing, Hammersmith & Hounslow Health Authority issued *Proposals to Relocate Queen Charlotte's and Chelsea Hospital*, a consultation document on the closure of Queen Charlotte's and Chelsea Hospital and the transfer of services into a new purpose-built maternity unit on the Hammersmith Hospital site in Du Cane Road. It is estimated that this development would cost £9 million, which would be realised from the sale of the old site.

Although clarity is awaited on the configuration of hospitals in north-west London, the merger of medical schools appears to be going ahead successfully. Thus, in July 1995, it was announced that the new merged medical school consisting of Charing Cross and Westminster and St Mary's medical schools together with the National Heart and Lung Institute (associated with the Royal Brompton Hospital) and the Royal Postgraduate Medical School (associated with the Hammersmith Hospital) would be housed in a new £61 million biomedical sciences building on the Imperial College site, which would be the main centre for pre-clinical work.

South London

The position of St George's Healthcare Trust in South London as the chief provider of acute hospital services has always seemed secure. In 1995 a South Thames review of neurological services recommended that St George's site at Tooting should be the region's second centre for specialist neuroscience services, moving existing resources from Atkinson Morley's Hospital, already part of St George's Trust. A consultation by the local health authority, Merton, Sutton and Wandsworth, on the transfer of services from Atkinson Morley's to St George's was about to finish as we went to press.

Unlike the pattern emerging in other sectors of London, St George's Medical School has maintained its independent status within the University of London.

In 1995 there were no other clear indications of changes to the pattern of provision in south London where the other main providers remain Queen Mary's Hospital, Roehampton, Kingston Hospital and St Helier Hospital.

South-east London

In early April 1995 the Secretary of State announced the outcome of a major consultation, carried out by Lambeth, Southwark & Lewisham Health Authority on the future configuration of services at the Guy's and St Thomas' NHS Trust. The issue here hinged on the options for the two main sites,

Guy's at London Bridge and St Thomas' at Westminster. The health authority had recommended closure of the A&E department at Guy's and the transfer of inpatient services to St Thomas'. As a result of consultation, this proposal was modified and in early March the authority recommended that Guy's A&E should stay open until at least 1999.

The Secretary of State agreed that St Thomas' should be the main site for acute inpatient and emergency services. Guy's would be developed as a major centre of excellence for medical education and research and would retain outpatient clinics, day-surgery beds and 112 inpatient beds, as well as a minor injuries unit to replace the A&E department. Closure of the A&E department would not take place until alternative facilities were in place, which is in line with the authority's modified recommendation.

Following a consultation document by Bexley & Greenwich Health Authority on hospital services for local residents, *Looking to the Future: a consultation document on proposals for changes to hospital services in Bexley and Greenwich*, the Secretary of State approved the conversion of the Queen Elizabeth Military Hospital (QEMH) into the main acute provider for Greenwich residents. Although this hospital previously was not part of the NHS, it had always treated some NHS patients.

This decision confirmed the closure of existing services at Greenwich District and the Brook hospitals, with the Brook's specialist neuroscience services transferring to King's College Hospital, and specialist cardiothoracic services to St Thomas'. At the same time renal transplant services would transfer from King's to St Thomas'. The closure of the Brook took place at the end of 1995. It is intended to move the A&E department at Greenwich Hospital to the QEMH by 1998, and thereafter Greenwich will cease to function as a district general hospital. This is dependent on the availability of capital, estimated at £35 million, for the refurbishment of the QEMH, and as with all schemes, under the PFI, private sector capital must be sought first. This may slow down the process if private capital is not forthcoming.

As in most other sectors, 1995 saw the building of a medical consensus around a major centre of education and research in south-east London. There is a commitment on the part of the United Medical & Dental School (associated with Guy's and St Thomas') and King's College London to merge. The Institute of Psychiatry, associated with the Maudsley, has formally associated with King's College.

Other parts of London

Changes have taken place affecting the delivery of services in the outer suburbs of London. Perhaps the most contentious was that in Barnet, certainly one which drew most media attention following the very public display of dissension by local MPs in the House of Commons.

After extensive consultation in 1994, the Secretary of State announced, in April 1995, that Barnet General Hospital would be upgraded, in two phases, to become the main acute hospital for Barnet residents. It was intended to replace the A&E department at Edgware Hospital with a minor accident treatment service, and inpatient services would transfer to Barnet and other local providers, effectively leading to the closure of Edgware as an acute inpatient hospital. The first phase of the redevelopment is under way at a cost approaching £29 million. This was expected to be completed in April 1997 and will provide a new A&E department as well as additional inpatient services.

The total cost of redevelopment on the Barnet site is £68 million. The second phase of the rationalisation of services at Barnet has been agreed in principle, and the issue of funding through private capital is being pursued. Meanwhile, in December 1995 Barnet Health Authority issued *Edgware Community Hospital: A consultation document*, which proposed further developments to Edgware Hospital, to provide a range of services including rehabilitation, care for people with mental health problems, care for older people and a children's treatment and therapy centre. This would involve the transfer of some services from existing sites at Colindale Hospital and the Northgate Clinics, which would then close.

The consultation on the future configuration of services at Watford General & Mount Vernon Trust in the north-west suburbs of London ended in February 1995 with a decision to replace the A&E department at Mount Vernon Hospital with a minor injuries unit from 1997. East London and the City Health Authority has just completed a public

consultation on the rationalisation of services at Newham General Hospital, which recommended the closure of St Andrew's Hospital. It is still the long-term intention of Havering Hospitals Trust, on the Essex borders, to develop A&E services at Harold Wood Hospital. Currently A&E services are provided at Oldchurch Hospital with a minor injuries unit at Harold Wood.

Who is co-ordinating?

The demise of the London Implementation Group (LIG) was announced in October 1994 but was not officially effective until the end of March 1995. Responsibility for the work of LIG passed to the two regional health authorities, part of whose remit covers London – North and South Thames. In an answer to the Health Committee of the House of Commons in early May 1995, the Secretary of State revealed that there would be 30 extra regional staff in London to enable RHAs to take on some of the responsibilities of LIG. On the same occasion, she suggested that LIG had been '*singularly successful*', particularly in those aspects of its work relating to developing centres of excellence in medical education and research.

Over its two-year lifetime LIG distributed over £230 million of NHS funds. Most of this was as transitional funding which enabled some of the major London Trusts to cope with the implementation of change. There was some funding for primary care development in the London Initiative Zone (LIZ) areas, although much of the £210 million made available for primary care development came directly from the Thames health authorities themselves.

However well LIG performed its task, there continues to be a need for co-ordination to ensure overall improvement in the health care available to Londoners. Significant efforts will be required on a number of fronts, including:

- the continued development of primary and community care;
- the brokerage of sectoral solutions for acute hospital provision and the development of models such as 'hub and spoke' for specialist services;
- the completion of developments in medical education and research;
- the implementation of effective mental health services for people with severe illness.

The two Thames regional directors are now charged with the difficult task of ensuring the successful implementation of all of this at a time when regions themselves are in the throes of great change as they formally become part of the NHS Executive from 1 April 1996.

Summary

The problems with extreme levels of emergency admissions experienced at Homerton Hospital illustrate the need for great care in the management of what are very difficult changes. In particular, it would seem better to err on the side of caution where predictions about future levels and patterns of demand are concerned, or where possibilities of more efficient provision leading to cost savings are assumed. The planning of these changes is at best an imprecise science and often little more than a best guess. There remains the need for better information on which to base decisions, the development of an analytic approach to take account of the complex system within which changes are taking place, and a realistic view of the possible errors, and consequences, in any future planning of service developments. When things go wrong the results are evident, as in the case of patients experiencing long waits on trolleys, of which there were many examples throughout 1995.

In the next section we examine what many feel is a prerequisite for improving health services in London – the development of primary and community care in the capital.

Developing primary and community health services

In last year's *Monitor* an attempt was made to describe the range of primary care development schemes upon which £125 million of NHS funds was spent in London over the two years from April 1993 to March 1995. In 1995/96 a further investment of £85 million brought the total over three years to £210 million.

In January 1995, anticipating the demise of LIG, the Primary Care Support Force was established to continue to support the development of primary care in those parts of London covered by the London Initiative Zone (LIZ). LIZ covers approximately four million people and consists of those areas where health care needs are reckoned to be high and primary care provision has traditionally been rather weak.

In this year's Calendar there is ample evidence of interesting new initiatives which have been undertaken in London as a result of the application of these funds. Some initiatives are relatively small, for example funding a smoking-cessation campaign. Others involve major capital investment, for example the development of a new health centre on the site of the old Prince of Wales's Hospital in Tottenham, or the development on the site of the Soho Hospital for Women of a community care centre.

Two questions arise from this spate of development activity. The first is the evaluation of each scheme against its intended contribution to the development of better health services in London generally. The second, perhaps more complex, is the extent to which these schemes will act as a counterpart to developments in hospital services by substituting for acute hospital-based care.

The first question, though apparently straightforward, can be rather difficult to answer. Individual health authorities monitor LIZ schemes in their area on a regular basis. However, there is relatively little published evidence upon which to base an evaluation of the schemes as a whole. Some considered view of this whole tranche of expenditures is required, if only from the perspective of examining the use of public funds. It is not clear how this will be delivered.

Moreover, evaluation is not straightforward: the question arises of criteria against which to measure. Returning to the original criteria upon which LIZ development funds were made available, these were:

- to get the basics right in terms of high-quality premises and staff;
- to develop new types of primary care services and settings;
- to encourage the transfer of care from hospital to the community.

The last category is related clearly to the impact of developments on the demand for hospital-based services. We return to this below. To understand if schemes undertaken on the basis of the other two categories – getting the basics right and new types of care – represent significant improvements, presumably evaluation of performance against some more detailed version of the above aims is required: a none too simple task.

Frequently it has been implied – in the Tomlinson Report, *Making London Better*, and indeed most public consultations which have taken place since – that these primary care developments are fundamental for the degree of rationalisation of acute hospital services envisaged for London. It is therefore crucial to determine the extent to which investments in primary care in London are likely to substitute for hospital-based services. The problem is the lack of any clear evidence. The Secretary of State, Virginia Bottomley, when questioned about the link between improvements in primary and community care and a reduction in the demand for acute hospital services, in evidence to the Health Committee of the House of Commons in May 1995, replied, *'I know of no definitive work to demonstrate a connection. I know some allege it increases the workload of hospitals. Frankly, I do not accept that but neither do I believe that it will dramatically reduce the workload on hospitals'*. She went on to say, *'It is an objective of the policy to improve primary care whether or not it reduces the need for hospital services'*.

There would be no disagreement with this latter objective. The lack of formal evidence linking developments in primary and community care to changes in the provision of hospital-based services is somewhat disconcerting. That is not to claim that such evidence may not be forthcoming. These links, if they exist, need to be made much more explicit, both in terms of establishing the best evidence available and also at the stage of planning service developments.

However, taking the objective of *improving primary care* at face value, we have two options: either to look at simple, readily available measures associated with effective primary care provision in order to understand, albeit indirectly, if these schemes have had any palpable effect in London; or to consider in detail the merit of individual schemes. The latter approach has much to recommend it, but is also particularly difficult as so

few schemes are readily open to public scrutiny. Moreover, as we have argued already, criteria for evaluation need to be established.

Instead, we observe on conventional measures that there has been little impact on the provision of primary health care in London, over and above the level of progress observable elsewhere in the country. Thus, the Facts and Figures section of this *Monitor* shows, for example, that 25 per cent of GP premises in London remain below a basic standard required by their responsible FHSAs. Admittedly, this covers just the first year of LIZ developments. It will be important to consider more recent evidence as this becomes available. Moreover, a more detailed consideration might examine the actual implications of poorer premises for the delivery of health care to people living in London. We note, however, that improving GP premises was an area of concern upon which *Making London Better* was explicit.

There remains also the question of the determination of a 'fair' level of funding for primary care in London, relative to the rest of the country. The Department of Health has recognised the need to develop a coherent approach to the allocation of resources for both hospital and community health services (HCHS) and family health services (FHS). This would provide an interesting overall perspective on the funding of developments in the capital. The Facts and Figures section of this *Monitor* shows that more was spent on family health services in London in 1993/94, relative to England as a whole, than was the case in previous years. However, this may still not be enough, given that an even greater share of NHS expenditure on hospital services is *deliberately* allocated to London on the basis of estimated extra needs and costs in the capital.

Is £210 million extra over three years likely to make much difference in London? If these schemes do represent a cost-effective approach to developing health care in the capital, then would it make sense to apply even greater levels of funding more quickly? Moreover, are problems arising because of the temporary nature of much of this extra funding?

One other area related to primary care provision in London, which we do not consider, is the development of GP fundholding, and especially multi-funds. Although London made a rather slow start in developing fundholding, it is beginning to catch up with the national trend. It will be important in next year's *Monitor* to examine the implications of this in more detail.

Mental health services

The picture painted last year of developments in mental health services in London was especially gloomy. There is little reason to change this prognosis, particularly with respect to the ability to respond to the needs of those people with acute psychiatric problems.

Nineteen ninety-five witnessed no less a spate of accidents, incidents and subsequent reports invariably condemning the level of services available. Several leading commentators and managers have reflected once again on the problems of London, from London coroners who seem increasingly to be dealing with the fall-out from the problem, to purchasers and Trust executives who have to cope within what seem increasingly tight resources. Where exactly does the problem lie: in resource shortage, in service management, or a combination of both?

There are special factors affecting the level of demand for services in London and the ability of these services to cope. It is difficult to judge whether current problems result from high levels of demand relative to the resources made available to the capital, or whether the solutions available elsewhere in the country are either not appropriate in service terms, within the London context, or are not being implemented as effectively.

In terms of the national formula allocating NHS resources to hospital and community health services (HCHS), 12 per cent is allocated on the basis of estimated needs for psychiatric services. This is based on what is actually spent nationally, rather than any attempt to calculate required levels of expenditure. This funding is then allocated on the basis of nationally-estimated needs factors, which include the proportion of adults who are permanently sick, the proportion of those of pensionable age living alone, the proportion of people in lone-parent households, the proportion of dependants with no carers, the proportion of people born in the New Commonwealth, and the standardised mortality ratio for people aged under 75 years. London, especially inner London, scores

high on these factors and so receives more resources relative to the rest of England.

However, many London authorities claim that these funds are inadequate, arguing that they already spend a greater proportion of their budgets on mental health services than the 12 per cent suggested by the national formula. To examine this claim would require consideration of how much of the total budget allocation of London authorities arises from this measure of the mental health needs of their populations, as opposed to their needs for other acute health services. It must also be remembered that the basis of these allocations is not intended to be prescriptive in the sense that authorities are not required to ring-fence sums to any particular service.

If it were established that London is receiving a 'fair' allocation of resources to meet the mental health needs of its population, relative to the rest of England, then the question arises of why there appears to be an inadequate service response. One possibility is that there remain special factors at work in London, such as the large number of individual agencies, which create particular difficulties; another is the underdevelopment of primary-care-based services in London relative to other parts of the country. On the other hand, in an article in the Analysis and Debate section, Duffett and Lelliott argue that the emphasis on developments in primary care may well be diverting energy and resources from dealing with those people who have severe mental health problems.

Whatever the reason, there have been a series of events reflecting failures of mental health services in the capital. These generally come to notice when serious incidents occur involving people with mental health problems. Often these are linked to a failure in the system of care for the particular individual. One such example, the subject of a report in 1995, was the stabbing by one voluntary patient of another at Worlands Day Centre in east London. The joint report from Newham Local Authority and East London and the City Health Authority concluded that a combination of individual error, poor communications and chronic underfunding was responsible.

The report on London from the Mental Health Task Force was discussed at some length in last year's *Monitor* where the serious difficulties associated with emergency access for those people with severe mental health problems were highlighted. In 1995 in *Mental Health Task Force London Project: Follow-up report*, the Task Force was fairly optimistic about progress, while recognising that it was unrealistic to expect dramatic improvements overnight. However, the Research Unit of the Royal College of Psychiatrists continued to monitor services in inner London publishing two reports in April and August. The results of these are discussed in more detail in the article by Duffett and Lelliott referred to above, but their conclusions remain essentially the same. In the words of the Director of the Unit, Dr Paul Lelliott, *'London's psychiatric admission units face serious problems of bed occupancy and violence'.*

As 1995 drew to a close, an incident which perhaps typifies the problems for inner city London services was the knife attack on a GP in Islington by a patient who was recently discharged from mental health care. Such events may be inevitable from time to time but unfortunately are becoming too close to the norm for comfort; and perhaps are also the only way to get some form of care for the individual patient involved. Throwing resources at a problem is not a welcome solution politically, but in this instance there may be a need to recognise London as a special case to be treated differently. The problems with London's mental health services might be compared to an epidemic, deserving an effective solution now before it gets so great as to overwhelm totally the ability of services to cope.

The London Ambulance Service

The problems faced by the London Ambulance Service (LAS) have been well documented in previous *Monitors*. In 1995 there were two substantial reports into the LAS. The first, in January 1995, resulted from a review chaired by William Wells, Chairman of South Thames RHA, following the death of Nasima Begum in east London in June 1994, who had waited 53 minutes for an ambulance to take her to hospital. The Wells Report found considerable cause for concern, highlighting continuing management weakness, lack of sufficient staff training, inappropriate staff distribution and shift changeover times, above-

average staff absenteeism and a lack of modern technology.

The report's recommendation that the LAS should continue as a single-management unit and be encouraged to seek NHS Trust status in April 1996, was predicated on the performance of the LAS improving to match that of other urban services. At the same time the report recognised the need to prioritise calls and recommended a review of the current set of national ORCON standards. A wide range of operational and managerial changes were recommended, together with increased financial resources comprising additional capital expenditure of £5.5 million in 1995/96 and £5.4 million in 1996/97, an increase in revenue costs of £2.7 million and a one-off increase of £3 million.

However, the report remained ambivalent about whether the LAS would be able to achieve national ORCON performance standards even with these additional resources, a point which was taken up in the second major report on the LAS, that published by the Health Committee of the House of Commons in June 1995. The Committee endorsed many of the recommendations of the Wells Report but expressed concern that the LAS will still fail to achieve standards. The Health Committee commented that *'the recent history of the LAS has provided an object lesson in how not to manage a public service'*.

The Committee particularly felt that opportunities to implement change to bring the performance of the service in line with others throughout the country had been missed following the 'computer disaster of 1992' – when the LAS computer-aided dispatch system failed within days of being introduced. The Committee found it *'difficult to resist the conclusion that* [there had been] *a complete failure of nerve on the part of those who were responsible for the LAS'*. Also recognised was the greater degree of difficulty in delivering services in London and serious underfunding in the late 1980s and early 1990s.

The Committee recommended that extra funding be made available to the LAS to allow it to meet national performance standards, but of equal importance was that LAS management implemented systems to allow resources to be matched to demand. The report strongly recommended the introduction of a computer-aided dispatch system as soon as possible and condemned the delay which had ensued since the failure in 1992.

These reports were highly critical and rightly so. However, 1995 saw some real progress within the LAS: progress in meeting existing standards for reacting to calls was slow but sure, and this in the face of substantial increases in demand on the service. As Kathy Jones points out in the Analysis and Debate section of the *Monitor*, in the face of a 10 per cent annual increase in demand, the LAS reached 73 per cent of calls within 14 minutes. This compares with a rate of 64 per cent in September 1993 but remains well below the required national target of 95 per cent, and still the worst in the country.

There has been substantial recent investment in the LAS. Thus, in 1994/95 additional funding of £14.8 million was made available, £8 million of which came from the London Implementation Group (LIG) and the remainder from the two Thames RHAs. The LAS has just completed its consultation with the aim of becoming an NHS Trust from 1 April 1996.

Changes are being suggested to the way in which ambulance services operate generally. It has been recognised that current performance standards, and hence operational procedures to meet these, do not take sufficient account of the likely outcome for patients. The move towards a more evidence-based health service should not leave emergency response services behind. There has been a national consultation on new performance standards which attempt to prioritise on the basis of a triage to establish the clinical need of callers. The response in London has been to look at ways of achieving these new standards taking account of the difficulties which the capital faces – increasing demand and a traffic system which can lead to snarl-ups.

A number of significant developments warrant attention: the move towards more paramedics on motorbikes in London to cope with traffic conditions; attempts to develop clinical audit systems for ambulance responses in order to get better assessments of what is an effective response; substantial investments in human and physical resources in the LAS; and finally, attempts to draw Trusts and purchasers at all levels into discussions of the service (these are considered in more detail in the article referred to above). The old-fashioned view of ambulance services purely as a means of

transporting patients to the nearest A&E department is being challenged as the LAS attempts to establish a position as an integral part of an emergency response service for London.

What remains to be seen is how effectively these investments in the LAS are managed, whether the people of London can be convinced that the introduction of a prioritisation system will represent an improvement in services, and whether the resources, especially human, will be available within a reasonable timeframe. Finally, will services be able to cope with what looks like an ever-increasing demand for an emergency response? A solution which solves the problem by excluding some kinds of demand is not acceptable if it is just another form of cost-shifting.

Conflict between short-term and long-term delivery of services

Most of the discussion so far has been in terms of changes to the organisational structure of services in London. However, these cannot be viewed in isolation from developing trends in the use of services. Last year we referred to the twin problems of, on the one hand, increases in the number of emergency cases presenting to hospitals; while on the other, a blockage appeared at the stage of discharging patients, with many hospitals experiencing difficulties in getting people out of hospital, when, in the view of clinicians and hospital management, their clinical needs no longer justified a continued stay.

The processes of change that we have chronicled are very much premised on a long-term view of the best configuration of services in the capital. It is important that this view is consistent with short-term trends and observations, and moreover, that during the period of transition, arrangements are in place to deal with any problems which may arise. Trends in emergency admission and difficulties with discharging patients are best seen in this light.

Neither issue has gone away in 1995, although significant efforts have been made to understand them better. Detailed analysis commissioned by the chief executives of the inner London health authorities was summarised in a report, *Hospital Services for Londoners*, published in February 1995. This report recognised that London's acute hospitals are operating under considerable pressure: in many cases averaging 90–95 per cent bed occupancy. Four key areas for improvement were identified:

- an agreed hospital-wide approach to the management of both emergency and elective admissions;
- bed managers to identify problems early, and with sufficient seniority to act;
- information systems that routinely monitor bed availability and occupancy;
- discharge planning arrangements agreed with community and social services.

Discharging patients

In 1995 there were examples throughout London of hospital managers indicating difficulties in discharging patients, evidently reflecting the national situation, as it was discussed in the 1994/95 annual report of the NHS Executive. Often these difficulties have been related to problems faced in implementing the new community care arrangements. This is not purely a problem for care of older people. Similar issues can affect younger people or children requiring continuing care as a result of accident or illness.

In February 1995 the Department of Health reaffirmed the responsibility of health authorities to fund and organise a full range of continuing care for their residents. However, this can only be achieved in the context of health authorities and local authorities working together to address problems which may arise. It is for both sets of authorities to agree policies and eligibility criteria which will work.

The focus has been primarily on problems with care for older people: the difficult issue of identifying when the right to, and need for, NHS care has been fulfilled, and how the transfer to care organised by local authority social services departments can best be achieved. The issue is further complicated by the question of funding: local authorities, hospital and community Trusts, and purchasers, often find difficulty in meeting demands within the resources available. In some cases the financial onus has been placed on the

individual receiving care. An issue of fairness then arises as there is considerable variation in policy and practice both across the country and within London.

Admitting emergencies

Similarly, there have been several analyses aimed at gaining a better understanding of the reasons behind increases in the level of emergency admissions, both at a national level and in London, with surprisingly little conclusion. An article in the Analysis and Debate section of this *Monitor* by Chris Garrett shows that the rate of growth in London as a whole is relatively small: less than 2 per cent per annum. Yet, still there is perceived to be a problem.

Other studies have suggested that this perception may arise from difficulties faced over a short period of time in meeting quite large fluctuations in demand, often within a tightening bed constraint. Thus a study of six acute Trusts (Harrison *et al.*, 1995) pinpointed the period between September 1993 and February 1994 as a time when quite large increases in demand occurred within a relatively smaller annual increase calculated over a longer time-period. The problem for managers is that they have to cope with daily fluctuations while struggling to maintain their long-term perspective. The danger is always that insufficient slack is left to cope with unpredictable rises and falls in demand. This must be balanced against the waste of resources if too much slack is left in the system.

The report *Hospital Services for Londoners* recognised this problem in highlighting the difficulty of sustaining levels of bed occupancy in some London hospitals of over 95 per cent. At such occupancy levels it does not take much variation to produce the kind of problems which are chronicled in the Calendar section of this *Monitor*.

Whatever the reality behind the difficulties faced in delivering services in the capital, many would agree with the following statement from Virginia Bottomley given in evidence to the Health Committee in May 1995 when she was Secretary of State for Health, *'Whatever the theory is, if somebody is stuck on a trolley then that hospital is not providing a good enough service and they want to look again at their provision, whether it is extra beds, better management or whether it is improving discharge arrangements'*.

Using the Secretary of State's own criteria, in 1995 many of London's hospitals have not *'provided a good enough service'*. This is a perception shared by many of those with first-hand experience of this provision, and one which has to be squared with the desire to make radical changes to the provision of health care in the capital.

Fair shares for London

Health authorities in London have been operating within an environment made more difficult by the fact that in 1995/96 many faced the need for significant cuts in their budgets. Thus the Department of Health has shown that London as a whole is spending £92 million more on hospital and community health services (HCHS) than the Department estimates to be a fair share of national resources. This has not gone unchallenged, from a number of quarters.

Thus, East London and the City Health Authority's annual public health report 1995/96, *Health in the East End*, questioned the new allocations to district health authorities on the basis of three general issues – underenumeration in the 1991 Census, the zero weighting applied to community health services, representing 24 per cent of the HCHS budget, and inappropriate weighting for age factors – and two specific issues relevant to its own resident population – no account is taken of the extra needs owing to the large homeless and refugee populations, and the extra costs associated with the diversity of languages in east London.

The Health Committee of the House of Commons investigated the issue in some detail in the summer of 1995, taking evidence from leading academics and commentators as well as Department of Health officials, health service managers and the Secretary of State, Stephen Dorrell. Much of this evidence has been published and a report is expected in 1996.

The difficulty with this issue is that it is confounded by a number of changes to the route by which NHS resources are allocated, mostly arising from the NHS reforms and further developments as the reforms have been extended. What might appear most significant, and perhaps is for other parts of the country – the adoption of a new 'weighted capitation' formula based partly on the

work commissioned by the Department of Health from a York University team – is only one element in a complicated series of adjustments which London purchasers are facing.

The other main component comprised structural changes to the NHS which affect the funding formula, particularly in London. These have tended to suggest that London authorities have a greater share of NHS financial resources than they deserve. Changes have acted in several ways, through:

- the introduction of special health authority (SHA) hospitals into the NHS market;
- adjustments for old long-stay patients;
- changes to the Service Increment for Teaching and Research (SIFTR);
- the devolution of previously top-sliced funds, i.e. funds which were not allocated directly to district health authorities.

Special health authorities

Until April 1994 the London postgraduate hospitals, which constituted the SHAs, provided care which was funded directly by the Department of Health and it was thus effectively 'free' to the health authorities whose patients used these hospitals. Somewhere in the region of two-thirds of these were from London. So the uneven distribution of the use of these facilities benefited those authorities making most use of them.

However, over a three-year period, these hospitals are being integrated into the NHS internal market. The Hammersmith, for example, is already part of an NHS Trust. As this occurs, the health authorities using SHAs have been allocated funds to purchase their existing estimated levels of care. In 1994/95 this was not regarded as part of their 'weighted capitation' allocation, and hence did not enter into targets. But in 1995/96 purchasers receiving SHA funds had these matched against allocation targets. As a large proportion of these funds went to London districts, the effect has been to worsen the position of the London authorities relative to previous allocation targets.

On the face of it this is quite fair. There is a sense in which London districts had been benefiting from the use of SHAs at the expense of other parts of the country. However, three issues arise: first, the allocations to purchasers should include only such sums as would pay for the care of their residents, that is elements of teaching and research are excluded; second, the option should be available immediately for purchasers to spend these 'extra' funds with other providers; and third, there should be a recognition of the problems which London health authorities face in managing already tight budgets within an environment of continual transition.

Taking the issue of the distribution of costs between the teaching, research and service elements of the work of SHAs, under the interim arrangements introduced in 1994/95, there are three main sources of funding:

- *market funding:* this is allocated to purchasers on the basis of previous referral patterns so as to allow them to continue to purchase an equivalent level of service as they had received free in the past;
- *excess costs:* central support for costs associated with undergraduate medical and dental education and research which is allocated by host RHAs to individual hospitals;
- *R&D support:* central support for clinical services required to maintain the approved R&D programme, which is allocated directly from the Department of Health to individual hospitals.

The market funding element is most clearly intended to represent service costs, and in 1995/96 was approximately 30 per cent of the total revenue funding, which was over £400 million for the former SHA hospitals. Excess costs represent just over 12 per cent, and are intended to be reduced to zero, with this element becoming a part of the market funding by 1997/98. The largest element, R&D support, at over 50 per cent, is clearly not a service cost, and accordingly would not be included as part of a district's allocation for the purchase of health services for its residents. In addition, approximately 6 per cent of the total revenue funding for the former SHA hospitals is distributed to the Thames RHAs to purchase medical, dental and non-medical training at individual hospitals.

In 1994/95 a so-called 'steady state' was established whereby purchasers were expected to use their market funding to contract with SHAs on the basis of previous referral patterns. From

1995/96 onwards, notionally at least, health authorities and GP fundholders have been free to move contracts away from the old SHA hospitals. To what extent this has happened will need to be examined.

The introduction of the SHA element into calculations of targets and actual allocations had extreme consequences for the London districts, moving London as a whole from what would have been a level of funding just below target to one estimated to be £92 million above in 1995/96. The report from East London and the City Health Authority quoted earlier estimated an impact on their budget of over £18 million, approaching 6 per cent of their total HCHS allocation.

Included in actual district allocations, and hence for the purpose of comparison with 'weighted capitation' targets, is what was referred to above as 'excess costs'. Given that these reflect excess costs of teaching and research, it is clear that these funds should not be treated in the same way as those allocated for the provision of patient care.

Old long-stay adjustment

Throughout the 1980s adjustments were made to allocations to RHAs to take account of their responsibilities for old long-stay patients as they entered the community as part of the Care in the Community policy. A recent review of these adjustments suggests that the cost of caring for this group of patients is greater than had been estimated. Further work is under way to establish definitive figures on the number of patients involved and the cost of their care. An interim increase of £80 million was made available for distribution to health authorities in 1995/96.

By adding these funds to district target allocations the effect has been to change these quite substantially in the case of some health authorities. Using East London and the City as an example again, the health authority moves some £4 million above target on the basis of this adjustment alone.

Adjustments to SIFTR

SIFTR is intended to compensate providers for extra costs arising from undergraduate teaching and research, and hence ensure that prices faced by purchasers exclude this element. A recent review of hospital costs associated with teaching and research indicated that more was being spent by hospitals on clinical teaching and research than was being funded by SIFTR. It recommended that the level of SIFTR should be increased; in 1995/96 it was increased by £40 million. This was to be financed by the transfer of funds from health authorities using these hospitals. Theoretically, the transfer should be neutral as it would be matched by a reduction in the prices charged by these hospitals. It was intended that a further £40 million be transferred in 1996/97. The extent to which the pricing assumption has proved accurate needs to be assessed.

The effect of this is most noticeable in London with its high concentration of teaching hospitals. Nevertheless, it is clear that SIFTR funds, which amounted to £540 million in 1995/96, are not properly counted as part of a district health authority's allocation to provide services for its resident population.

Devolution of top-sliced funding

The policy of devolving central budgets to district health authorities continued in 1995/96 with a number of former central budgets being included in allocations and hence affecting distances from target.

Summary

It is important to establish whether the new formula for allocating HCHS resources is 'fair' in the sense that it takes account fully of those extra needs factors which London districts face and the extra costs of providing care in London. This debate is set to continue with the latest round of allocations for 1996/97 announced at the end of 1995, which will still tend to put pressure on most London purchasers to reduce their budgets in line with national targets.

In a period of rapid transformation in health service provision it will be even tougher for London health authorities to achieve the changes which are being sought – in terms of the rationalisation of acute hospital sites, the bringing together of specialties into tertiary care centres, the pursuit of private financing for substantial capital investments and the creation of a structure of primary and

community care which will facilitate the extent of change in the capital's hospital system which is anticipated – within an environment created by the continual need to find ways to reduce their overall budgets.

Conclusion

Once again, it is difficult to draw firm conclusions from the experiences of the health care system in London in 1995. Two issues recur: managing a difficult process of change and assessing a fair level of funding for London relative to the rest of the country.

The need for evidence-based approaches to clinical care has caught the imagination of those who work in the NHS. This commentary indicates an equal need for evidence-based approaches to the development and management of policy. There is a high degree of uncertainty in much of the planning of service development. Moreover, changes take place within a complex system where marginal shifts in one area of service delivery may have unconsidered – by the planner – effects on another, both within and outside of the NHS. It may be politically difficult to admit to uncertainty but if a scientific approach to the development of health services is accepted then such uncertainty must be embraced.

A starting point to such a process would be for the full business cases, upon which so much of the decision making in London and elsewhere depends, to be subject to a degree of public scrutiny. Given the extent of disagreement which can arise when analyses are carried out by different groups of management consultants on behalf of what are effectively different interest groups, it may prove useful to have recourse to some independent arbitration. This is only likely to be possible if business cases are opened up for public scrutiny. This issue, when touched upon by the Health Committee of the House of Commons this year, met with a somewhat reticent response from politicians and health service managers.

The question of funding for London health authorities has been discussed at some length. As NHS funds are devolved down to district health authority level, it should become clearer how much of their total expenditure is devoted to their responsibilities for patient care. It may then be possible to prevent some of the fruitless debate surrounding the actual and 'fair' levels of expenditure in London, prevalent over the last few years, often because of misinterpretation of various published figures.

This commentary raises a number of fundamental issues. As ever, the need for more appropriate, accurate and timely information is underlined. It will also prove important to develop an understanding and analysis of complex systems – and health care provision is one of the more complex – in order to use the information that is available to make the correct decisions. Finally, it is important that decisions are made which can stand up to the light of public scrutiny which an independent assessment may afford.

Part 2
Facts and figures

Facts and figures

This part of the Monitor presents the latest available information describing the population of London, its health, the health care services available in the capital, and the use which is made of these services. As ever, the availability of compatible data is a limit on how comprehensive such an enterprise may be.

Nevertheless, we are able to provide a snapshot of some of the main features of the health and health care of Londoners. In some cases an update is given of the tables in previous *London Monitors*, in others we present new information. This provides a basis for comparison with previous reports on London – particularly those published by the first King's Fund London Commission (Benzeval *et al.*, 1992; Boyle and Smaje, 1992; Boyle and Smaje, 1993) and previous *London Monitors* (1994, 1995).

The position in London is compared with that of England as a whole using a variety of perspectives which are primarily dictated by the data available.

1 Barking and Havering
2 Barnet
3 Bexley and Greenwich
4 Brent and Harrow
5 Bromley
6 Camden and Islington
7 Croydon
8 Ealing, Hammersmith and Hounslow
9 East London and the City
10 Enfield and Haringey
11 Hillingdon
12 Kensington, Chelsea and Westminster
13 Kingston and Richmond
14 Lambeth, Southwark and Lewisham
15 Merton, Sutton and Wandsworth
16 Redbridge and Waltham Forest

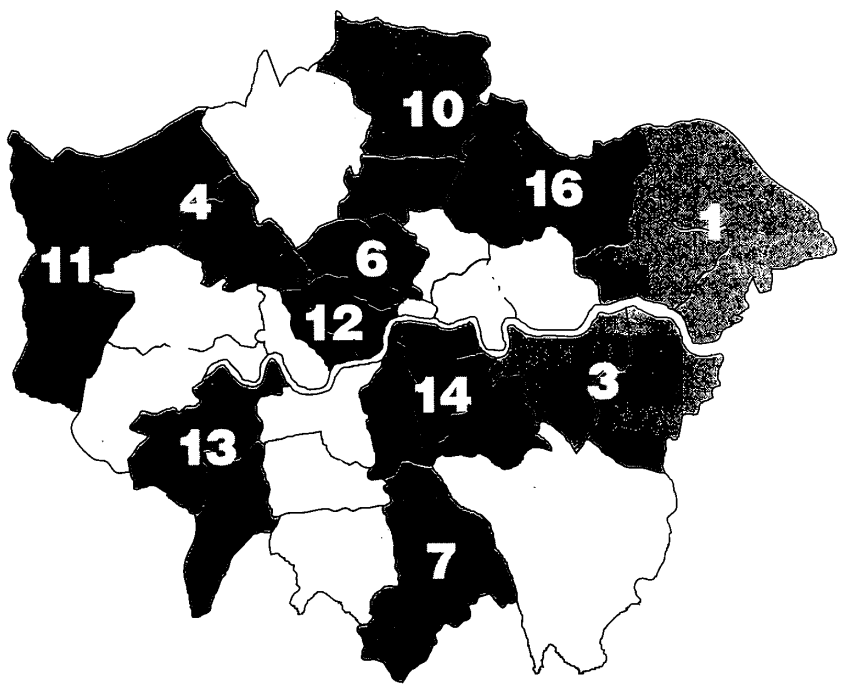

Figure 1 The London purchasing authorities, 1996/97

Information is presented on a London-wide basis, and in most cases using a categorisation of London into three types of area: inner-deprived, mixed status and high status, based on a classification system devised for the original King's Fund Commission work referred to above. This groups areas of London according to their socio-economic and demographic characteristics.

Usually, data are organised by health agency: where data are organised differently, this is made clear. Four districts are identified as inner-deprived London purchasers: Kensington, Chelsea & Westminster; East London & the City; Camden & Islington; and Lambeth, Southwark & Lewisham. Of the remainder, five are classified as mixed status: Ealing, Hammersmith & Hounslow; Enfield & Haringey; Redbridge & Waltham Forest; Merton, Sutton & Wandsworth; and Brent & Harrow; and the remaining seven are high-status areas.

The map of London in Figure 1 shows the current boundaries of the London purchasers. There are over 40 acute hospital Trusts in London and 20 community or mental health Trusts. Both acute and community or mental health Trusts may be responsible for the management of hospital sites, and in some cases, Trusts have responsibility for several sites. Of the acute Trusts, over two-thirds are in north London; 17 are in inner-deprived London. There are a few single specialty hospitals, although it is probable that these will merge eventually with multi-specialty hospitals as a result of the current reviews of London hospitals.

THE FACTS AND FIGURES OF LONDON'S HEALTH AND HEALTH SERVICES: DATA SOURCES

The first section, using Office of Population Censuses and Surveys (OPCS) estimates for 1994 and projections to 1998 based on the data underlying the Health Services Indicators (HSIs) for 1993/94 (Department of Health, 1995), provides information on the structure of the population of London purchasers. Data provided by the London Research Centre have been used to show longer-term population projections, and also to consider some of the economic characteristics of the population of London. This is followed by a section presenting some broad indicators of mortality based on the data underlying the HSIs.

The third section considers the availability of resources in London, both funds available to London purchasers and the availability of beds in London. The total revenue expenditure of London district purchasers is presented, and a breakdown of expenditure on family health services (FHS) is also given using Department of Health data. Figures on the availability of hospital beds, based on the latest Department of Health data (Department of Health, 1995), are also presented and contrasted with the availability of places in residential care homes (Department of Health, 1995).

The fourth section provides information on the use of hospital and community health services (HCHS) by residents of London. The analysis refers to 1993/94 and is based on the data underlying the HSIs. Section 5 presents some important indicators of FHS quality and staffing levels using a mixture of information from the 1993/94 HSIs and general medical services (GMS) basic statistics for April 1995.

An important omission is data on the use of human resources in London as well as measures of efficiency of provision such as length of stay or cost per case. It is currently not possible to repeat the type of detailed analysis of hospital costs and staffing which was carried out for the first King's Fund London Commission on the basis of 1989/90 data (Boyle and Smaje, 1992). This relied heavily on national data sets covering a wide range of health service variables which, unfortunately, are no longer available.

In each section graphical figures are provided which allow a ready comparison between London, its constituent parts and England as a whole. Tabulations of more detailed data to support these figures are available on request. Broadly, these data refer to the third and fourth years of the NHS reforms.

London's population

This section presents the most recent estimates of the current population of London, based on OPCS 1994 mid-year estimates, broken down by age-group. Health care purchasing agencies are used as the basic geographic unit. As last year's *Monitor* acknowledged, recent changes to the health care purchaser boundaries, while bringing the definition of London in health care terms closer to the local government-based definition of Greater London, also made comparisons of population over time impossible, both of London as a whole, and also of the socio-economic classifications of health agency areas. Examples of these changes have been comprehensively described in previous *Monitors*. We have ensured that the population bases used throughout correspond as closely as possible to the areas for which London purchasers had responsibility, at the time to which the data refer.

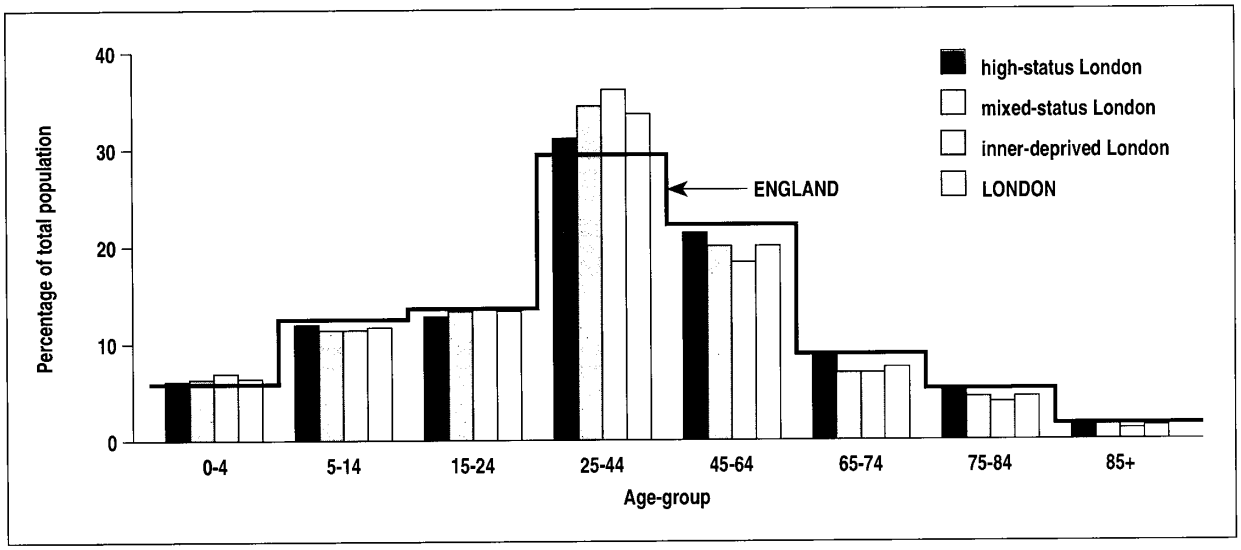

Figure 2 The age distribution of London's population, 1994

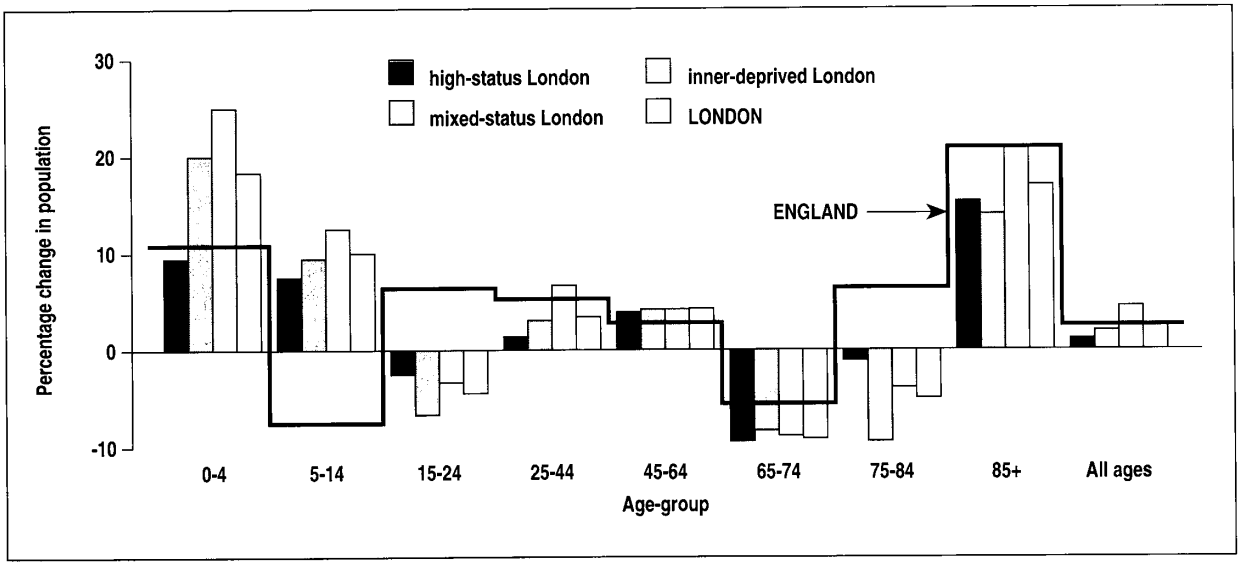

Figure 3 Projected percentage changes in London's population between 1994 and 1998

Figure 2 compares the breakdown, by age-group, of the population of London with that of England as a whole. London has a relatively younger population and, in particular, has considerably more 25–44 year-olds. There are also clear differences within London: high-status London areas generally have an older age profile than the inner city.

Population projections for 1998, based on current trends in fertility, mortality and migration, are used in Figure 3 to show the proportionate change in London, by age-group. The overall population of London is projected to grow by over 175,000 by June 1998, a rate of change similar to that of England as a whole – over 2 per cent. The population of inner-deprived London is expected to grow at twice the national rate, though this still represents a small absolute increase over the period. However, there will be significantly greater increases throughout the country in the 85+ age-group, with an increase of 21 per cent in inner-deprived London, similar to that expected for England as a whole.

The London Research Centre (LRC) has produced longer-term projections of population in London. These are used in Figures 4 and 5 to show changes in the percentage of the total population aged 75+ and 85+ respectively in London compared with England and Wales. Although not in absolute age-group terms as in Figure 3, the broad trend is confirmed up to 1998. Thus, Figure 4 shows the percentage of the population aged 75+ continuing

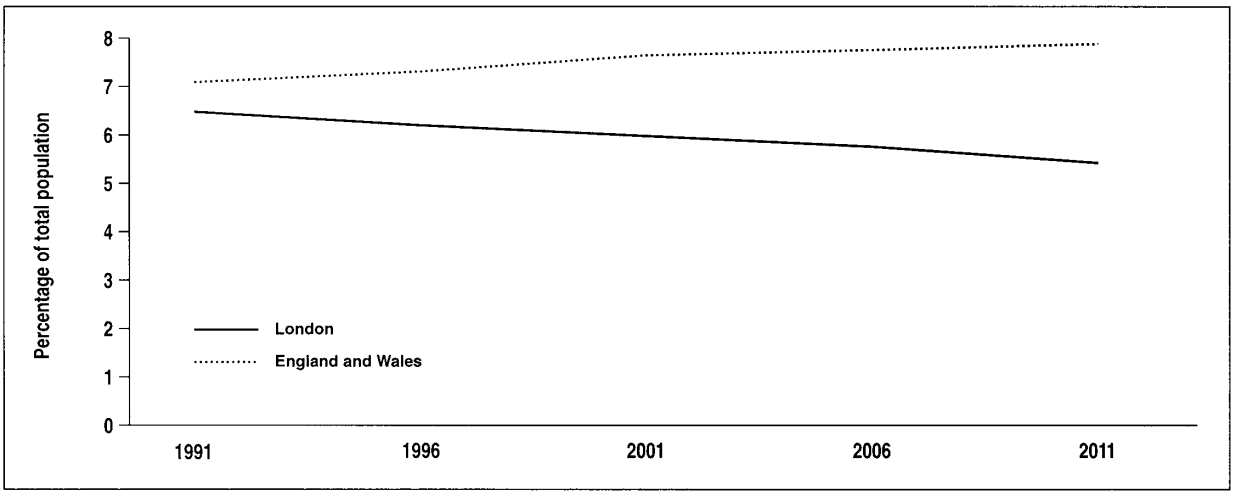

Figure 4 Percentage of population aged 75+ in London and England and Wales projected to 2011

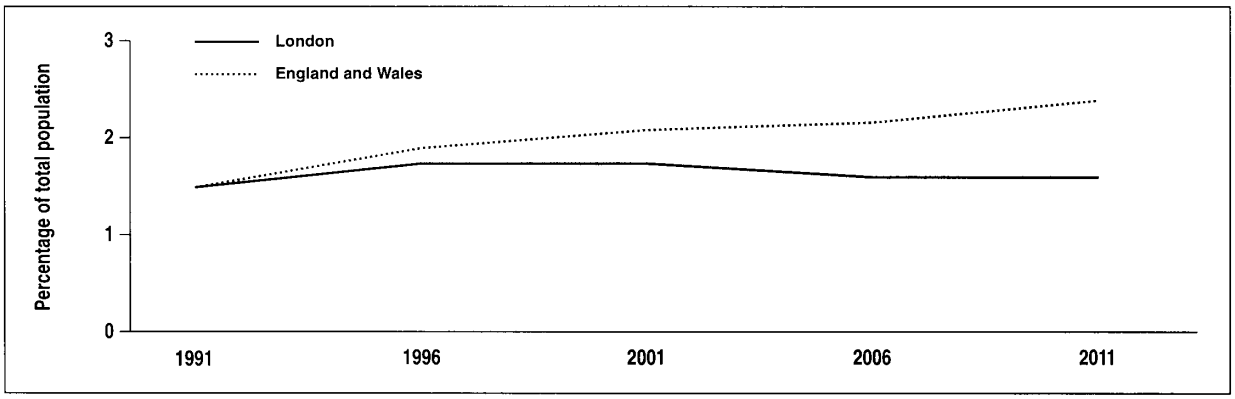

Figure 5 Percentage of population aged 85+ in London and England and Wales projected to 2011

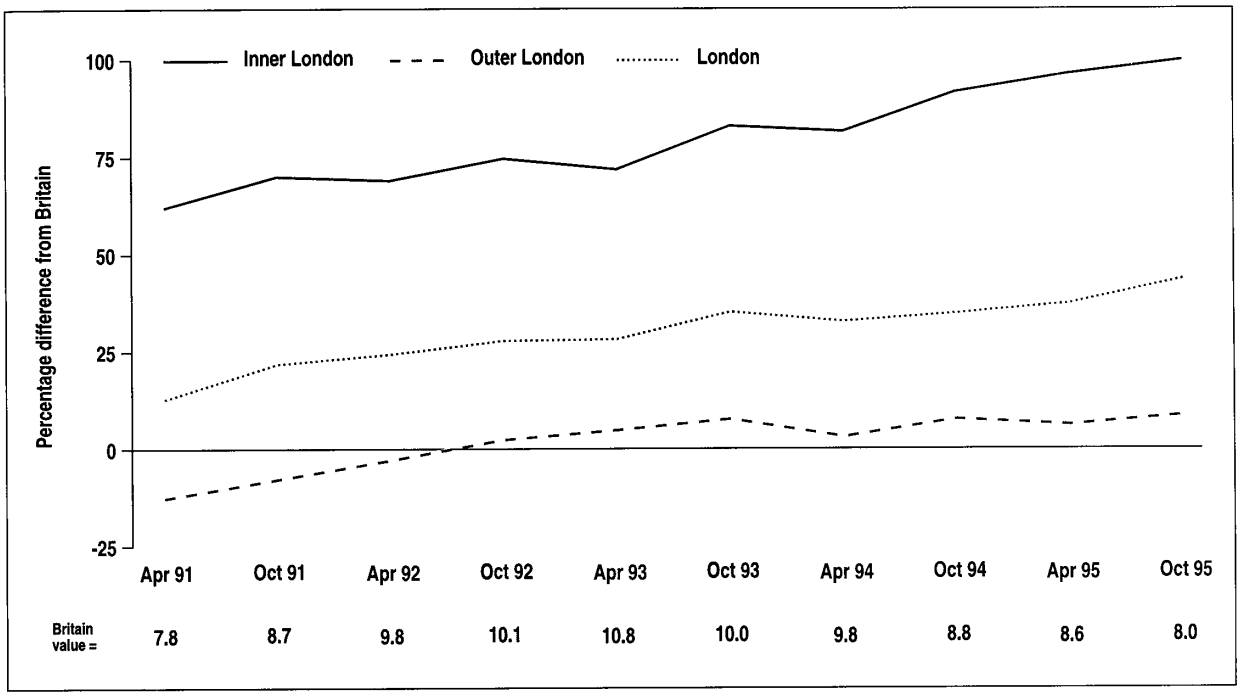

Figure 6 The rate of unemployment in London, 1991–1995

to fall in London up to the year 2011, in contrast with increases in England and Wales where continued growth is expected.

Figure 5 shows the same projections for the percentage of the population aged 85+ and confirms that this percentage will grow until around 1998, in England and Wales at a faster rate than in London. However, at this point, the proportion of the population aged 85+ starts to level out in London, and eventually falls back, whereas the percentage in England and Wales continues to grow.

Last year we presented some detailed information on the social and economic conditions facing Londoners, based on analysis by the LRC. An update of this analysis is presented again using LRC figures.

The unemployment rate in London increased steadily from April 1991, reaching a peak of 14.1 per cent in August 1993. Although this rate fell to 11.4 per cent by October 1995, it was still 3.4 percentage points above that of Britain, which was 8 per cent. Figure 6 compares the increase in unemployment in London with that of Britain as a whole. Inner and outer London in this instance are defined in terms of inner and outer London local authorities.

The proportion of people unemployed in London relative to that in the rest of Britain has been increasing steadily since 1991. By October 1995

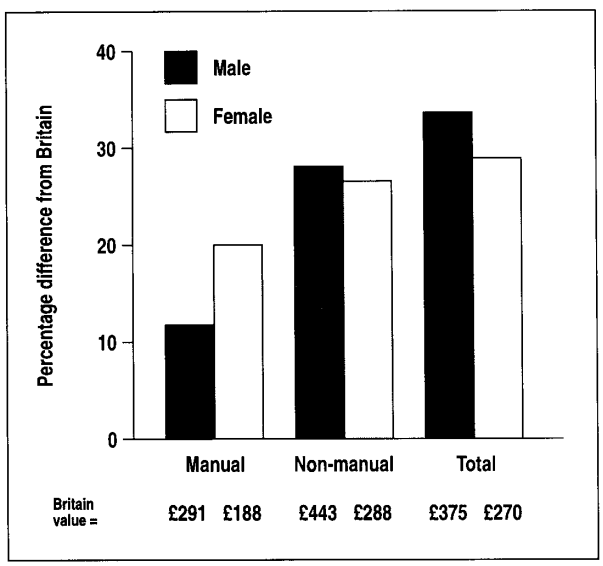

Figure 7 A comparison of average earnings between London and Britain, 1994

the unemployment rate in London was nearly 43 per cent more than the national average. The unemployment rate in inner London is now twice that of Britain. Thus 1991 Census figures underestimate considerably current differentials between unemployment in London and the rest of the country.

An LRC analysis of the 1995 *New Earnings Survey* revealed the extent of the difference between labour costs in London and the rest of Britain. Figure 7 shows the percentage difference between average gross weekly full-time earnings in London and Britain, for manual and non-manual workers, male and female. Non-manual labour costs are approximately 28 per cent higher in London in the case of males and 26 per cent higher for females; manual labour costs are over 12 per cent higher for males in London compared to the national average, and over 20 per cent higher for females.

The differential between London earnings and those elsewhere in Britain has, if anything, widened between 1993 and 1994 with the biggest change occurring for both categories of male. These findings reflect wage differentials generally, but this evidence may be assumed to support the common assertion that the cost of health care production is higher in London than elsewhere.

The health of Londoners

This section presents some information on the health of Londoners relative to the rest of England. Last year, it was seen that substantial differences may exist between age-groups. This continues to be reflected in the latest figures.

Once again, standardised mortality ratios (SMRs) are used to reflect the health of the population (Department of Health, 1995). The SMRs reflect the rate of death in an area relative to an age-standardised norm, which in this case is derived from English death rates. Figure 8 shows differences between high-status, mixed-status and inner-deprived London, and London as a whole, for SMRs of three age-groups, 0–14, 15–64, 65+, together with the SMR for all ages.

A positive difference indicates that there are more deaths than would be expected on the basis of national rates for that age-group; a negative difference, fewer. It is immediately apparent that the direction and extent of differences between areas of London and England as a whole are very much dependent on which age-group is considered. The SMR in inner-deprived London is considerably higher than the national value in all but the 65+ age-group: in the case of 15–64 year olds, who make up

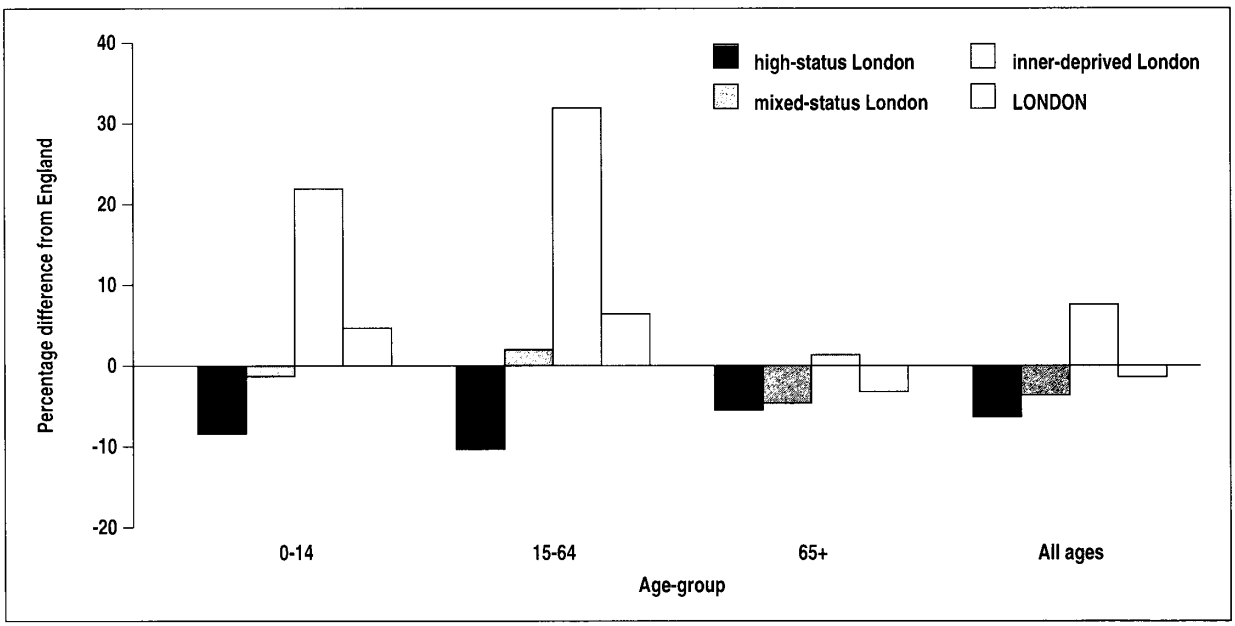

Figure 8 Percentage differences in all-cause SMR between London and England, 1994

65 per cent of the population, by over 30 per cent.

However, for the 65+ age-group, all except inner-deprived areas of London exhibit a lower SMR than is the case nationally. Over 80 per cent of deaths occur in this age-group: the 65+ SMR thus is the main determinant of the value which the all-age SMR takes. The all-age SMR is 7 per cent higher in inner-deprived London than is the case elsewhere. This represents a deterioration on rates last year. Nevertheless, taken as a whole, London appears to be healthier than average with an SMR 1.6 per cent below that of England, a slight change for the worse compared with last year. High-status areas of the capital would appear to be healthier than average for all age-groups.

Although the SMR is not a perfect proxy for ill health, it provides a starting point for looking at the health of any population group. Thirty-two per cent more residents of inner-deprived London areas in the 15–64 age-group die annually than would be predicted on the basis of national figures, and 22 per cent more children under the age of 15. If these are good predictors of ill health among these age-groups, then the evidence suggests that the majority of inner-deprived London residents suffered more ill health than is the case nationally.

Resources in London

Expenditure on health services in London

We turn now to how much is spent on health services in London. In 1995 the issues of how much is spent on the health care of Londoners and what is a fair amount to spend relative to expenditure in the rest of the country continued to be central concerns for national policy makers and health service managers alike.

In the past the first question was not as trivial as it would seem. What is spent in London comes from various sources and rationales, and in many cases is not strictly attributable to expenditure on the residents of London. For example, a considerable amount is spent on medical education and research. The use of simple district expenditure figures may therefore mislead. However, the recent tendency to devolve budgets down to district health authority (DHA) level has served to clarify the position. One such example is the inclusion of special health authority (SHA) hospitals in the NHS market. These issues are addressed more fully in this year's Commentary. However, it is useful as a starting point for any discussion to know exactly how much is spent by London DHAs.

The second issue of what is a fair amount to spend on the health care of Londoners is also complex. The Department of Health has applied the new 'York University' formula as the basis of the allocation of HCHS funds to regions. Regions have also used these formulae to determine target allocations for their DHAs. The level of funds available to London purchasers has generally been higher than that nationally. This reflects three factors: the higher cost of inputs in London which is taken into account in the new formula through a modified market forces factor; the higher level of need in some London districts, reflected in adjustments to the needs elements of the formula; and finally, the historic overfunding of London districts which is gradually being reduced. This overfunding element was estimated by the Department of Health at £92 million for 1995/96.

In this section we present information both on total expenditure by purchasers on HCHS, and on the estimated differences between the funds received by London districts and their 'fair shares'. We also consider the main constituents of FHS expenditure.

Figure 9 is based on information provided by the Department of Health, and refers to 1995/96 allocations to London districts by the Thames regions together with regional estimates of what 'fair' allocations would be on the basis of the national 'weighted capitation' formula. How this is actually done varies between regions. These figures exclude capital charges and allocations for general medical services.

The figures presented here are not strictly comparable with those in last year's *Monitor* as they take account of allocations of funds by regions which were not part of the Department of Health's original allocation on a weighted population basis. The data show that per capita expenditure in London as a whole is intended to be almost 12 per cent above the England average: this varies across London, with inner-deprived London districts intended to be almost 25 per cent greater than the England average, mixed-status districts 10 per cent

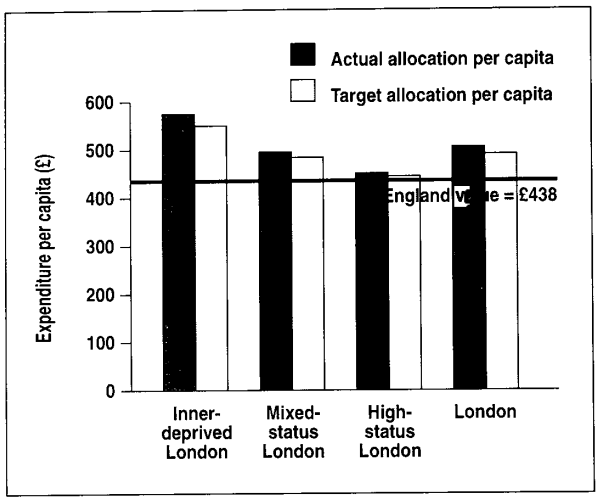

Figure 9 London purchaser allocations and capitation targets, 1995/96

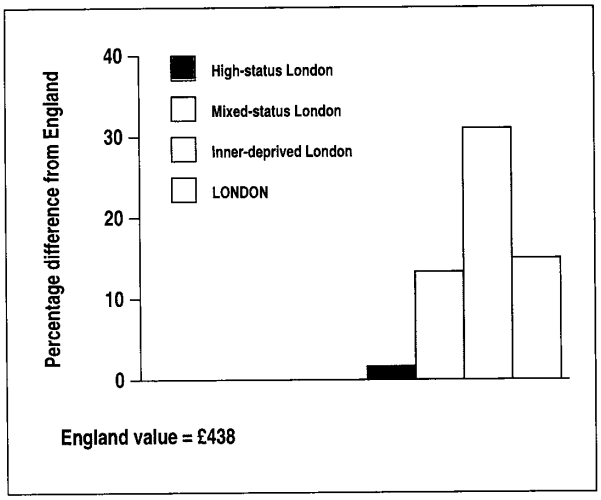

Figure 10 DHA revenue allocation per capita, 1995/96

more and high-status districts just 2 per cent more.

If these are regarded as 'fair' targets based on some notion of the needs and special conditions in all parts of England, then, as Figure 9 shows, actual allocations in 1995/96 indicate an 'unfair' level of expenditure in some parts of London. London as a whole is estimated to be almost 2.7 per cent over its 'fair' target allocation. High-status areas as a whole are more or less on target, mixed-status areas are on average 2.2 per cent above target, and inner-deprived areas of London 5 per cent over. However, there is considerable variation even between areas of similar status in London. It is on the basis of these allocations and the attempt to correct what is seen as London's 'unfair share' of national resources, that many districts in the capital are struggling to bring their budgets in line with these targets. This issue is discussed in more detail in the Commentary.

Using the same source, Figure 10 compares per capita expenditure in London in 1995/96 with per capita national expenditure. We see that in London as a whole, expenditure per capita was 15 per cent greater than the England average: inner-deprived London per capita expenditure is 31 per cent greater than the England figure.

Turning to expenditure on family health services (FHS), a somewhat different picture emerges. Using the HSI data for 1993/94, Figure 11 shows the breakdown of FHS expenditure in London compared to the national picture in terms of general medical services (GMS), pharmaceutical services (PS), ophthalmic services (GOS) and expenditure by the FHSA as a whole.

Inner-deprived London FHSAs spend over 25 per cent more per capita resident population on GMS than their counterparts in the rest of England. London overall spends 14 per cent more. This is a similar finding to that for HCHS expenditure, although the disparity in inner-deprived London is less. A different picture emerges when expenditure on PS is considered. All London districts spend between 6 and 16 per cent less than the national average. This is due to a lower level of prescribing in London.

The effect though is to make the overall level of FHSA expenditure in London just 2 per cent more than that of England as a whole: overall expenditure in inner-deprived London remains 8 per cent more than the England figure.

Comparisons with last year show an upward trend in FHSA expenditure, both nationally and in London, but with London increasing at a faster rate: last year FHSA expenditure per capita in London was actually less than the England average. The policy of improving primary health care services in London would appear to be having some effect, at least in terms of how much is being spent.

Availability of beds

It is often claimed that beds are not a useful measure of the availability of care in an area. This is

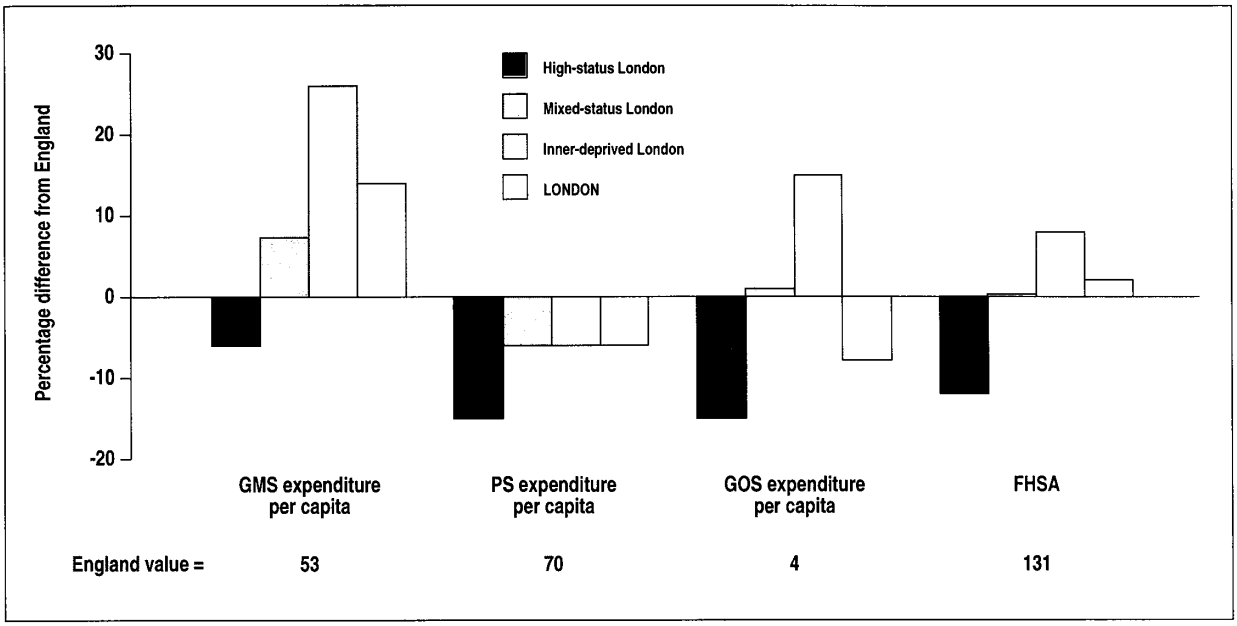

Figure 11 FHS expenditure per capita, 1993/94

based primarily on the assumption that in future there will be less hospital-based care, with more services delivered in community settings. Moreover, what is delivered in hospitals will require fewer beds as the proportion of day cases increases ever more rapidly. Nevertheless, the need for hospital beds (and staff) remains, and so there is some validity in comparing the situation in London with that in England as a whole – if only because a central tenet of recent policy is that there are too many beds, and hospitals, in London. It is only by examining how many beds there are now that we can begin to answer if these are the correct number.

The decline in the number of acute beds in London relative to the rest of England is well documented. The latest figures for 1994/95 confirm this trend. Between 1982 and 1994/95 the number of acute hospital beds in England reduced by 25 per cent, from 143,500 to 108,000. In the same period the number of beds in London fell by over 40 per cent, from 29,250 to 17,100 (these figures include SHA beds).

Figure 12, which is based on the latest bed availability figures from the Department of Health (Department of Health, 1995), compares the number of beds available in London per capita resident population with that in England as a whole for the period 1982–1994/95. Such comparisons over time are complicated by the fact that some London authorities have lost responsibilities for parts of their populations, some acute Trusts are no longer strictly part of London, and other hospitals are now part of Trusts not wholly inside London.

Bearing this in mind, the number of acute beds in London as a whole has fallen by nearly 600 since 1993/94, compared to a decrease of 1,700 acute beds in the rest of England. Figure 12 shows that London's 'excess' of beds per capita when compared to England as a whole is rapidly disappearing. If SHAs were excluded from the analysis, then London would have approximately the same number of beds as the England average. Inner-deprived London purchasers have over 40 per cent of the total acute beds in the capital within their boundaries, but the geography of London is such that very often these hospitals serve as local hospitals for the residents of mixed-status areas.

Figure 13, from the same source as Figure 12, compares the provision of beds per capita in acute and geriatric medicine specialties in London with that in England as a whole. As can be seen, a 6 per cent higher provision of acute beds is set alongside a 3 per cent lower provision of beds allocated for the care of older people, leaving an overall higher provision of just over 3 per cent. This compares with a 5 per cent higher provision in 1993/94.

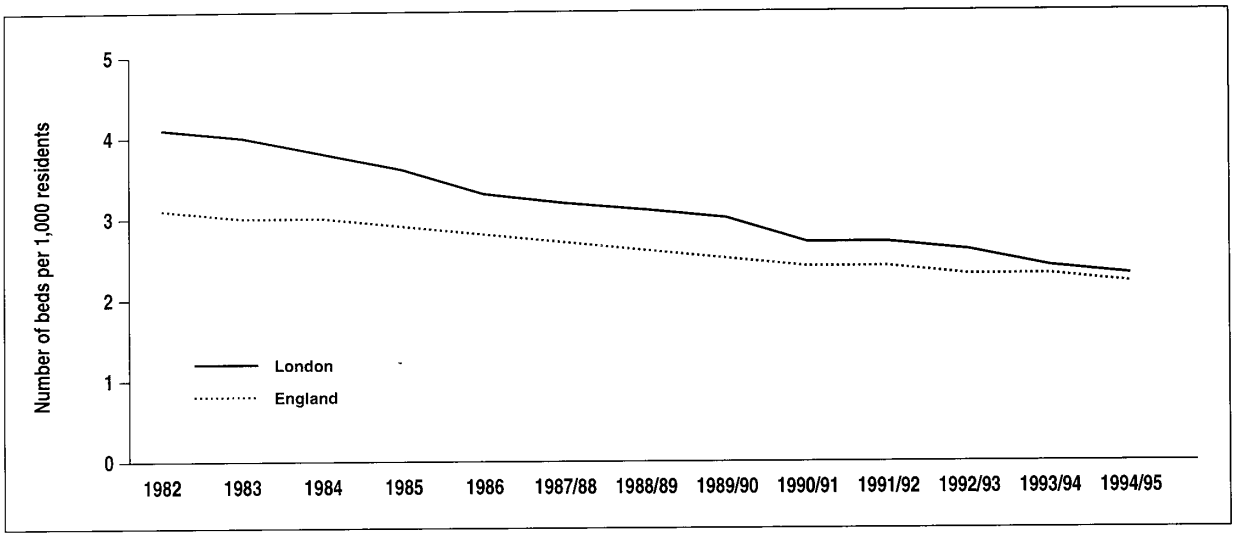

Figure 12 Acute beds per 1,000 residents, 1982–1994/95

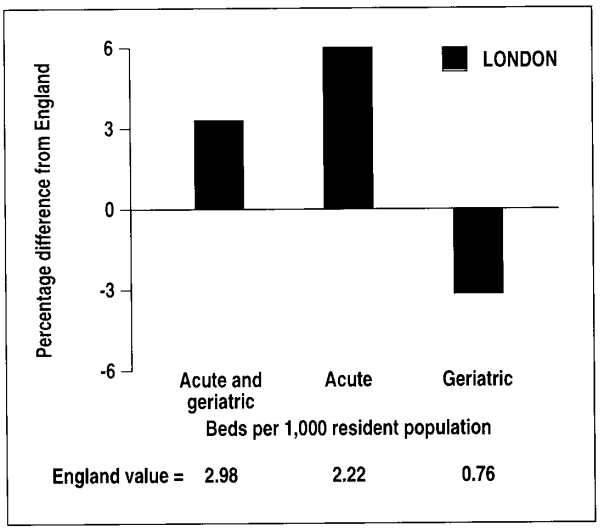

Figure 13 Availability of beds for acute and geriatric medicine specialties, 1994/95

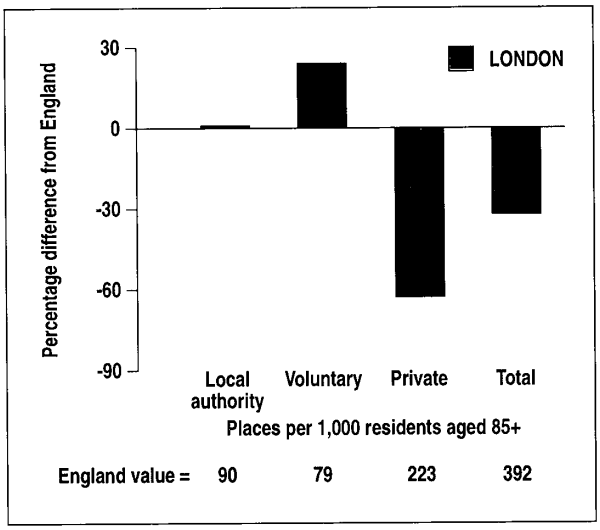

Figure 14 Availability of residential care places in London, March 1995

It is important when considering care of older people to look at the availability of residential care, as lack of such places may result in greater and inappropriate pressure on hospital beds. Figure 14 shows there are considerably fewer residential care home places for London's older population than is the case nationally. The majority of people using such homes are in the 85+ age-group, and so availability has been expressed in terms of places per capita resident population aged 85+. The results are largely unaltered if the 75+ age-group is used.

London as a whole has only 70 per cent of the national average number of residential care places per capita. As Figure 14 shows, this is primarily due to a lack of places in private care homes, which make up 57 per cent of such care nationally but only 30 per cent of the care in London: the availability of private care places in London is just 36 per cent of the England average. The voluntary sector in fact accounts for a large proportion of residential care in London. This lack of residential care in London (and a similar situation exists when

nursing care places are considered) is reflected in hospital admission figures for the 75+ age-group in London which, as we show in the next section, are higher than average.

The use of health services by Londoners

In this section we look at three aspects of the use of hospital and community health services by Londoners: the number of inpatient and day cases in the major specialties; the use of mental health services and services for the care of older people; and the use of district nurse and health visitor services in terms of contacts. In each case 1993/94 HSI data are used.

Hospitalisation

Figure 15 presents standardised hospitalisation rates for high-status, mixed-status and inner-deprived London, for seven major specialties, plus a total acute figure which is the sum of all of these specialties except paediatrics, plus some smaller medical sub-specialties; as would be expected, the total acute figure excludes the specialty 'geriatric medicine'. Hospitalisation rates are a measure of utilisation of hospital services, expressing the number of inpatient and day cases per capita resident population.

According to these data, London residents use approximately the same level of acute hospital services – standardised for age structure of the population – as the rest of the country, much the same as last year. However, in the seven highlighted specialties London's comparative utilisation has diminished. This is because hospitalisation rates have remained constant in London at a time when England as a whole has seen an increase in utilisation, particularly in general medicine and paediatrics.

In the general medicine specialty, where over 25 per cent of total acute activity takes place, there is less use of services in all three types of London areas. However, for medical sub-specialties such as cardiology, medical oncology and thoracic medicine, London has far higher levels of utilisation than England, particularly in inner-deprived and mixed-status areas. This greater sub-specialisation may be a consequence of the location of tertiary referral centres in central London, causing patients who would have been treated by general physicians in the rest of the country to be classified as patients of smaller sub-specialties. As Figure 16 makes clear, if these sub-specialties are included with general

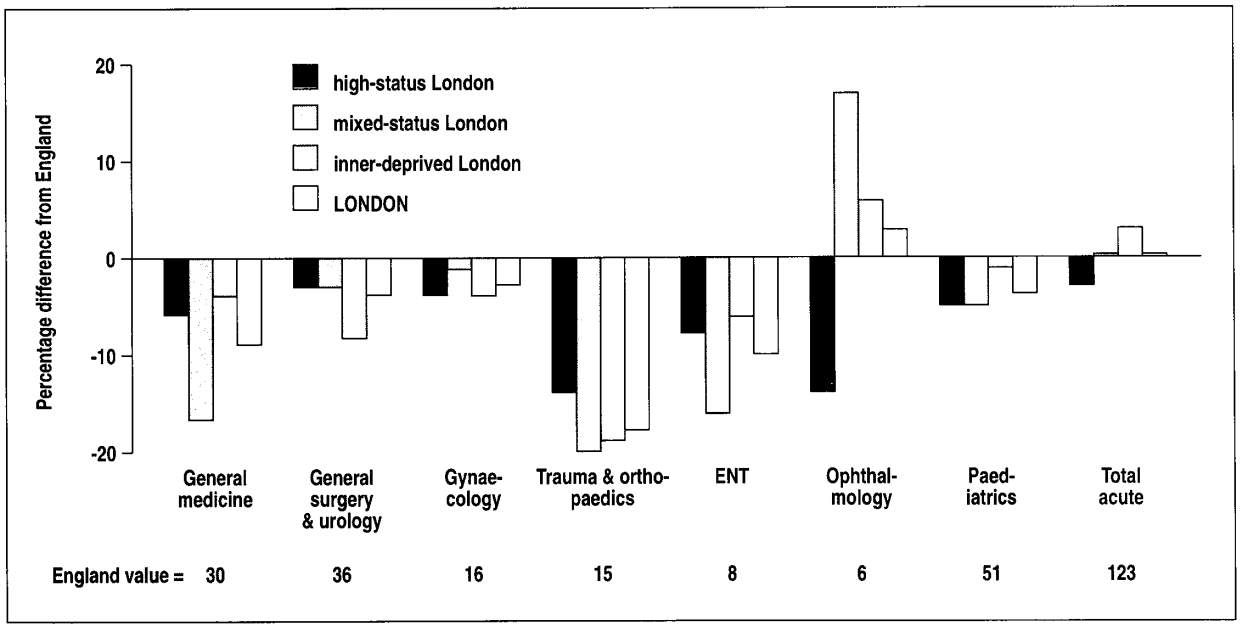

Figure 15 Standardised hospitalisation rates per 1,000 resident population, 1993/94

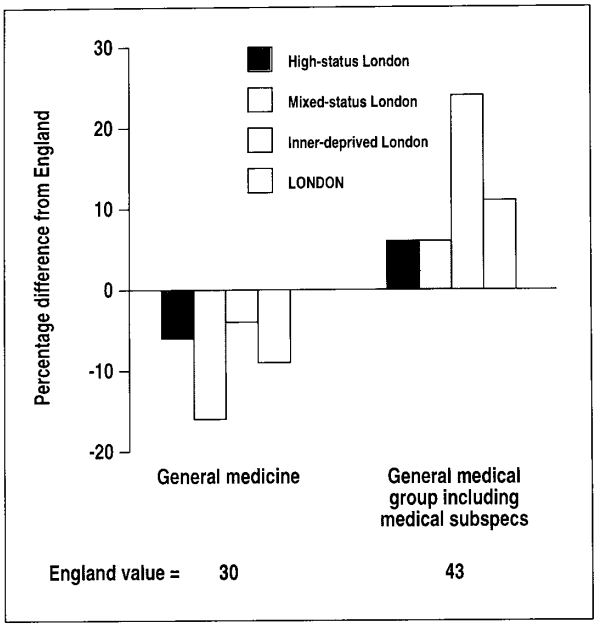

Figure 16 Comparison of standardised hospitalisation rates using two definitions of general medicine, 1993/94

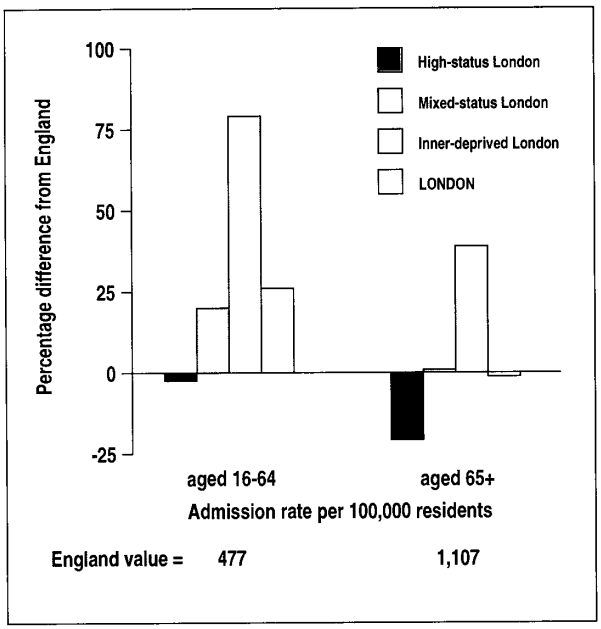

Figure 17 The use of mental health services in London, 1993/94

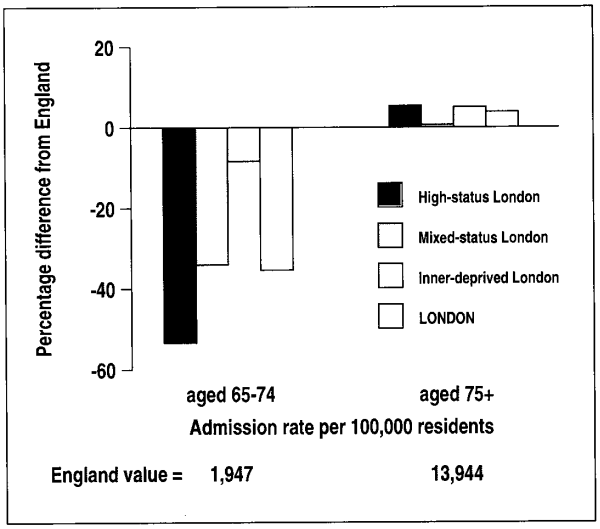

Figure 18 Health care for older people in London (geriatric medicine), 1993/94

medicine, then the hospitalisation rate for this general medical group is higher in London than elsewhere in the country.

Taken at face value these data provide further evidence of a trend identified last year: efforts to reduce levels of hospitalisation in London relative to those nationally have had a definite impact, both specialty by specialty, and in terms of total acute care.

Care for older people and people with mental health problems

Figures 17 and 18 show the use of mental health services and services for older people in 1993/94, measured in terms of resident population. Figure 17 reveals a varied pattern of utilisation of mental health services in London. Considerably greater use is made of acute mental health services by the 16–64 age-group. London as a whole has 26 per cent more adult mental health episodes than the national average. However, in the 65+ age-group there is 1 per cent less utilisation in the capital. In both age-groups there is a higher rate of utilisation in inner-deprived London, which is 79 per cent above the national average for the 16–64 age group and 39 per cent above for those aged 65+. High-status London residents, by contrast, use fewer mental health services: residents aged 65+ use some 20 per cent less mental health services than the average for England as a whole.

Figure 18 compares the utilisation of services for older people in London with that in England as a whole. Again, a varied pattern emerges. In the 65–74 age-group there is a remarkably low rate of utilisation in London – 65 per cent of the England average. This may be an artefact of the data reflecting the fact that this age-group is more often cared for in another specialty. Although the data underlying Figure 15 do not show greater utilisation of acute services generally, further detailed analysis would be required to confirm this result for the 65–74 age-group.

In the 75+ age-group there is greater utilisation in London – approximately 4 per cent more in London as a whole. This may be a reflection of the lack of residential care available in the capital, and needs to be considered in the light of the evidence which was presented in Figure 14. Utilisation in inner-deprived London appears to have fallen off: though still 5 per cent above the England average, this contrasts with 15 per cent in the previous year.

Community nursing

In this section we look at the use of community health services in London by considering contacts with two types of community nurses: district nurses and health visitors. A different picture emerges for the two types of health professional.

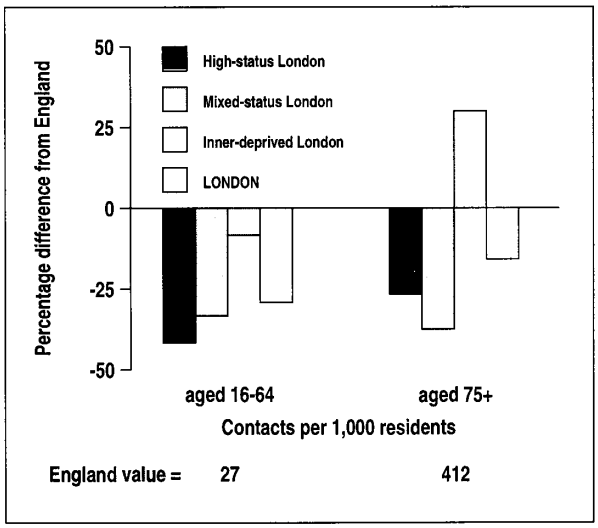

Figure 19 District nurse first contacts per capita in London, 1993/94

Figure 19 compares the number of district nurse contacts in London with the national average for two client age-groups, 16–64 years and 75+ years. Most contacts actually take place with the latter client group, in some areas five times as many as in the 16–64 age-group. In both cases, as the figure shows, London residents have fewer contacts per capita than the England average. In the more important 75+ age-group there are 16 per cent fewer contacts per capita in London overall, although in inner-deprived areas of the capital there are 30 per cent more. In the 16–64 age-group, there are almost 30 per cent fewer contacts per capita in London as a whole. On the basis of these data the situation in London as a whole appears to have remained relatively stable between 1992/93 and 1993/94.

Figure 20 shows similar information for contacts by health visitors with three client groups, the one-year-old age-group, the 2–4 year-old age-group and those aged 75+. In this case it is in the two younger age-groups where most activity takes place. In the youngest age-group London has 3 per cent more contacts per capita than the England average. Inner-

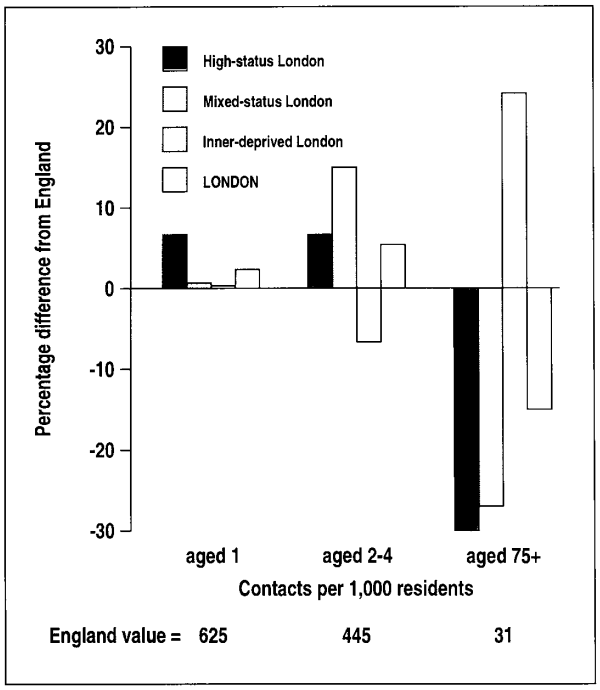

Figure 20 Health visitor first contacts per capita in London, 1993/94

deprived London is close to the national average, but high-status London areas have 7 per cent more contacts per capita. This contrasts with the situation in London in 1992/93 when inner-deprived areas had nearly 65 per cent more contacts than the national average.

In the 2–4 year-old age-group London residents make 6 per cent more use of health visitor services; for the 75+ age-group, contacts per capita in London are 15 per cent below the national average. As was the case in 1992/93, there is a wide diversity between types of London area with high- and mixed-status London almost 30 per cent below the England figure and inner-deprived London nearly 25 per cent above.

Primary health care provision

This section compares the level of staffing of family doctor services in London with that nationally and presents a profile of those services. Usually, in this section, we have considered the provision of support staff such as practice nurses where London has previously been underprovided. Unfortunately, these data were not provided this year in the GMS Basic Statistics (Department of Health, 1995).

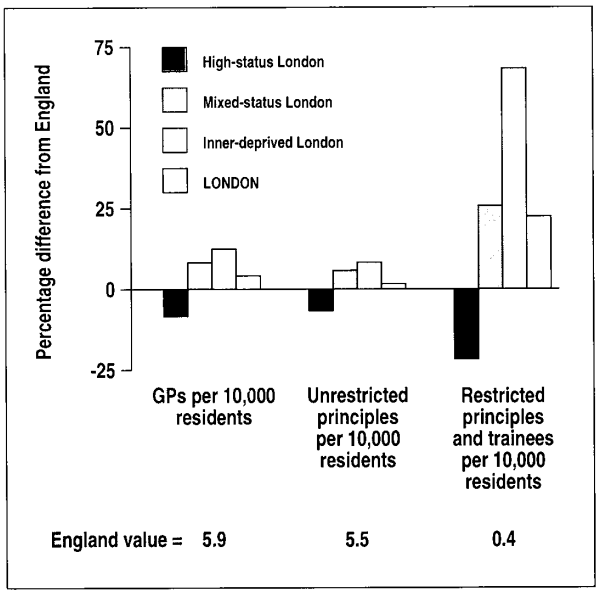

Figure 21 Primary care staffing in London, April 1995

Instead, we present a further refinement based on GP type.

Figure 21, using data for April 1995, shows, in terms of the usual measure of GPs, which is 'unrestricted principles', that London as a whole has approximately 2 per cent more GPs per capita than the England average, a similar picture to that presented last year. Again, there is some variation across the capital, with 8 per cent more in inner-deprived areas and 7 per cent less in high-status areas. However, there are considerably more restricted principles and trainee GPs in London, especially in inner-deprived London, where there are nearly 70 per cent more per capita than is the case nationally.

Figure 22 presents a profile of family doctor services comparing London with England as a whole on a number of indicators, derived from the HSIs for 1993/94. The situation in London, particularly inner-deprived London, is very different from England as a whole, and continues to confirm the picture of an underdeveloped service which has been highlighted elsewhere (Boyle and Smaje, 1993).

Thus 36 per cent of inner-deprived London practices and 31 per cent in mixed-status London operate from premises which fail to meet the minimum standards required under the rent and rates scheme. In London, overall, more than 25 per cent fall below these basic standards compared to England where the figure is 8 per cent. If anything, the position in London has deteriorated since 1991/92, and certainly compared to England as a whole. The proportion of London GPs offering minor surgery to their patients continues to improve but remains low compared to the England figure.

Seventy-eight per cent of GPs nationally offer minor surgery to their patients. In inner-deprived London the figure has increased to nearly 40 per cent and in high-status London 66 per cent are now providing this service.

London has long been characterised as having more single-handed GPs over the age of 65 than the country as a whole, which, though not necessarily problematic in itself, may be indicative of the special difficulties which London faces in providing a fuller range of family doctor services. In 1993/94 London as a whole had almost twice as many single-handed GPs and over twice as many aged

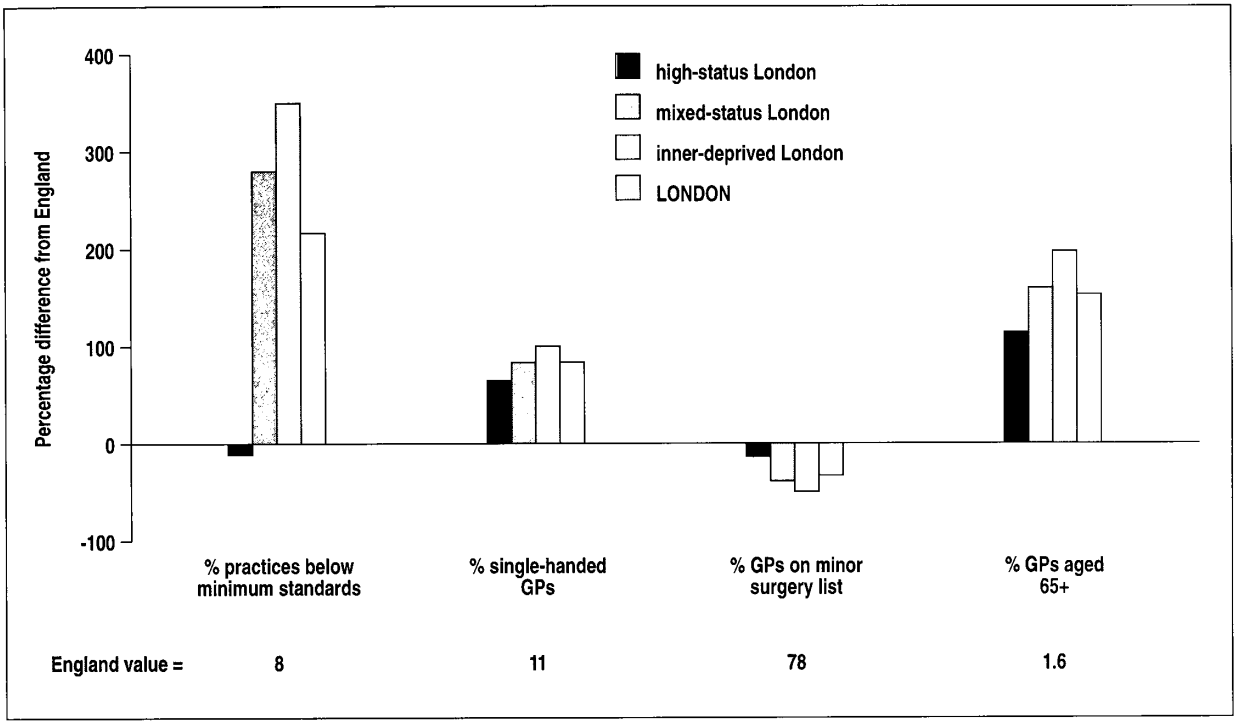

Figure 22 Primary care profile, 1993/94

65+. In the inner-city areas of London the position is marginally worse.

There is little evidence of improvements in the infrastructure of family doctor service provision on the basis of the nationally available comparators which we have presented, although as we saw in the section on finance, there appears to have been an increase in funds devoted to family health services, relative to the rest of the country. However, in the case of basic minimum standards, for example, London is standing still in relation to other parts of the country.

Conclusion

The information in this section provides an insight into the continuing development of London's health services following the King's Fund London Commission report, the Tomlinson Report and *Making London Better*. Three years on from Tomlinson there is still little evidence that planned improvements in London's primary and community care services have taken hold. Indeed, the underprovision of primary care in London in comparison with the rest of England is no better than it was in 1992/93.

Last year the *London Monitor* concluded that the continued provision of appropriate, detailed and timely information is crucial to any attempt to assess the development of health services in London. This conclusion stands. There must be a firm commitment from health services agencies at all levels to make their reports and underlying data available for independent assessment of fact and argument.

Part 3
Analysis and debate

Trends in emergency admissions in London

Chris Garrett, Public Health Analyst
North Thames RHA

This article analyses emergency admissions in London over the period 1991/92–1994/95, using routine data supplied by providers to the Thames RHAs clearing houses. The data and a more detailed analysis have aready been shared with all purchasers and acute providers in the Thames regions. Key findings are listed in a box on page 64.

Recently there has been considerable attention, both in London and nationally, to the issue of increasing emergency admissions. Some providers and purchasers have suggested substantial increases in the level of emergency admissions. Various explanations have been put forward for the increases, including data artefact, improved data collection, inconsistencies in the definition of emergency, lowering of admission thresholds, changes in the needs of patients and supply-induced demand. Unexpected increases in emergency admissions may pose a significant problem to a provider or purchaser, in terms of bed shortages, overspending and cancellation of elective admissions.

In February 1995 the two Thames RHAs, in response to some of the issues raised by the Inner London chief executives' report *Hospital Services for Londoners*, launched a joint programme of work on emergency admissions. This article describes the outcome of part of this work, on the analysis of routinely collected data on emergency admissions.

I would like to acknowledge helpful comments by colleagues, namely Judie Yung at North Thames, Tim Young, Tera Younger and Julie Taylor at South Thames and Francis Dickinson at the Department of Health.

The objectives were as follows:

- to set out the pattern of emergency admissions over time for each acute provider and for all purchasers in London;
- to identify where there are larger than average increases or decreases;
- to consider how purchaser trends compare with those of their main providers;
- to identify whether trends can be quantified in any way.

Analysing the data

This paper considers trends in emergency admissions in London using quarterly data for the period 1991/92 to 1994/95. The analysis is presented in terms of acute providers, the suppliers of care, and of purchasers, reflecting the demand for care by London residents.

The analysis by provider is based on all emergency admissions to the main acute hospital Trusts in London. Emergency admissions to other hospitals or community Trusts are excluded. The number of emergency admissions to each community Trust, by quarter, is relatively small and appears to be random, and there is some evidence that the data covering these Trusts are incomplete. London acute providers are those geographically located in a London borough.

The analysis by purchaser is based on all emergency admissions for London residents irrespective of the location of the provider or the type of provider. London is defined as those health authorities covering London boroughs.

The data provided are generally presented by quarter. Where this is so, data have been corrected for the different number of days in each quarter: so quarterly data are standardised to a quarter length of 90 days.

DATA SOURCES AND VALIDITY

This paper uses routine data obtained from the Thames clearing houses. Clearing house data comprise submissions from all local providers together with data on residents from non-local providers. These data have been used directly from the clearing houses: no separate data validation exercise has taken place. If there are errors in the base data then these will be reflected in this analysis.

The benefit of using routine data in such an analysis is that common data are available across both Thames regions and these data are relatively accessible to users. However, analysis of routine data may suffer from data quality problems which may affect the validity of the final results.

During the period under consideration there have been several changes in provider configurations, in particular around the Riverside acute Trust in west London, and in east London. Where changes have occurred, it has only been possible to consider directly comparable data for the complete period for such providers in aggregate.

Data for Hammersmith Hospital are excluded, since complete data are not available on the North Thames (West) clearing house system for the period when Hammersmith Hospital was part of the special health authority. However, data on London residents treated at the Hammersmith are available from 1991/92 to 1994/95, and therefore the analysis by purchaser includes residents treated at the Hammersmith.

Admissions, not episodes

NHS hospital activity is often measured in terms of finished consultant episodes (FCEs). However, for this analysis it was felt more appropriate to consider admissions. This avoids the problem of multiple episodes associated with a single admission. Admissions have been defined as first episodes, i.e. those FCEs where the episode number equals one.

There has been some suggestion that increases in emergency FCEs may be simply due to changes in coding practices, with the effect that the average number of episodes per admission has increased, creating an apparent increase in the number of emergencies. In fact the ratio of emergency FCEs to admissions varies considerably across providers in London. The highest ratio observed among London providers is 1.61, i.e. 1.6 FCEs for each admission, compared with the lowest level of 1.02, with an average of 1.15 FCEs per admission in the first nine months of 1994/95. The ratio of emergency FCEs to admissions for London providers overall has increased from 1.12 in the first nine months of 1991/92 to 1.15 in the first nine months of 1994/95.

Table 1 Total emergency admissions in London acute providers, 1991/92–1994/95

YEAR	Quarter 1	% change	Quarter 2	% change	Quarter 3	% change	Quarter 4	% change	Total for Year	% change
1991/92	107,423		105,356		113,348		109,714		435,841	
1992/93	107,311	-0.1	106,578	1.2	110,836	-2.2	113,486	3.4	438,210	0.5
1993/94	109,718	2.2	108,428	1.7	116,544	5.2	115,309	1.6	449,999	2.7
1994/95	112,842	2.8	110,552	2.0	115,500	-0.9	115,605	0.3	454,500	1.0

These are financial quarters. So Quarter 1 is 1 April – 30 June. Each quarter's data are corrected for the number of days in the quarter

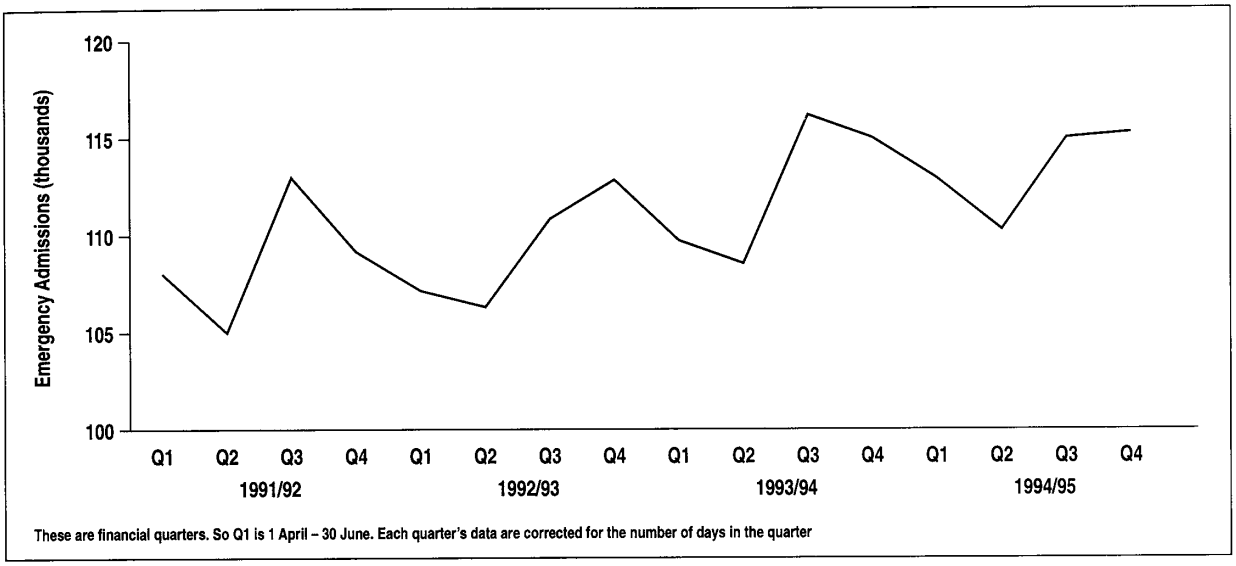

Figure 1 London acute providers – emergency admissions, 1991/92 – 1994/95

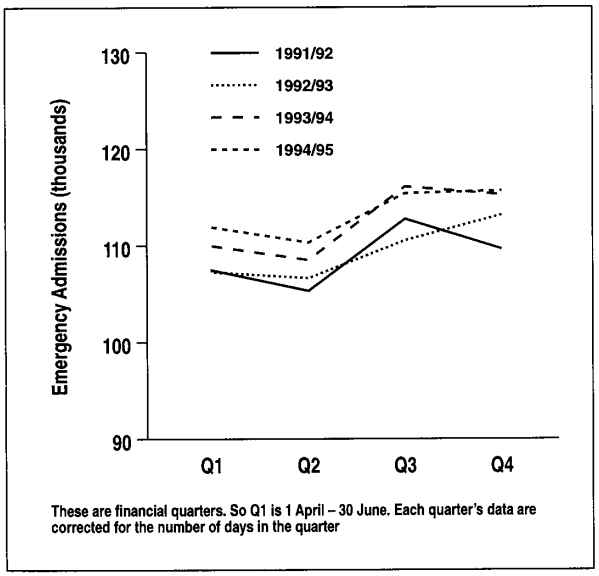

Figure 2 London acute providers – emergency admissions, 1991/92 – 1994/95

Emergency admissions by hospital provider

London as a whole

Figure 1 shows the total number of emergency admissions for all acute providers in London, by quarter, from the first quarter of 1991/92 to the fourth quarter of 1994/95. There has been a slight increase in the level of emergency admissions, after allowing for the effect of seasonal variations.

The seasonal pattern is shown in Figure 2: on average there has been an annual increase of 1.3 per cent. Table 1 shows the absolute and percentage changes on a quarterly and an annual basis.

There seems to be a peak in emergency admissions in the third (financial) quarter of each year. It is perhaps unexpected, given that the third quarter covers the period October to December and that other indicators of emergency admissions show peaks in the fourth quarter. However, this may depend on the severity of the winter: when and whether there is a 'cold snap'. It may also reflect particular pressure at Christmas. Alternatively, other indicators of pressure may just be picking up the result of the peak in emergency admissions in the third quarter.

These results for London are broadly in line with increases in emergency admissions reported elsewhere (see Bensley, 1995; London Health Economics Consortium, 1995).

Variation across hospitals

A range of different patterns over time emerges when the number of emergency admissions by each individual provider is examined. There are complete data for the period for 27 acute providers:

those not affected by reconfiguration, major service change or major data problems. For most providers there seems to be an upward trend in the number of emergency admissions. The average annual percentage increase for these providers varies between +9 and -7 per cent. Four providers have an average annual increase greater than 5 per cent. Twelve have an increase between 0 and 5 per cent, 10 have a decrease between 0 and 5 per cent and one has a decrease greater than 5 per cent.

However, it is worth noting that data from an individual provider cannot totally reflect the demand faced by that provider for emergency admissions. Once the provider is 'full', emergency admissions may be restricted in some way, the most severe restriction being a provider closed to any further emergency admissions. In providers where this occurs, a supply constraint therefore operates. This will result in reducing the rate of increase in emergency admissions over what it would otherwise have been. In extreme examples, it may result in a decreasing trend in emergency admissions for the provider even though demand is increasing. However, it is likely that such unfulfilled demand will result in admission to another provider.

Simple comparisons of one quarter with another do not take advantage of the whole time series that is available for each provider. The evidence suggests the trend in emergency admissions for most acute providers is a combination of two main effects: a general linear increase or decrease and a seasonal pattern which tends to be highest in the third quarter of each year (October to December). It is possible to fit a statistical model to the data on emergency admissions for each provider which takes account of both the trend and seasonal effects, and this has been done although the results are not reported here.

Emergency admissions by purchaser

London as a whole

Figure 3 shows the total number of emergency admissions for all London residents by quarter from the first quarter of 1991/92 to the third quarter of 1994/95. Again, there has been a slight increase in emergency admissions, after allowing for the effect of seasonal variations.

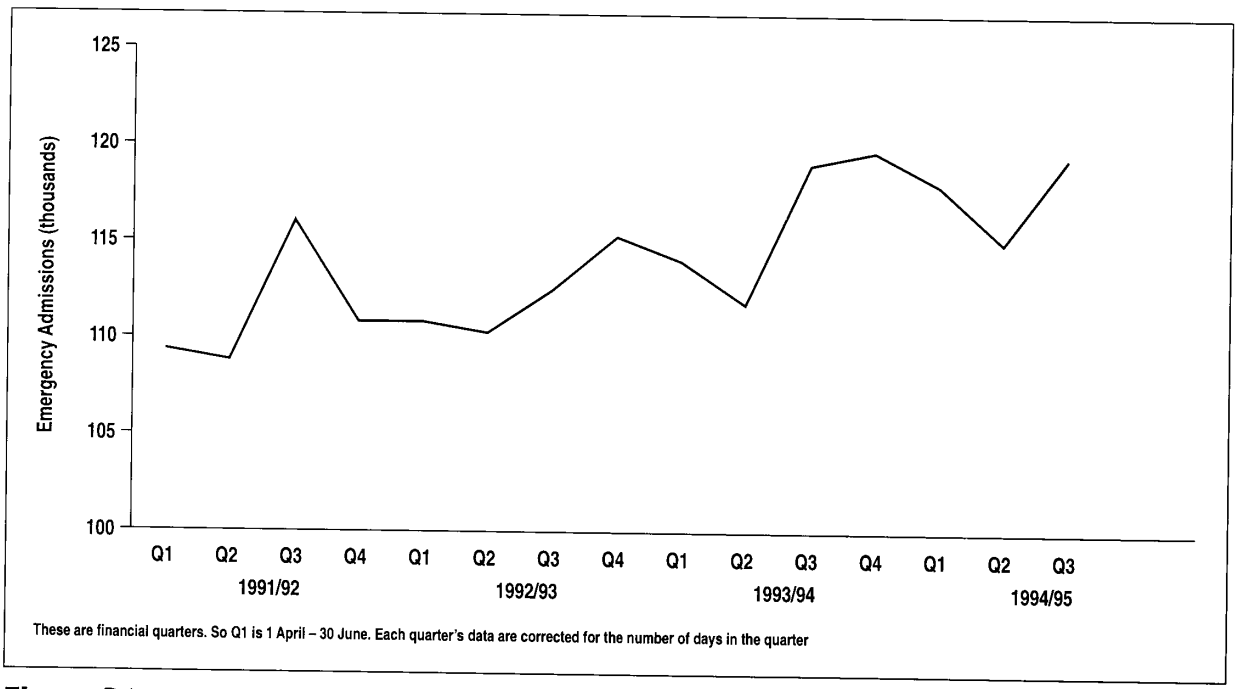

Figure 3 London health authorities – emergency admissions, 1991/92 – 1994/95

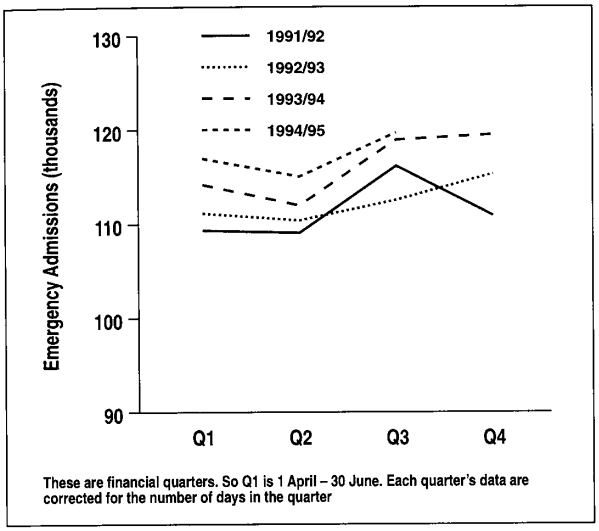

Figure 4 London health authorities – emergency admissions, 1991/92 – 1994/95

The seasonal pattern is shown in Figure 4: on average there has been a year-on-year increase.

Over the period there has been an average annual increase of 1.6 per cent in London. This differs from the average annual increase in emergency admissions in London acute providers of 1.3 per cent, the difference reflecting the different time periods over which the increases have been measured and also different data coverage. For example, the increase for London providers includes only acute providers and excludes the Hammersmith. The increase for London health authorities covers all emergency admissions whether treated at a London acute provider or not. Some of these admissions will be to providers outside London and some of the emergency admissions treated in London acute providers will not be residents of London authorities.

The increase in emergency admissions across London health authorities as a whole is shown in Table 2.

Comparing with increases in elective work

The increase in emergency admissions can be compared with increases in other types of admission. Figure 5 overleaf shows the trend in admissions by type of admission – emergency, elective inpatient and daycase for the residents of North London health authorities. There has been a dramatic increase in daycases from the first quarter of 1991/92 to the third quarter of 1994/95 – an increase of approximately 80 per cent. As a result, total admissions have increased at a greater rate than emergency admissions, although elective inpatient cases have declined.

Variations across purchasers

A range of different patterns over time emerges when the number of emergency admissions by each individual purchaser is examined. For most purchasers, there would seem to be an increasing trend in the number of emergency admissions.

To compare purchasers more directly, emergency admission rates have been calculated for each purchaser by dividing the number of admissions by the relevant mid-year OPCS population estimate. Figure 6 overleaf shows the emergency admission

Table 2 Total emergency admissions of residents of London health authorities, 1991/92–1994/95

YEAR	Quarter 1	% change	Quarter 2	% change	Quarter 3	% change	Quarter 4	% change	Total for Year	% change
1991/92	109,650		109,192		116,314		111,172		446,327	
1992/93	111,176	1.4	110,599	1.3	112,492	-3.3	115,363	3.8	449,630	0.7
1993/94	114,138	2.7	111,857	1.1	118,719	5.5	119,725	3.8	464,439	3.3
1994/95	116,906	2.4	114,987	2.8	119,429	0.6				

These are financial quarters. So Quarter 1 is 1 April – 30 June. Each quarter's data are corrected for the number of days in the quarter

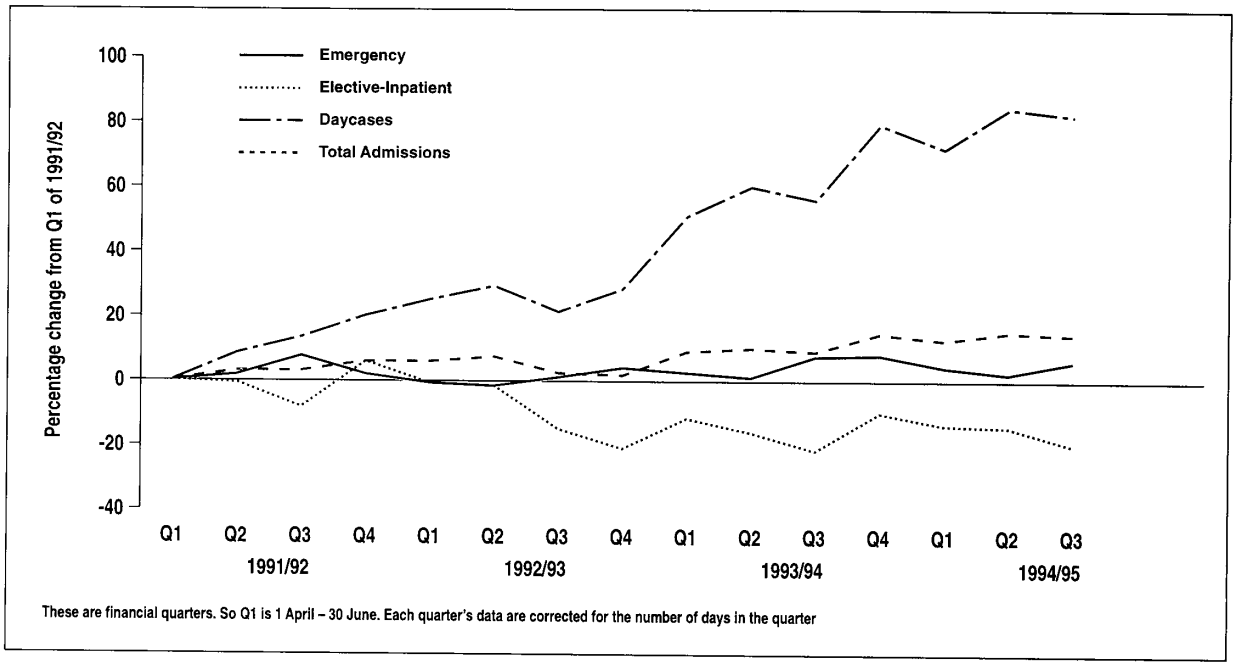

Figure 5 Change in admissions by type of admission compared to the first quarter of 1991/92

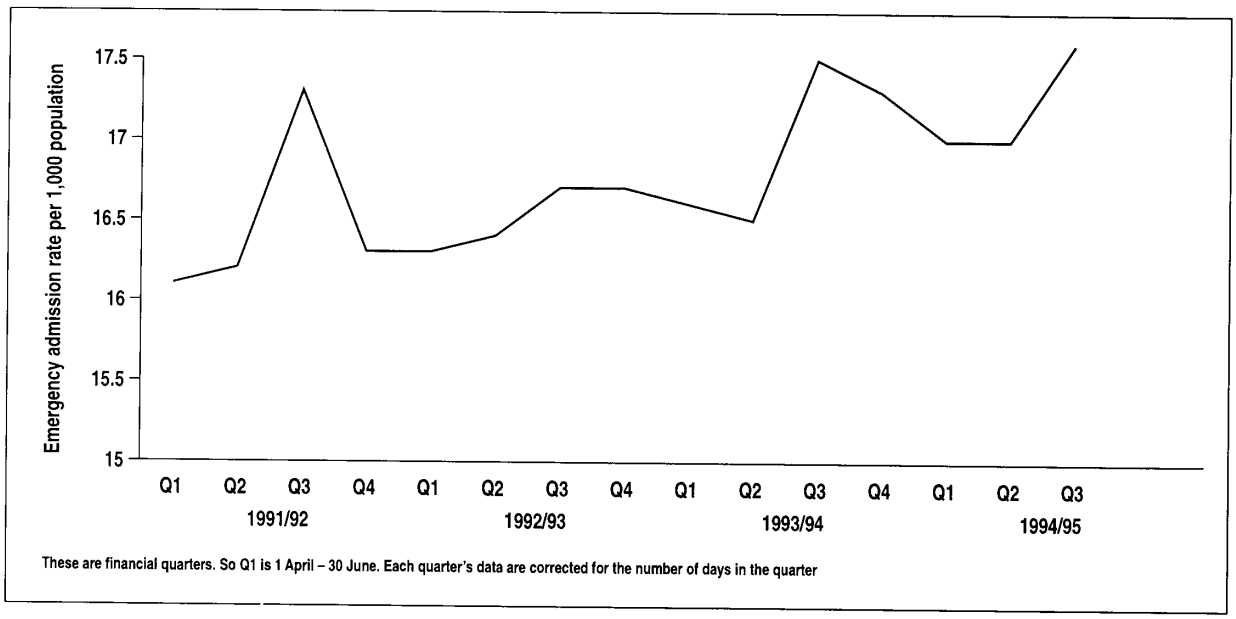

Figure 6 London health authorities – emergency admission rate per 1,000 population

rate per 1,000 population in London has increased by 9 per cent from 16.1 in the first quarter of 1991/92 to 17.6 in the third quarter of 1994/95.

Emergency admission rates vary considerably across individual health authorities. Of the 16 authorities in London, 13 have emergency admission rates between approximately 12 and 18 per 1,000 population, while three have rates generally above 18 per 1,000 population. In the first quarter of 1991/92, the emergency admission rate

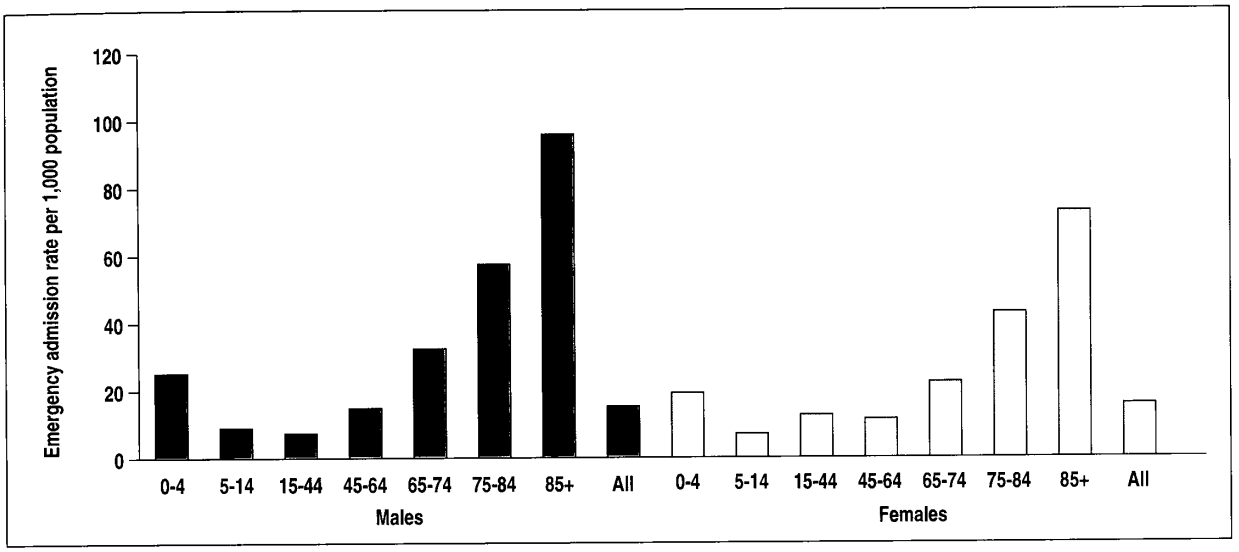

Figure 7 Emergency admissions per 1,000 population per quarter, average for Thames RHAs, 1994/95

was just 12.4 admissions per 1,000 population in one London authority and 20.1 in another. Some of this variation may be caused by different population age and sex distributions, but differences in age and sex composition alone are unlikely to explain the difference.

There are 15 authorities in London which have no major data problems over the period 1991/92 to 1994/95 and therefore have complete data for the period. The average annual percentage increase for these purchasers varies between +3 and -2 per cent. Twelve London authorities showed an increase between 0 and 5 per cent and three a decrease between 0 and 5 per cent.

As for the data on London's acute providers, the trend in the emergency admission rate per 1,000 population for most London authorities is a combination of two main effects: a general linear increase or decrease and a seasonal pattern which tends to be highest in the third quarter of each year (October to December). Again, it was possible to fit a statistical model to the data on this basis but the results are not reported here.

The impact of age and sex

The impact of the age and sex distribution of the resident population on the overall number of emergency admissions was considered in more detail for all patients resident in the Thames RHAs using data for 1994/95. The number of emergency admissions in each age/sex group was divided by the relevant population taken from the most recently available OPCS mid-year estimates (1993) to give emergency admission rates per 1,000 population per quarter for the residents of the Thames RHAs. These admission rates are shown in Figure 7.

On average the admission rate per quarter is 16 per 1,000 population, but the rate increases considerably in the population aged 65+. The admission rate per quarter for males aged 85+ is 96 per 1,000 population, 6 times the overall average; the rate per quarter for females aged 85+ is 73 per 1,000 population, 4.5 times the average rate.

Figure 7 demonstrates clearly that the age and sex structure of the resident population of a health authority will have an impact on the expected number of emergency admissions. However, generally those authorities in London with the highest emergency admission rates per 1,000 population have a population age and sex structure that would suggest an overall emergency admission rate at or below the average. This implies that other factors are involved.

Conclusion

The increase in emergency admissions across London, both by acute provider and by purchaser, is less than was expected, given the degree of

attention which this subject has attracted. However, this does not allow the issue to be dismissed. Even small increases in emergency admissions – and their cumulative effect – can have a significant impact on a provider. Where there is considerable daily variation in the numbers of emergency admissions, this may also add to the problems of managing the uncertainty. Unless there is good reason to believe that the overall trend in London does not apply locally, purchasers and providers would do well to plan for increases in emergency admissions.

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KEY FINDINGS

Providers

- The average annual increase in emergency admissions across acute providers in London was 1.3 per cent for the period 1991/92 –1994/95. Similar analyses in other parts of the country have reported average annual increases of up to 4 per cent.
- Of 27 acute providers in London with suitably consistent data series, four have experienced average annual increases over the period 1991/92–1994/95 of 5 per cent and above. Some of these increases result from service changes either at the hospital concerned or at a local provider, e.g. a new hospital, or a nearby hospital closing A&E. One provider out of the 27 experienced an average annual decrease in excess of 5 per cent.

Purchasers

- The average annual increase in the emergency admission rate per 1,000 population resident in London was 1.6 per cent for the period from 1991/92 to 1994/95.
- There are large variations in admission rates per quarter between health authorities: from 12.4 admissions per 1,000 population in one London authority to 20.1 admissions per 1,000 population in another.

General observations

- Age is a significant factor in determining emergency admission rates. Large variations were shown with males aged 85+ having a rate six times the average and females aged 85+ having a rate approximately 4.5 times the average.
- The ratio of finished consultant episodes (FCEs) to admissions has increased from 1.12 to 1.15 between 1991/92 and 1994/95, taking London acute providers as a whole. This explains 48 per cent of the increase in emergency FCEs in this period. The remainder of the increase in FCEs is due to an increase in admissions. Therefore trends in emergency admissions measured in terms of FCEs will overstate the increase.

The London Ambulance Service:

recent progress and future prospects

Kathy Jones, Corporate Development Manager
London Ambulance Service

Three years after the famous 'computer crash' of October 1992, the London Ambulance Service (LAS) is reaching over twice as many calls within 14 minutes. This article provides a detailed picture of improvements in performance in the face of a substantial increase in demands on the service.

It is now widely recognised that targets based purely on response time bear only a partial relationship to health outcomes. More sophisticated measures of ambulance service quality are required based on evidence about the impact of clinical care as well as journey times on patient outcomes.

More general measures of performance are considered, taking as a starting point the recent interim report of the Department of Health steering group's review of ambulance performance standards. The debate is moved beyond ambulance service provision alone to a new model for the provision of 'direct access' NHS care.

Improving the performance of the LAS

In September 1995 the LAS reached 73 per cent of its '999' callers within 14 minutes. The national target for urban services is 95 per cent. Although still below national standards, this performance was 9 percentage points better than that of two years previously, and this despite a 18 per cent increase in workload.

The full range of performance standards which ambulance services are expected to meet are given in Table 1.

Figure 1 shows the increase in demand for ambulance services, in terms of number of calls per day, over the period December 1992 to September 1995. In common with many A&E departments and ambulance services across the country, the LAS has seen a marked change in demand patterns over the

Table 1 Current national performance standards for ambulance services

Standard	Definition	Target
Activation time	Time between when the '999' call is answered and when the ambulance is mobilised	95% within 3 minutes
Response time	Time between when the '999' call is answered and when the ambulance arrives on the scene	50% within 8 minutes 95% within 14 minutes*
Urgent response time	Time of arrival at the designated hospital as a result of a GP request	95% within 15 minutes of requested time (before or after)

* This target applies to urban areas. The rural target is 95 per cent within 19 minutes.

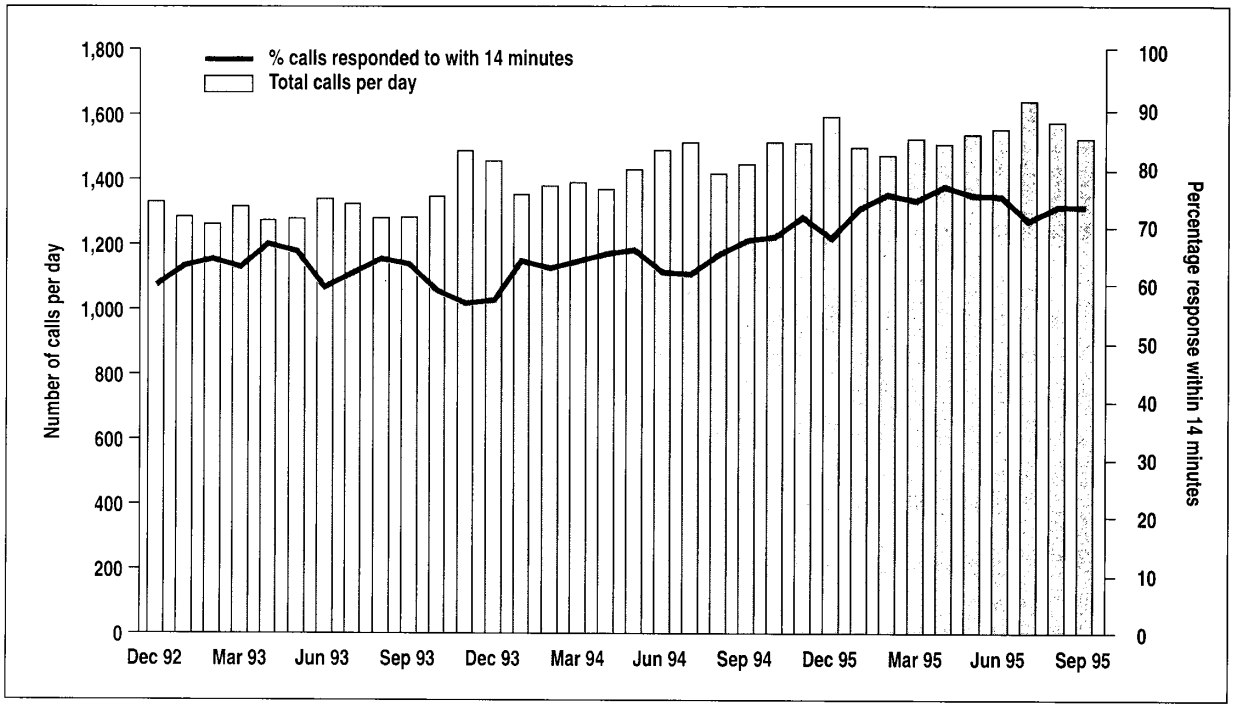

Figure 1 LAS demand and performance, December 1992 to September 1995

last two years. Following a number of years of relative stability in the numbers of '999' calls, there was a sudden increase in demand in November 1993, which has continued consistently since, at around 10 per cent a year. Furthermore the pattern of demand has changed, with the traditional Christmas peak now being matched by a summer peak. July 1995 was the first month in which the number of responses to '999' calls topped 50,000 in London.

Figure 1 also illustrates improvements in LAS performance against the 14 minute standard during this period – the LAS is seeing more patients, more quickly.

In order to show more clearly the impact of demand upon performance, the LAS produces indices of calls per day and calls responded to within 14 minutes. These are shown in Figure 2, which demonstrates that while demand in

Table 2 Numbers of patients seen per LAS resource, July 1992 and July 1995

	July 1992	July 1995	Percentage change
Emergency calls per front-line vehicle	127	155	+ 22%
Emergency calls within 14 minutes per front-line vehicle	65	110	+ 69%
Emergency calls per qualified ambulance technician	27	30	+ 11%
Emergency calls within 14 minutes per qualified ambulance technician	14	21	+ 50%

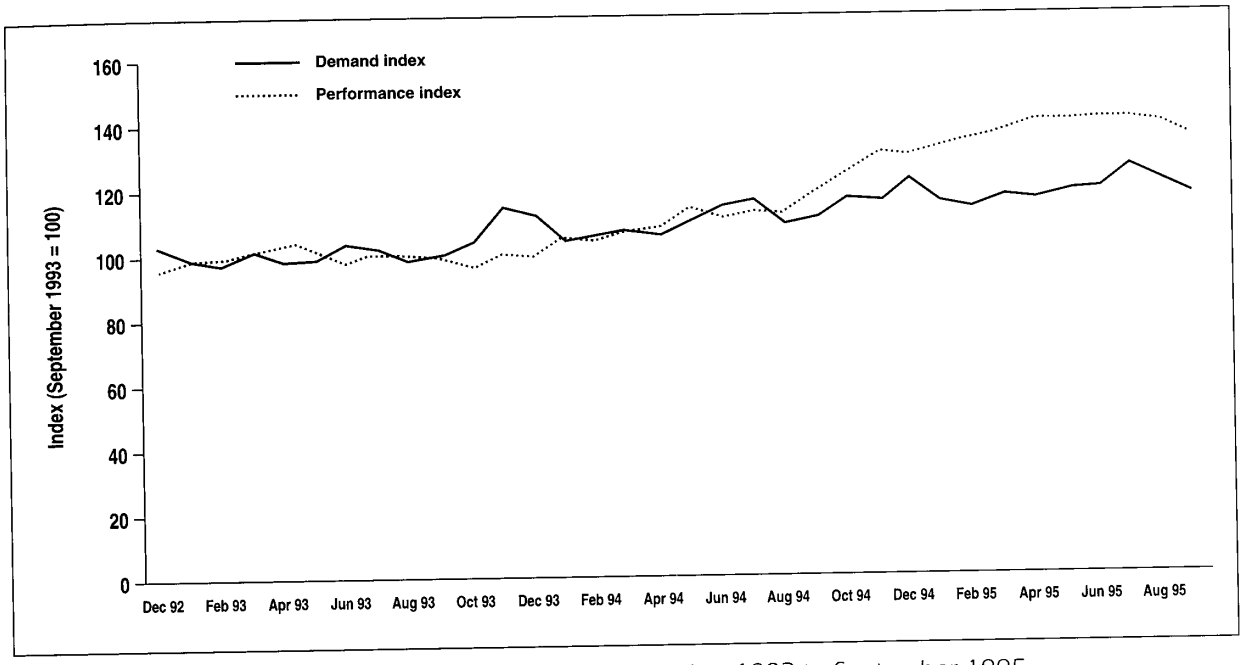

Figure 2 Index of LAS demand and performance, December 1992 to September 1995

September 1995 was 18 per cent higher than that two years earlier, the number of calls reached within 14 minutes increased by 36 per cent. The LAS is chasing a moving target, but is gaining on it.

Extra funding has been used to increase front-line staffing and replace vehicles as well as invest in technology. If performance improvements are expressed in terms of resource utilisation, it is possible to see how well the LAS has used the extra resources. This is shown in Table 2. Again, a picture of rapid and significant improvement emerges.

Achieving change

Improved performance has been achieved by a substantial programme of investment in both human and physical resources. Following the well-publicised computer collapse of October 1992, the first priority of the new chief executive was to re-establish stability. The control room returned to manual systems and considerable attention was paid to restoring relationships between staff and managers across the organisation. The next phase was one of rebuilding. More funding was secured, management capacity was strengthened and the basis of technological improvements was laid.

Specific measures which have contributed to performance improvement include:

- *Increased resources:*

  – 180 new ambulances;
  – 240 extra crew staff in 1994/95, and a further 300 by May 1996.

- *Improved resource deployment:*

  – an expert analysis of demand and performance, leading to new rosters and staff deployment which were introduced in May 1995;

  – a dedicated team for dependent but non-urgent patients so that other crews are always available for '999' and urgent work;

  – an increased number of sector desks in the control room in order to reduce the number of ambulances being controlled by each despatcher.

- *Improved technology support and infrastructure:*

  – total replacement of the headquarters' electrical and telephone systems;

  – preparatory work for the re-introduction of an automatic vehicle location system, computerised gazetteer and computerised 'on-screen call-taking';

– hand-held radios for ambulance crews, making them accessible at all times and enhancing their safety.

- *Improved staff skills:*

  – 610 paramedics by the end of September 1995 (compared with 455 in September 1994);

  – increased investment in management training.

- *Improved accountability:*

  – regular performance reports to South Thames Regional Health Authority which are widely circulated, and an open and proactive media relations strategy;

  – a permanent team dealing with complaints and enquiries.

- *Improved management:*

  – a new divisional structure designed to improve responsiveness to the rest of the NHS;

  – a new management structure designed to devolve decision-making and cut out unnecessary layers of management;

  – a new senior management team, bringing in specialist expertise in a range of crucial areas;

  – a new staff consultative mechanism;

  – improved management information systems.

Next steps

Much of the improvement in the short term will come from reducing activation times – the time taken to mobilise an ambulance once a call is received. A new Control Room at the LAS's Waterloo headquarters opened in January 1996. The new technology available to Control Room staff, combined with the increasing availability of front-line staff, is designed to result in radically improved response times.

On the assumption that activity increases by no more than a projected 10 per cent in the 1995/96 financial year, the LAS expects, by the end of March 1996, to meet the *Patient's Charter* target of reaching 50 per cent of '999' patients within eight minutes, and 95 per cent of patients within 14 minutes. The LAS also expects to be getting 90 per cent of urgent patients to hospital within 15 minutes of the time agreed with their GP.

However, the discussion of efforts to meet current time-based standards provides only half the picture. In a changing health care world, the LAS will have to adapt to different types and levels of service requirement. The next section considers how the ambulance service of the future will look and what this will mean for London.

The future of ambulance services

Dealing with demand pressures

The increase in emergency calls to ambulance services in London is reflected around the country. The reasons for this are still not fully understood. There have been many suggested explanations – an increase in illnesses related to poor air quality, the reluctance of GPs to attend patients out of hours, an increase in the number of older people living alone, increases in the level of hospital re-admissions, the impact of community care, higher patient expectations associated with the *Patient's Charter* – none of which prove convincing on their own.

Patient habits may have changed. In the past people have been accustomed to accessing the rest of the health service through their GP. Increasingly, there appears to be a proportion of the population which seeks to access the NHS through the emergency route, regardless of the seriousness of their condition.

One response to this might be public education designed to encourage appropriate use of emergency services. Paradoxically, such campaigns can be counter-productive, discouraging those who are already reluctant to 'cause trouble' for the emergency services and increasing the incidence of inappropriate use as a result of the publicity for the service.

Another approach is to work with, rather than against, the grain of public expectation. This would mean providing health services, to coin a phrase, 'when the patient wants them and where the patient wants them'. The challenge is to determine what the most appropriate response is, and to develop services accordingly which are cost-effective and clinically effective as well as consistent with patient expectations.

An ambulance service which was empowered to

send the most appropriate response would play a very different role within the NHS. Its performance would also be measured in a different way.

More relevant time-based standards

Ambulance service performance standards are time-based rather than clinical measures. In some circumstances, time standards can of course act as proxies for clinical outcomes. There is some evidence on the impact of time between onset of illness or accident and definitive treatment in certain conditions, including heart attacks and some cases of trauma (Cobbe *et al.*, 1991). However, apart from cardiac cases, this evidence does not lead to clear conclusions about how soon an ambulance should arrive with such patients. In fact the evidence may be more helpful in devising protocols for where to take patients and how soon they should be there. However, current ambulance performance standards are exclusively about the time of arrival with the patient.

The national standard that 50 per cent of ambulances should arrive within eight minutes bears some relation to what is known about survival from heart attacks. However, the current standard makes no distinction between the immediately life-threatening cases such as these, which would benefit from the earliest possible response, and the less serious, for which speed of response will have less effect on outcome.

In July 1995 a Department of Health steering group published proposals designed to produce ambulance performance standards which take account of the severity of the patient's condition (Department of Health, 1995a). Three performance targets have been suggested (see Table 3).

Target times would relate to the arrival of qualified assistance on scene, rather than the arrival of a particular type of vehicle. The proposals recognise the massive changes that have already taken place within UK ambulance services, from being emergency services that delivered first aid, to being medical services that can transport patients, if required.

These proposals open up the possibility of the ambulance service being able to send one or more of a range of vehicles. In London, with its all-day traffic congestion, the paramedic motorbike service will play a crucial role. There are now ten motorcycle response units, which service both central and outer London.

Currently motorcycle units reach between 55 per cent and 60 per cent of patients within eight minutes and around 95 per cent within 14, even though at present they are always mobilised after a front-line vehicle. The LAS estimates that it would be possible to meet the target for Category A (immediately life-threatening) patients if the number of motorcycles is increased to 50.

Prioritisation of '999' calls

The Department of Health's review proposed that Category A should include the following categories of patients:

- adults with chest pain associated with any of the following: pallor, cyanosis, shortness of breath, sweating, nausea or vomiting; but specifically excluding those for whom the pain is intensified by breathing;

Table 3 Proposed ambulance performance standards

Category	Definition	Proposed time standard
A	Immediately life threatening	90% of cases to be attended within 8 minutes
B	Serious	50% within 8 minutes and 95% within 14 (urban areas) and within 19 minutes (rural areas), i.e. current standards
C	Not life-threatening or serious	'Health authorities and providers should develop a local system of arrangements and standards for these calls'

- individuals who are unconscious, fitting or unresponsive for any cause;
- individuals with severe breathing problems who are unable to speak whole sentences;
- individuals who have suffered trauma with penetrating injuries to the head or trunk;
- any individuals recognised as having anaphylactic shock (e.g. due to an allergy to nuts).

Concern expressed in the press about the proposal to prioritise calls has focused on the difficulty of making a decision about the severity of a patient's condition based on information taken over the telephone. It is feared that some patients may receive a slower response than their condition warrants and that the decision-making required of call takers will put too much of a burden on them.

However, priority dispatch systems have been in use in the USA for some time and are designed precisely to establish, within rigorous safety margins, the speed and type of response required. The two main systems in use are currently being tested for their safety at Derbyshire and Essex ambulance services in a study being carried out by the Sheffield University School of Health and Related Research on behalf of the Department of Health.

The LAS is also carrying out its own project to consider the implications of operating a priority dispatch system in the circumstances of high call volume and relatively under-developed primary care that exist in London. It is combining information on the number of calls which might fall into each category with its demand and resource model in order to determine how many of which type of resources would need to be deployed, when and where, in order to meet the proposed new performance standards.

A clinical focus

This project is part of a programme to develop a more clinically focused LAS. The purpose of this is to focus on the type and quality of care that is delivered and to see it as part of a total package of care delivered through co-operation between NHS providers and social services.

Another important part of this programme is the development of clinical audit and research. In May 1995 the LAS appointed a clinical audit manager. Work in progress includes audit of the pre-hospital care offered to asthma sufferers, including an assessment of the recognition of asthma cases by crews, whether appropriate treatment is administered, and patient views on the quality of care received.

The LAS is also developing a system routinely to follow up patients suffering out-of-hospital cardiac arrests through A&E, their inpatient stay and up to one year after discharge for survivors, according to an internationally agreed template. Fundamental to the soundness and success of audit and research is a project to rationalise the collection and collation of patient-related information.

The LAS is also interested in developing research and, in collaboration with others, has submitted proposals to the NHS Executive R&D programme on:

- obstetric skills training for paramedics;
- paediatric trauma skills for paramedics;
- the nature and severity of mental health problems presenting through the '999' system.

A further proposal is being prepared for submission to the North Thames R&D programme. This would look at the implications in London of the proposed new ambulance performance standards.

Recent NHS Executive guidance (Department of Health, 1995b) has laid out the responsibilities of the new health authorities to ensure a co-ordinated and coherent approach to clinical audit in all their providers. While ambulance services may represent only a small contract to each purchaser, they have considerable data to assist in reviews of case management and form an important link in the chain of care. The LAS is interested to work with the 16 London purchasers to develop a co-ordinated approach to clinical audit along the lines suggested in the NHS Executive guidance. Audit and research can contribute to the development of new, more appropriate ambulance care in all three categories of call proposed by the steering committee.

Dealing with primary-care '999' calls

At the less serious end of the scale, Category C (not life-threatening or serious) calls may not require admission to an A&E department. LAS control superintendents recently produced a list of such calls, which included dealing with blocked catheters, responding to depressed and lonely people, carrying out social services such as lifting people back into bed (while checking for injuries), securing a GP visit for a patient, securing emergency dental care, or securing medication or oxygen for patients who have run out of their own supply.

These cases vary greatly in their nature and severity. What they have in common is that they do require a response, but not within 14 minutes nor do they need to be conveyed to an A&E department. The steering group estimates that these may constitute as many as 30 per cent of '999' calls. Their proposals offer an opportunity for ambulance services and their purchasers to consider what alternative, more appropriate assistance should be offered to this important group of patients.

Beyond time-based standards

The steering group's proposals also provide the opportunity to extend the current NHS interest in evidence-based health care to ambulance services. There is a very meagre literature on the effectiveness of pre-hospital care, especially outside the areas of cardiac cases and trauma. As this literature grows, the Department of Health and purchasers will wish to consider the full range of evidence about impact on outcome. As well as the time taken to arrive on scene, of equal importance are the treatment given at the scene, the time taken to convey to hospital and the appropriateness of the treatment centre to which the patient is taken.

The proposals for new ambulance performance standards give purchasers and ambulance services alike the opportunity to reconsider the role that the emergency response should play in the total package of direct-access care that is available to the community if they dial '999'.

The role of ambulance services is currently somewhat limited. They must send a vehicle capable of conveying a patient. They must convey that patient to the nearest A&E department, except under certain, limited circumstances. They are not allowed to diagnose or to discharge. They are not normally allowed to convey a patient to minor injuries clinics.

The tendency of the current rules is therefore to escalate the response to the patient's condition. Patients with blocked catheters and sprained ankles end up in A&E departments. Frequently, they then wait for long periods while more serious cases receive attention. They get a delayed service and the acute hospital carries out a procedure which could have been done more promptly in the community. The way that ambulance services are currently obliged to operate runs directly counter to the aim of developing a primary care-led NHS.

A model for the future of immediate access to NHS care

The move towards standards which focus on the patient's clinical condition gives an opportunity to develop a model of a total NHS response to immediate needs. Figure 3 shows how it could work. The key elements might be:

- **A single telephone answering point** for '999' calls, calls from GPs, etc. making arrangements for admissions, out-of-hours calls from patients to their GPs, advice and help lines.
- **A telephone triage system** to deal with all calls according to clinically determined protocols and categorise them according to their seriousness and the type of response required. Immediate response could be:

  – referral to another agency according to agreed protocols;

  – sending a 'conventional' ambulance service response, e.g. a paramedic response unit (or the most appropriate vehicle for the circumstances) and/or a front-line ambulance, staffed with the appropriately skilled people;

  – sending a 'new style' response such as a GP, district nurse, midwife or health visitor, accompanied if appropriate by an ambulance service driver/navigator.
- **On-scene triage,** which means that once the

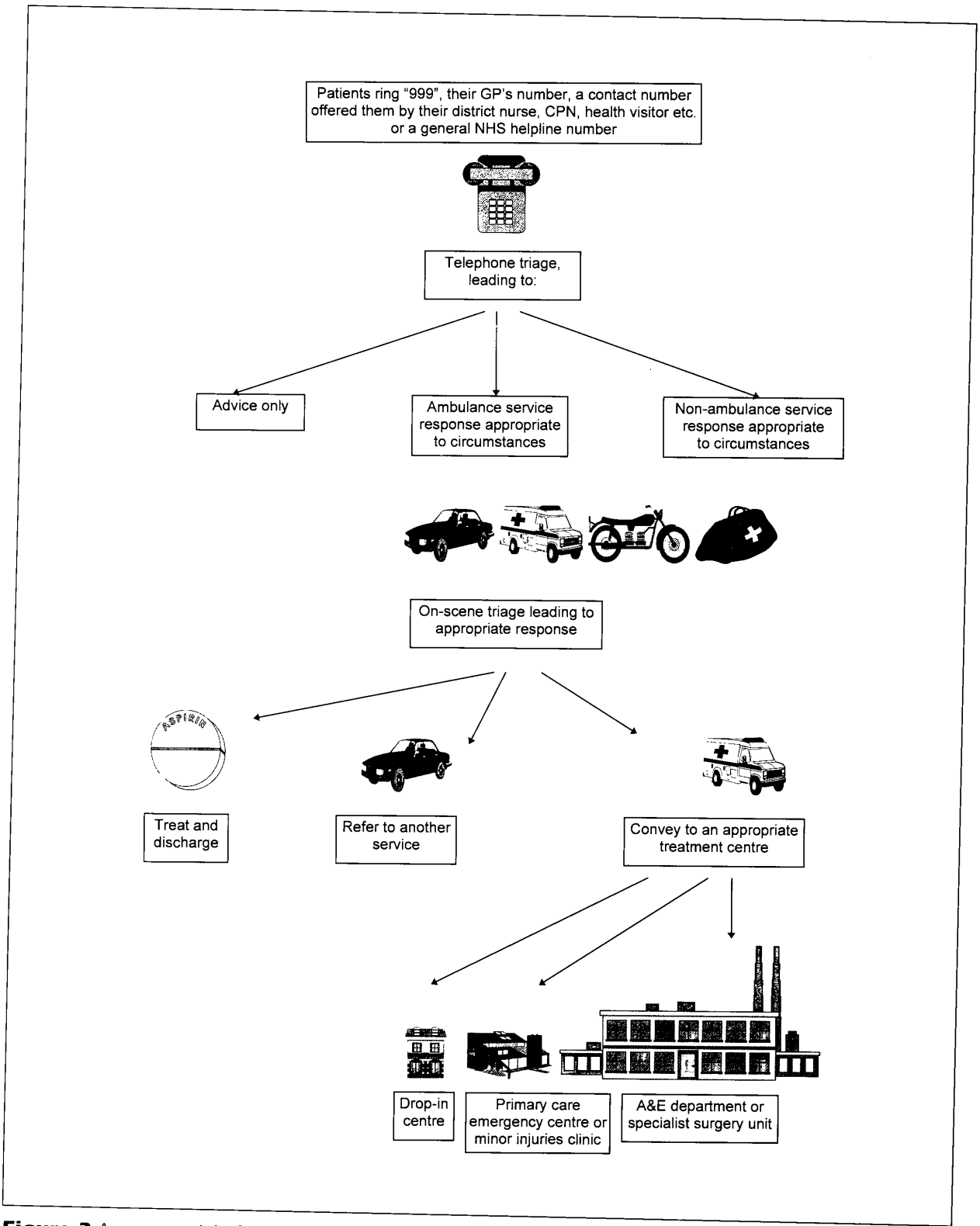

Figure 3 *A new model of immediate-response NHS care*

response has arrived with the patient, a decision will be made about what happens next:

– treat and discharge (which currently can only be done if a doctor is present);

– refer to another, more appropriate service;

– convey the patient to the appropriate treatment centre, e.g. specialist unit (surgery, burns, etc.), A&E department, minor injuries clinic, primary care emergency centre, psychiatric service, etc.

This model would be difficult to establish. It would require research into appropriate care pathways for a wide variety of patients. A consensus would need to be developed between purchasers, ambulance services and a wide range of other health and social services about these care pathways and how to set patients going on their journeys down them. Numerous treatment and referral protocols would need to be discussed and agreed.

However, there are a number of possible advantages:

- appropriate care can be provided first time round, instead of the current treat and transfer model;
- primary care needs would be met in primary care settings, not 'escalated' to the acute sector;
- other needs, such as psychiatric services, could be secured far more quickly for the patient;
- conversely, patients who underestimate the severity of their condition and call their GP, would get an ambulance service response because their call is answered by the ambulance service and triaged alongside other calls;
- the 'social care' needs currently met by the ambulance service would be correctly identified;
- co-operation and understanding between different health and social services would be maximised.

A colleague from Durham Ambulance Service currently working at the LAS describes this vision in terms of the British Telecom response when a caller rings '999'. Currently, the operator asks the caller whether they want 'Police, Fire or Ambulance'. Instead, under this proposed model, the response should be 'Police, Fire or Health'. The *Patient's Charter* right to an emergency response is safeguarded, but the nature of the response is determined by the nature of the emergency.

Conclusion

In London, with its 16 purchasers and up to 100 providers, it may seem a daunting task to establish a new model of providing direct-access NHS care. The LAS wishes to contribute to discussion about the model by working with interested purchasers and providers on a range of pilot projects designed to test the feasibility of this flexible and patient-centred approach to providing immediate aid. Each will cover a specific group of patients with identified needs and experiment with different ways of meeting those needs, through referral to other agencies, through the ambulance service providing the care itself, or through admission to appropriate alternative treatment centres. The LAS intends to share the experience of these pilot projects at a seminar or conference in 1996 in order to enable commissioners to consider the development of a pan-London approach to the future of immediate-response NHS care. It is possible that the joint work and co-operation involved will be a fruitful source of thinking about services far beyond what the ambulance service provides.

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Psychiatric emergencies:
a dilemma for London mental health services

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London's emergency psychiatric services assess thousands of people each year. Many of these people are so ill, or pose such a risk to themselves or others, that they require inpatient care. Unavailability of psychiatric admission beds, or of community alternatives to inpatient care, makes the management of these patients very difficult and puts tremendous strain on front-line workers. Too often, the burden of making these emergency assessments, and resulting decisions, falls on junior psychiatrists. This article describes some of these pressures and the actions which might address them. It also presents four case vignettes which are common scenarios for London services and illustrate the difficulties frequently faced by patients, carers and staff.

Miss J, a 22-year old white woman, had taken an overdose and been admitted to a medical ward of the district general hospital (DGH) serving the catchment area. The medical team which had treated her for the physical effects of the overdose, now thought her medically fit for discharge and requested a psychiatric assessment. Miss J told the consultant psychiatrist who interviewed her that she had been in social services care as a child and now had no contact with her family. She misused a variety of drugs (including opiates) and had harmed herself repeatedly through overdoses and by cutting at her wrists. This behaviour meant that she had had repeated contacts with a number of London's mental health services; most recently, she had been receiving support from a social worker. Since leaving care, she had lived in a series of squats and, for the previous six months, in temporary accommodation in another part of London. She had left this accommodation after an argument with another resident and had taken the overdose during her first night in a local hostel for the homeless.

The psychiatrist thought that Miss J's most pressing need was for settled accommodation and that the most appropriate action was to engage her with community services. The psychiatrist therefore phoned the social services department which had been supporting Miss J while she was in temporary accommodation. They said, however, that she was no longer their responsibility because she had now moved out of their area. A subsequent referral to the local community-based crisis intervention service was rejected because there was no immediate likelihood of Miss J being offered even temporary accommodation. Two days after the initial psychiatric assessment, and while awaiting the outcome of the referral to the crisis team, Miss J took a further overdose on the medical ward. The duty psychiatrist who reassessed her thought that admission to the psychiatric ward was the only option in the absence of any immediately available community care. It was a further three days before a psychiatric admission bed became available, during which time Miss J remained on the medical ward under continuous observation by a psychiatric nurse seconded to the ward just for that purpose.

Mrs F, a middle-aged white woman with no previous contact with mental health services, had become so distressed by a panic attack at 2am on a Saturday morning that she had begged her husband to take her to the casualty department. The panic attacks had started six weeks previously. Her GP had first prescribed an anti-depressant and then, when she had not improved after four weeks, referred her for a psychiatric outpatient appointment which had been fixed for a fortnight's time. Mrs F's panics were so frightening that she had become virtually house-bound, and her family found it increasingly difficult to cope with her distress. The duty doctor making the assessment found Mrs F's panics to be associated with depression and that she had clear suicidal thoughts.

Mrs F might have been treated at home with intensive support from a team of mental health nurses able to visit her when required. However, since the local mental health nurse team did not work out of hours, no such visit could be arranged until Monday morning at the earliest nor could visits be made after 5pm should Mrs F's panics recur. Under these circumstances, admission was the only humane option, both for Mrs F and for her family. The admission ward being full, Mrs F was asked to wait in the busy casualty department until 8am. When the ward day shift came on duty and the ward patients were out of bed, the charge nurse and duty doctor considered who could possibly be sent home on leave to create a bed for Mrs F. Discussion with the consultant confirmed that the only option was to ask Mr K, a patient detained under the Mental Health Act 1983, to go home on leave. This was not ideal, as Mr K lived alone and aftercare arrangements for his discharge under the care programme approach were not fully in place; there was also the possibility that he may have refused to return to the ward on Monday morning. However, the need to deal with the crisis faced by Mrs F and her family over-rode these concerns.

A young white man was brought into casualty at 1am by the police using their powers under the Mental Health Act 1983. He had been reported to the police by the manager of a club who had found him washing his hair in a toilet bowl. When he arrived at hospital he started to strip off his clothes and sing loudly. It was obvious to the duty psychiatrist that he was suffering from a manic illness. After three hours of coaxing by the psychiatrist and the social worker, who had been called in by the police, he was finally persuaded to give his name – Mr D – and his address, which was in another part of London. When his catchment area hospital was contacted, it was established that Mr D had a history of manic episodes, had been admitted there informally a few months earlier and was still attending as an outpatient.

Mr D said he would be willing to be re-admitted to the hospital close to his home, but there were no beds available. Because the psychiatric admission ward serving the casualty department was also full, the only option was to try to locate a bed at another hospital and have Mr D admitted as an 'extra-contractual referral' (ECR). Searching for an ECR bed was a familiar procedure, and at 5am the duty psychiatrist and a senior nurse began to phone a list of hospitals, both private and NHS, at first in Greater London and then further afield. After five hours, and more than 20 calls, a bed was finally located at a hospital on the south coast. When Mr D, who was being watched in casualty by a police officer, a social worker and a nurse, was told of the location of the hospital he refused to go because it was too far away for his family to visit. He therefore had to be placed on a Section of the Mental Heath Act and transported by ambulance against his will, with a nurse and social worker as escort. He arrived at 4pm.

Mr W was a 24-year-old Afro-Caribbean with schizophrenia who had been known to the mental health service for five years. A mental health nurse in the community visited him each week as part of his care programme approach (CPA) plan and also administered his medication by fortnightly injection.

His parents, with whom he lived, reported that he had become increasingly withdrawn over the previous month, had stopped attending a local work project and had been muttering to himself, apparently in response to imaginary voices. He had also been verbally aggressive towards his parents. Mr W's community nurse had asked for his outpatient appointment with the consultant psychiatrist to be brought forward, but Mr W had not got out of bed that day and so had missed it. The consultant had visited Mr W the next day with the nurse and, having decided that Mr W was suffering a relapse of his schizophrenia, suggested an increase in the dose of his injection and prescribed other medication in tablet form. The consultant would have preferred to have admitted Mr W for a short period while medication was being adjusted, but the ward was full.

Two days later, Mr W threatened to hit his parents. They called in their GP who, because it was 6pm, referred him to the casualty department. The duty psychiatrist who saw Mr W did not know him and did not have access to his notes which were kept at the community health centre; she was, however, able to obtain information from the parents. The duty psychiatrist would have admitted Mr W for assessment, to monitor the effects of medication and to relieve the parents, had a bed been available. Instead she thought that, because he had not actually harmed anyone and had a supportive family, sending him home was preferable to disrupting the continuity of his care by trying to admit him to a distant hospital as an ECR referral. Unfortunately, three days later he punched his mother claiming she was trying to poison him. Because by this time he had become so ill that he no longer believed he needed help, he had to be admitted against his will under a Section of the Mental Health Act. He responded well to treatment in hospital but when he was considered fit for discharge, four weeks later, his parents refused to have him home for fear for their own safety, should he relapse. He remained on the ward for a further six weeks while a hostel place was found for him.

What makes a psychiatric emergency?

As the vignettes presented above show, it is rarely severity of psychiatric symptoms *alone* which leads to a patient presenting to the mental health services in crisis; the person's social circumstances and extent of psychological and social supports also play a part. When assessing these factors, those dealing with psychiatric emergencies have to consider also the effect of intervention (or lack of it) on their carers. Particular consideration must be given to the possible risk of harm, either to the patient or others, arising from their illness and consequent behaviour (this harm may result from acting on delusional beliefs or in response to voices, from agitation or over-activity leading to accidents or injury, from self-harm or from self-neglect).

Admission to hospital may be the only safe option for people who pose significant risk to self or others. It may also be the most appropriate intervention for others who, although not an immediate danger, would benefit from a short period in an environment with 24-hour nursing and medical input, and away from a home situation which might be close to breaking point. Such planned or 'elective' admissions can prevent a crisis which would ultimately lead to a longer hospital stay and will certainly support community carers (formal or informal). The experience of Mr W illustrates what can happen when an admission is delayed.

Mental health services in many parts of London are so stretched that even people who pose immediate risk of acting dangerously often cannot be admitted to their local psychiatric unit. For these services, planned or elective admissions are a thing of the past.

Problems with London emergency mental health services

High demand

Demand for mental health care for severely mentally ill people is directly related to high levels of poverty and unemployment. These are features of inner cities and in particular inner London, which contains ten of the 17 most deprived districts in England. Demand is probably as much as four times as great in inner London as in socially privileged parts of the country.

London also has many homeless people, both street homeless and those in temporary accommodation, a group with high prevalence of mental illness. Contrary to common belief, most of the homeless mentally ill are not people who have been discharged from long-stay hospitals, and then fallen through the safety net, but rather those who have become ill since the closure of the asylums. A recent survey found that only about one-fifth of homeless people with severe mental illness had ever had a psychiatric admission exceeding six months (Craig *et al.*, 1995).

Even if homeless people are excluded, the population of inner London is highly mobile. This, coupled with the concentrated population and resulting small geographical area covered by sectorised services, means that patients often move across catchment boundaries. Under these circumstances, it is often difficult to maintain continuity of care, as responsibility passes from one NHS provider to another and often from one social services department to another. In the case of those with severe mental illness, these moves often occur at a time when the patient is unwell, either because their illness leads to their eviction or because services relocate them to where residential accommodation is available. The problems of these mobile patients were highlighted in *The Report of the Inquiry into the Care and Treatment of Christopher Clunis* (Ritchie *et al.*, 1994), who in the space of five years moved across three of the four London RHAs and had contact with ten separate psychiatric services.

A survey found that, during a six-month period, 297 patients presented for assessment by the duty psychiatrist at a single inner London casualty department. This figure is an underestimate because records were incomplete and patients assessed in other locations, e.g. on medical wards, were not included. Less than one-third of these patients had been referred by GPs showing that the majority had by-passed primary care; 8 per cent were brought by the police. Over 50 per cent of the psychiatric assessments took place out of hours (i.e. between 5pm and 9am, Monday to Friday or at weekends); 57 per cent of these resulted in admission. Homeless people or those who lived outside the catchment area, who constituted 13 per cent of all patients, were much more likely to attend out of hours.

Over-occupancy of admission beds

As the vignettes suggest, London's psychiatric admission wards are often full and therefore unavailable to local emergency services. The extent of this problem has been highlighted by the project to Monitor Inner London Mental Illness Services (MILMIS). The MILMIS group has conducted three censuses of 12 inner-city psychiatric services providing care to nearly three million Londoners (MILMIS Project Group, 1995).

The first survey in June 1994 found that all units had more patients on their inpatient list than admission beds available. Because beds were full, 204 patients who needed an admission bed were lodged elsewhere; 53 of these were in local psychiatric beds intended for other purposes, 102 in distant ECR beds and 14 in prison or police cells. Even excluding inpatients who were on leave ('hot-bedding' means that these patients do not actually have a bed), inner London services had 22 per cent more patients needing an admission bed on census day than there were admission beds available. The repeat surveys, in January and July 1995, painted a very similar picture.

The difficulties raised by not having access to beds for patients in crisis are vividly illustrated by the vignettes. In the week of the first MILMIS survey, 82 per cent of the MILMIS sites reported that at least one patient, whose psychiatrist thought would benefit from it, was denied admission because beds were full (as with Mr W) and in 64 per cent of sites at least one patient was discharged prematurely to make way for a more urgent admission (as with Mr K). It is a frequent occurrence for doctors or nurses to spend many

hours phoning to find a bed in a distant hospital (Mr D). On some days, it has appeared that there are no admission beds available in the whole of southern England. Sometimes the problem is 'resolved' when the patient becomes fed up with waiting and absconds. The problem of managing distressed patients waiting for admission ties up staff and delays assessment of other urgent cases. If the patient is in a bed on a medical ward, the delay in finding a bed frequently increases to days (as with Miss J). The result of these bed shortages often means a junior doctor's first thought on referral of a patient is not, 'How can I best treat them?' but, 'How can I avoid admission?'.

Poor conditions on admission wards

While some patients request admission to a psychiatric hospital to 'get away from it all', psychiatric admission wards are far from being health clubs or holiday camps. Even new, purpose-built units, which offer building standards comparable to the best general hospitals, rarely give patients access to quiet areas or extensive grounds where they can be alone. Wards which are still based in the old psychiatric hospitals built in the last century, or in converted medical wards of DGHs, are often totally unsuited to housing the very ill, and often disturbed, patients admitted today. In such wards, it is difficult for staff to observe potentially dangerous or suicidal people and increasingly the only way to contain a volatile situation is to lock exit doors. Only a tiny minority of London admission wards are single-sex, despite clear preference expressed in user surveys and strong representation by user groups. The MILMIS sites reported frequent incidents of sexual harassment by patients on admission wards.

Conditions on some London wards might be likened to a pressure-cooker. MILMIS found that one-half of patients on admission wards on census days were detained under the Mental Health Act and that violent incidents were commonplace. In these conditions, much of staff time is taken up with containing or defusing dangerous situations; this, coupled with the constant search for beds, means that therapeutic work with patients often takes second place.

It is likely that a vicious cycle exists in some units whereby the pressure on beds creates a high threshold for admission so that only very disturbed people are admitted and conditions on wards make people reluctant to stay. These two factors combined mean that people are more likely to be detained under the Mental Health Act. The resulting highly charged ward environment and over-stretched staff mean that patients recover more slowly and discharge is delayed, leading to further pressure on beds.

Inadequate emergency assessment services

In some areas of London a multi-disciplinary team (MDT) of experienced staff assesses emergency referrals; such services, however, are invariably only available during normal office hours and often only to people living in the catchment area. As was shown above, over half the assessments took place out of hours, so even where these specialist services exist, they may only see about half of all emergency contacts. It is usual that during the remaining 128 hours of the week in these areas, and for the whole week elsewhere, urgent psychiatric assessments are conducted by a junior psychiatrist, often in a DGH casualty department.

These junior doctors are usually registrars or senior house officers (some working in psychiatry for only six months as part of their training to become GPs). They are often both the least experienced member of the MDT and also, because they rotate from hospital to hospital, the least familiar with the range of local community services and how to access them. This last problem has been compounded in recent years by the otherwise desirable trend for services to be sectorised and delivered by community teams located in bases distant from the DGH. A duty psychiatrist in casualty will often provide cover to an area which spans several such community teams. In the absence of adequate mental health information systems, this dispersal of services means that doctors in casualty often cannot access information on individual patients nor on what services are available, especially out of hours. The same strictures apply to the on-call consultant who provides back-up to the duty doctor.

Despite the initiative on junior doctors' hours, the duty psychiatrist usually starts a 'routine' day's work at 9am, immediately following a night on call. A full programme of ward rounds, outpatient clinics, education, clinical audit and research rarely permits time to be allocated specifically to following up actions taken in the course of emergency work. Although outstanding problems are handed over with the 'bleep', it is difficult to ensure that telephone referrals made by the duty psychiatrist to an answerphone, or hand-written requests for a patient to be seen sooner than otherwise planned, are acted upon. If these requests are rejected, for example on the grounds that the patient does not live in the catchment area or the waiting list is too long, it becomes unclear who is responsible for ensuring alternative care.

Thus continuity of care becomes difficult to achieve for the very patients who need it most. Although this issue has been highlighted by a number of inquiry reports, the systemic problems that underlie it have never been adequately addressed. The human consequence is that sometimes it would be untruthful to reassure distraught patients, or carers, who present at night that they will be seen the following day, or even the day after that.

Other pressures on local authority social services departments, particularly from child protection work, mean that they can rarely make a contribution to out-of-hours emergency psychiatric services beyond fulfilling their statutory obligation of providing approved social workers for Mental Health Act work.

Lack of alternatives to admission

As the vignettes and the description of existing services show, admission to hospital is often the only option available to people who present in crisis, particularly out of hours. Experimental work in London has shown that use of beds can be reduced by dedicated MDTs available 24 hours a day to deal with emergencies (e.g. Burns *et al.*, 1993; Marks *et al.*, 1994). Whether such teams can be replicated with 'ordinary' staff in 'real' services and then sustained has yet to be proved. The problems of staff burn-out and the tendency of such services to drift towards working with less disabled people, who might not be the ones who use admission beds, have yet to be fully overcome.

The MILMIS surveys found that about 12 per cent of admission beds were occupied by people who had been in hospital for more than six months. This figure confirms the finding of a national survey of new long-stay patients in 50 English mental health services, that 10 per cent of 'acute' beds are occupied by people who were admitted more than six months but less than three years previously (Lelliott and Wing, 1994). Apart from the inappropriateness of vulnerable people 'living' for such long periods in highly charged and non-domestic environments, this is a wasteful use of a valuable resource. The survey mentioned above found that nearly two-thirds of new long-stay patients could have been discharged and that the commonest reason they had not been was unavailability of alternative accommodation, usually staffed hostels.

Poorly integrated services

Integration between health and social services, and between secondary and primary care, remains an aspiration rather than reality. For patients, carers and front-line clinicians, miscommunications, bureaucratic referral and assessment procedures and duplication of effort remain the common experience. The resulting inefficiency and lack of co-ordination often lead to lengthened inpatient stays.

Low morale

It would be surprising if the problems described in this article had not had an adverse effect on staff morale. Working in London mental health services, either as a purchaser, or a provider, or as a clinician, can be a thankless task. When a patient or carer is in a crisis, it is quite understandable that they are only concerned that the appropriate help is given at the right time; if it cannot be, because of service limitations, it is the clinician or local manager who fields the complaint. The constant spectre of the formal inquiry if things go wrong hangs over staff's heads. The vignettes and MILMIS findings illustrate the dilemma for psychiatrists as they try to balance conflicting demands. For example, the expectation that discharge planning should be thorough (care programme approach (CPA) guidance is clear that

patients must not be discharged until all aftercare arrangements are in place) conflicts with the competing demand for inpatient care of people in the community. Two studies have suggested that fully implementing the CPA can lead to longer admissions, at least in the early stages (Tyrer *et al.*, 1995; Pierides *et al.* 1994).

Morale was identified by the recent Clinical Standards Advisory Group on Schizophrenia as a key issue for the quality of a service. Although not yet quantified, there are many unfilled consultant posts in London mental health services and a worrying trend for psychiatrists to move from London to areas with less pressing demand.

Low morale is not confined to psychiatrists. The advent of CPA and supervision registers has brought the responsibilities of key workers into sharp focus. Caseloads of key workers, who are mainly mental health nurses in the community, are often too high for them to discharge these responsibilities adequately. Training in their new role also sometimes lags behind the expectations placed on them.

What can be done?

There is wide consensus that the policy to move the focus of care from large and isolated asylums to the community is in the best interests of people with severe mental illness. There is a grave danger, however, that this humane movement will be reversed by public and political pressure resulting from highly publicised reports of failures of community care, such as that into the care of Christopher Clunis.

Given that the threat to the future of community care is coming from concern over the treatment of people with severe mental illness who pose a risk to self or others, it is difficult to escape the conclusion that this group should have greatest priority for services. Government guidance supports this view but other policy imperatives are not always consistent with it. Thus, an insistence on developing a primary care-led health service creates a pressure in the opposite direction, that is towards services for the mass of people with minor psychiatric disorders who are the mainstay of primary care mental health work. There is an imbalance in purchasing power, which means that too often negotiations with GPs revolve around the support that secondary care services can give to the primary care population, rather than the part that primary care teams should play in caring for severely mentally ill people.

The first task therefore is to establish that the top priority for NHS providers and purchasers, GPs, local authority social services and local voluntary and private sector groups is to develop better services for the most severely ill and, in particular, to improve emergency services and conditions on admission wards. This might involve some service planners reconsidering their plans and shelving developments of speculative programmes aimed at providing support to primary care teams or to people settled in the community. Even if such developments achieve the often stated objective of 'preventing' future mental health crises (and the evidence for this is sparse), the effect will be slight and not soon enough to impact on the immediate problems facing emergency services. If agreement is reached on this priority, the following course of action might be considered.

- **Ensure that money from psychiatric hospital closures is re-invested in community care.** Seventy-five per cent of psychiatric beds have closed over the past four decades. History suggests that there has not been an equivalent investment in community services. Purchasers must ensure that the proceeds of any future closures are ploughed back into mental health care for the severely mentally ill.
- **Re-invest mental health ECR expenditure in local services.** The 102 MILMIS patients admitted to distant hospitals are funded by London health authorities with money which is often directly or indirectly taken from expenditure on local services. To this must be added other ECR expenditure, particularly on secure beds. In effect, more privileged areas of the country, and the private sector, are gaining at the expense of over-stretched London services. This is a parody of national resource allocation formulae.
- **Initiatives to reduce pressure on beds.** This is central to the development of successful community care, which cannot function without the safety net of free access to inpatient facilities

when needed. Some services might have to (and some already have) increase bed numbers until other developments have demonstrated their ability to reduce demand. Bed management strategies should be led and supported by senior Trust managers and clinical directors and a commitment made by purchasers that investment will follow.

Strategies might include diverting people from admission by providing comprehensive, accessible and round-the-clock home care to people for whom admission would otherwise be the only option. Community teams might give absolute priority to those in hospital, responding immediately to requests for input when this would shorten a hospital stay. Stays might also be shortened by providing instant access to community-based accommodation; there is a particular need for high-staffed facilities with 24-hour waking cover by experienced staff (ideally with nursing qualifications).

If the aim is to reduce pressure on beds, the only criterion of success for any new initiative must be the number of hospital bed days it prevents. Only by constantly gauging new services against admission bed occupancy can they be prevented from drifting towards working with a less disabled client group.

- **Improve emergency assessment services.** It is difficult to see how emergency services can be greatly improved without introducing fully staffed, experienced MDTs available around the clock. Such teams would be expensive, and to involve senior psychiatrists as members would entail a radical overhaul of consultant numbers and working practices.
- **Support front-line staff.** Mental health services in London are in danger of unravelling because of loss of quality staff. It is the responsibility of all, including Government and purchasers, to work to improve morale and explore the system of incentives and disincentives which influence the willingness of mental health care professionals to work in London.

Conclusion

A concerted effort is required from Government, purchasers (including GPs), NHS providers, social services and local voluntary and private sector groups to address the crisis in London's emergency psychiatric services and admission wards. Only if these problems are resolved can mental health services provide adequate care to the capital's severely mentally ill people. If these problems are not resolved, community care may fail and political and public demand may lead to some form of re-institutionalisation.

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The building of appropriateness

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This article uses the example of the South Westminster Centre for Health to illustrate the diverse range of services which can be associated within one building – a primary care resource centre.

When one of its buildings is demolished, the underlying strata that are exposed can give an indication of the evolutionary dynamics of a city. A stratum associated with the Great Fire is a clear and dramatic example of this in London. In terms of what that building is then replaced with, architecture is more than the mere configuration of bricks, concrete, mortar, glass and tiles. New buildings are 'concrete' statements that give messages about our culture, the way we organise our lives, and they offer insights into our perceptions of the future. The new British Library near Euston, in London, is a contemporary example where these statements, and their associated controversies, are being aired in public.

Change is not always controversial; when it is, this is because either it raises doubts about whether change should take place at all, or there is a dispute about the direction of change and who should lead it. Those working for, and with, health care organisations in London, live with constant change, and the uncertainties associated with the controversy surrounding the reconfiguration of London's health care services. What is the right balance between acute hospital and primary care (King's Fund Commission, 1992; Department of Health, 1992)? If some hospitals close, what will replace them?

Debate about health care changes in London is involved, and often appears abstract as the arguments are repeatedly rehearsed. This paper takes a different approach, that of looking at one of the 'products' of the current evolutionary forces affecting London's health care services. It looks for insights from a recent building development project that houses a range of primary care-led services that are intended to ameliorate the effect on local patients of closing a hospital. Can an understanding of this new service provision, and the local health care needs it seeks to meet, offer a perspective, if not a vision, of how health care will be delivered in the future?

A primary care resource centre

The building in question is the South Westminster Centre for Health (SWC), in London, which opened in 1993 as a primary care resource to compensate for changes in local access to health care, when the Westminster Hospital closed. Establishing the SWC meant radically transforming a former nurses' home into a primary care resource centre that now contains the services shown in Table 1. The SWC serves a local population of approximately 40,000 people; it also caters for people from elsewhere who use the family planning services and the minor treatment centre (MTC). There are two general practices 'on site' at the SWC, and eight other surrounding practices regularly refer patients for services provided there.

Service provision has grown steadily since the SWC opened in April 1993. Figure 1 shows the growth in outpatient attendances over an initial 18-month period. Direct-access diagnostic X-ray and ultrasound are available, and numbers of investigations have built up to 300 cases per month over the same period.

Table 1 Services provided at the South Westminster Centre for Health

Outpatient clinics
Paediatrics/Paediatric Surgery
Ante-natal
Gynaecology
Dermatology
Gastroenterology
General Medicine
Medicine for the Elderly
Diabetics
Neurology
General Surgery
Vascular Surgery
Orthopaedics

GP practices
Victoria Medical Centre
Westminster & Pimlico Practice

Facilities
X-ray and ultrasound
Minor Treatment Centre
Information Room
Areas for Voluntary Groups

Paramedical services
Audiology
Child and Adolescent
Mental Health
Child Psychology
Occupational Therapy
Physiotherapy
Massage
Osteopathy
Acupuncture
Speech Therapy
Reflexology

Primary services
Social Services
Child Health Clinic
Dentistry
Foot Health (Chiropody & Podiatry)
Dietician
District Nursing, School Nursing
Health Visiting
Leg Ulcer Clinic
Family Planning & Well-Woman Services

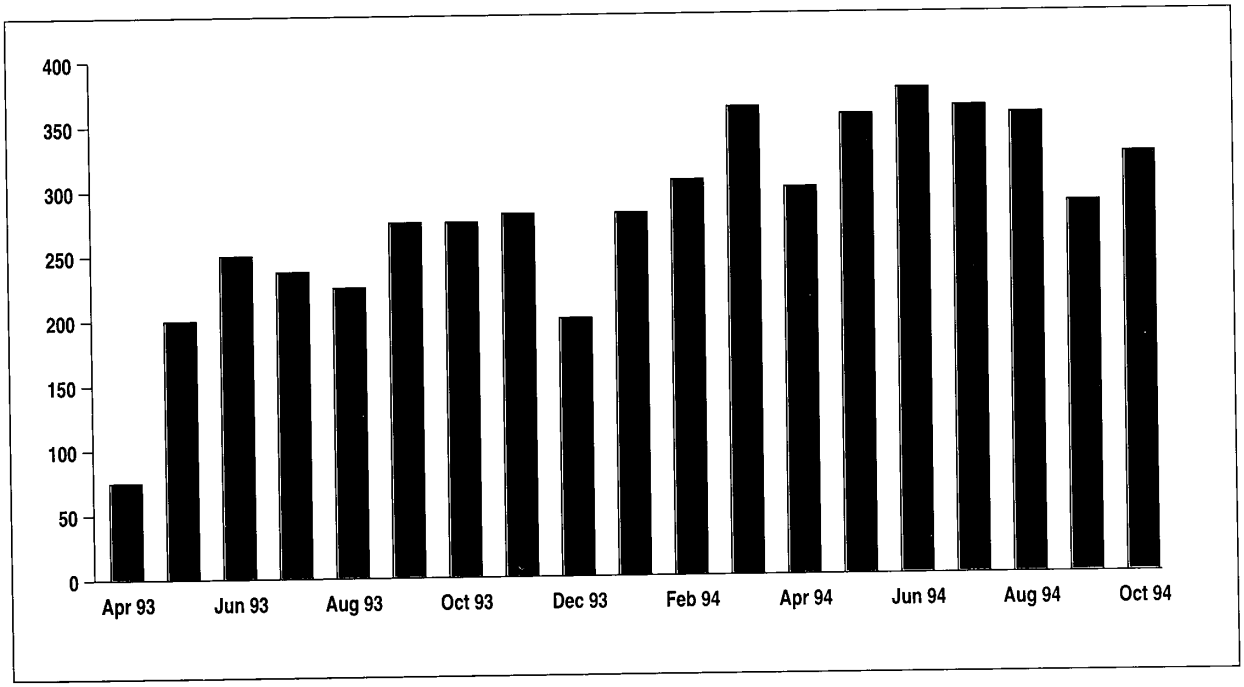

Figure 1 Number of outpatient attendances, April 1993 to October 1994

Table 2 Community clinic attendances and contacts, April 1993 to October 1994

Service	Patient/Client Attendances/Contacts
Family Planning	455
Dentistry	1,141
Dietetics	47
Physiotherapy	1,393
Speech Therapy	232
Foot Health	1,613
Health Visiting	2,339
District Nursing	4,067

Designated clinic space and a physiotherapy suite at the SWC mean that a range of locally accessible clinics are provided. These facilities enable provision of alternative services such as massage, osteopathy, reflexology and acupuncture. Figures for attendance at a range of primary care clinics are shown in Table 2.

Substituting for A&E

The MTC is a nurse practitioner-led walk-in service that is available on weekdays and Saturday mornings. From the time of opening, this service has grown to the extent of now seeing approximately 1,000 patients/clients each month. MTCs are one way of providing an alternative care pathway for the 'inappropriate attender' in A&E departments – those who need primary care services. South Westminster Centre for Health's MTC has a clear identity, although the principles upon which it is based are essentially those that the NHS Management Executive (1994) *Study of Minor Injury Services* used to define minor injury services, explicit in which is that the service will not provide a continuing care role. Of the clients that attend, 81 per cent are managed directly by the nurse practitioner, 2 per cent are referred to A&E and 12 per cent are referred to a GP.

Disparate services, same site

In providing these services, the SWC is meeting its original aim of accessibility for the local population to health care services. The data provided above demonstrate this. What these data do not show, however, is the added value of having services either in direct proximity or closely linked, and that the boundaries of professional practice are changing. Although the SWC is a primary care resource, traditionally disparate elements of health-related care from tertiary care, secondary care, primary care, social services, voluntary organisations and community groups are drawn together under one roof.

Some illustrative examples of the cross-professional and cross-service 'links' at the SWC include the following.

Links with general practice

The SWC acts as a resource for general practice locally. There are economies of scale associated with offering services for a population base of 40,000, such as: direct-access X-ray and ultrasound, which reduces patient travel; consultants in a range of specialties regularly visit the SWC; a physiotherapy treatment suite; and opportunities for joint meeting and sharing facilities.

Links with secondary care

The SWC acts as a 'feeder' for the Chelsea & Westminster Hospital. Consultants run outpatient clinics for new and follow-up patients. There is a direct link with the hospital patient administration system. These links mean that closer working relationships have been developed between primary and secondary health care teams.

Direct on-site links with social services

A social services children and families team operates from offices in the building. Advantages of this arrangement include: ease of referral of, or consultation about clients; and proximity of working, enabling joint project development in areas of common interest. Currently, areas of joint

interest between health and social services where further links are possible include: joint assessment; HIV / AIDS care; care for older people; child protection; palliative care.

Links with alternative therapies

There is close co-operation between NHS services at the SWC and alternative therapists who use the same facilities. These collaborations are important because they acknowledge the wider sphere of health care and sympathise with clients' preferences to use other therapies.

Links with voluntary organisations and community groups

Local voluntary organisations and community groups use the SWC. These include: a toy library; Befriend a Family; residents' associations; carers' support groups; mums' information and support groups.

Telemedicine link with Royal Victoria Hospital, Belfast

A current project at the SWC is a telemedicine project to evaluate this technology as a means of nurse practitioners in the MTC obtaining expert advice 'on demand' from consultants in A&E at the Royal Victoria in Belfast.

The links between the SWC and other organisations emphasise the 'health' aspects of the centre. Local residents are able to access services from a diverse range as appropriate – the indices of appropriateness being their individual preference combined, where necessary, with professional support and expertise. Kensington, Chelsea & Westminster Health Commissioning Agency is a key agent in forging the links and facilitating the processes necessary to develop the breadth of provision available at the SWC.

Changing professional boundaries

Boundaries within professions and between professions are changing. There are several reasons for this, including: resource constraints on delivering health care; professional developments; changes in junior doctors' hours; information technology; data about clinical effectiveness; and changing case-mix patterns.

In the SWC there are changes in the roles of district nurses and health visitors and in the professions allied to medicine. The development of the nurse practitioner illustrates the breadth of change that is occurring and its effects.

The nurse practitioner role

As already mentioned, the SWC is a place where different organisations and client groups in health and social care come together. The MTC is an area that exemplifies this 'crossroads' between different sectors of care. Nurse practitioners staff the MTC and require the skills and competences to treat when appropriate, or to channel patients into other primary or secondary care services.

The term 'nurse practitioner' is becoming ubiquitous in health care, and often used without a clear definition. Currently, it is difficult to define a nurse practitioner. In broad terms, it is defined as one who practices nursing (Stilwell, 1989). This definition is clarified by calling the nurse practitioner an 'advanced clinician' (Cable, 1994). In professional terms, the Royal College of Nursing (RCN) defines the nurse practitioner as 'offering direct access to clients seeking health care' (Royal College of Nursing, 1989). The RCN further defines a nurse practitioner as 'making autonomous decisions for which s/he has sole responsibility'. The United Kingdom Central Council (UKCC) does not recognise the term 'nurse practitioner' and refers to 'advanced practitioners'. Advanced practitioners, it is suggested, will adjust the boundaries for the development of future practice by pioneering and developing new roles responsive to changing needs.

The MTC at the South Westminster Centre for Health is staffed, in these terms, by advanced practitioners. With the emphasis of their further development on acquiring skills and competences, nurse practitioners have an important role to play in developing links between agencies and sectors of care. Nurse practitioners in primary care centres such as the SWC and in general practice are likely to be important change agents in altering current arrangements of care and enabling transfer of services from secondary to primary care.

The future direction of health care

Consultant outpatient clinics, integrated information systems and telemedicine demonstrate that services can move out of hospital to the patient, unlike in the past when the expectation was that patients would move to the services. This movement suggests that health care may parallel other social changes, where city centres are altering as people use local shopping centres, and working practice is away from large factories and offices towards smaller units, even working at home.

Underlying reasons for these changes are complex, and lie beyond the scope of this paper to explore in any detail. However, consumer pressure for convenience, technological change and redefined working roles are all influential factors. Are we seeing a change in health care provision that is similar to the social changes in work and shopping?

If this is so, there are important lessons to learn from this project. Consumer acceptance of the closure of a hospital and the opening of the SWC needed nurturing through. While local consultation accepted the inevitability of change, inherent within this change process was an understandable sense of 'losing something'. This feeling of loss probably contributed to an initial local opposition towards the new centre, which led to restricted planning permission for opening times. It took another year, after opening, for this to be lifted, and this was co-incident with the local residents' association choosing to hold its meetings at the SWC. The Centre is now an established facility which is accepted as being wanted and needed by the local community.

Viewed from a wider perspective, the SWC, as currently configured, may be analogous to a concept car at a motor show. The particular design and organisational arrangements of the SWC are 'styled' towards supporting local delivery of services based on primary care. If there is a 'wider market' for this approach, replicating the SWC may not be the answer. The SWC, like many concept cars may fail to reach mass production. However, the features of primary health care provision under test in the SWC may represent key components that feature in the generality of how health care is provided in the future (see the box opposite).

Whatever logic supports delivering health care at a local and primary care level, there is an inescapable need for acute hospitals to exist. What is in question are the numbers and configuration of hospitals that will be required to meet the health care needs of Londoners in the future, and the way that these will integrate with primary care. This paper cannot answer that question. What it can do, is to suggest that the equation governing this will be based on a formula that goes beyond bed days, finished consultant episodes and contacts: it will include an appreciation of the way in which care is organised, as well as delivered and matched to need.

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PRIMARY CARE RESOURCE CENTRE

A review of the South Westminster Centre for Health suggests the following important features are key components for a primary care resource centre:

- Accessibly situated in the community.
- Convenient for GP referral.
- Flexible facilities that can be shared by a wide range of groups.
- Staffed by practitioners, not only nurse practitioners, with flexible approaches to their roles and responsibilities.
- Working practice based on methods of practice supported by protocols and guidelines. Diagnostic facilities 'on site'.
- A close working alliance with a specialist acute hospital centre.
- Good communication links, transport and information technology.
- A 'user friendly' environment.
- Enlightened health care commissioners.

The London Emergency Bed Service

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This article provides an account of the size and scope of the London Emergency Bed Service (EBS). It is based on work carried out as part of a package of studies on aspects of emergency admissions in the North and South Thames Regional Health Authority areas.

The EBS in London was established in 1938 by the King Edward's Hospital Fund for London (the King's Fund), following an approach by the London Voluntary Hospitals Committee. It was intended to assist general practitioners (GPs) with referrals of emergency cases to hospitals on a 24-hour basis and has continued to provide this core service in a similar way ever since.

In 1978, the EBS became funded by the predecessors of the North and South Thames Regional Health Authorities (RHAs). Management of the service is the responsibility of South Thames RHA, with operational management responsibility lying with Lambeth, Southwark and Lewisham Family Health Services Authority (LSL FHSA).

Budget, operations and policy are reviewed and monitored by the EBS Policy Committee, which includes members representing the North and South Thames RHAs, the LSL FHSA, hospital clinicians, GPs, the EBS manager and an EBS staff representative.

I would like to acknowledge helpful comments by colleagues, namely Judie Yung and Chris Garrett at North Thames and Tim Young and Tera Younger at South Thames, and the very obliging and invaluable assistance of Graham Hayter, the EBS manager.

What the EBS does

The EBS provides a range of services from its offices at London Bridge. The core service is still the management of GP referrals to hospital. However, other services are offered. These include a neonatal intensive care information service which has been provided for some years and a recent addition – the intensive care enquiry service. These services are described in some detail below, together with a brief description of other services.

The core service

The core service of the EBS is to manage *GP-sponsored* emergency referrals. It does not assist with self-referrals through A&E departments nor with elective admissions. The EBS service is patient-specific, aiming to match individual patients with hospital services. It covers an area bounded approximately by the M25 – somewhat larger than the usual definition of Greater London, as it includes parts of Surrey, Kent and Essex. Hospitals within this area are automatically included in the EBS service. The routine operation of the service is described in a box on pages 94–5.

Analysing time trends

Total EBS caseload has fallen every year since 1984 with the exceptions of 1985 and 1993 (see Figure 1). This is in line with a longer-term trend of gradual fall in caseload since 1953. On the other hand, the number of medically refereed cases generally increased up to 1990 (see Figure 2). Since then, this indicator appears to have fallen but a clear trend is not discernible because of wide fluctuations. Total caseload in 1994 was 18,024 (approximately 1,500 cases per month). This represents about 4 per cent of all emergency admissions in the London area. Total emergency admissions in the year ended

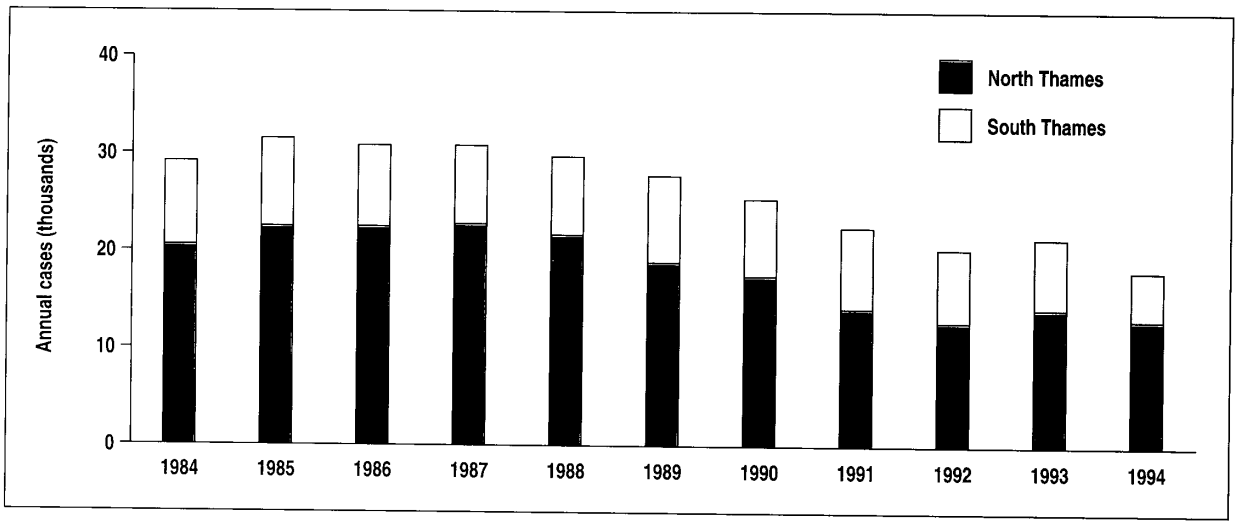

Figure 1 EBS total caseload, 1984–1994

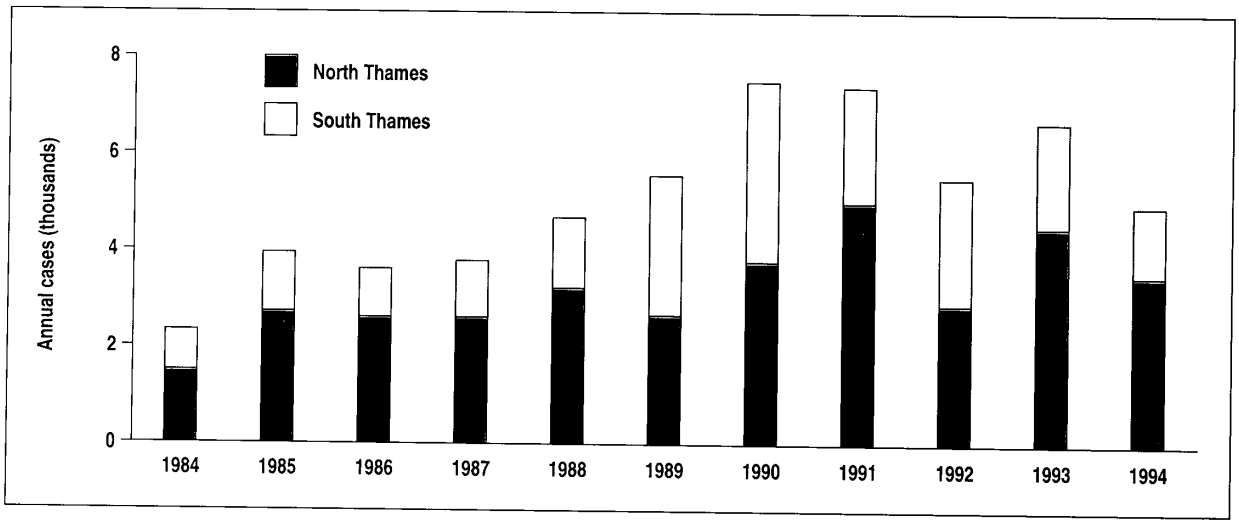

Figure 2 EBS medically refereed cases, 1984–1994

March 1995 were 454,000.

In 1994, the medical referee procedure was required for 4,936 patients, 27 per cent of total caseload, down from a peak of 33 per cent in 1991. Of the balance, most are voluntarily placed and a small percentage are cancelled.

It is apparent from Figure 3 that over the same period the proportion of cases medically refereed tended to be somewhat higher in South than North Thames. However, the two regions have experienced very similar proportions in the last two years.

Patterns in 1994

A more detailed look at total and medically refereed caseloads during 1994 shows considerable fluctuation on a daily basis. Some seasonal trends emerge, and a pattern within the week is also discernible.

Figure 4 shows that monthly averages for both total and medically refereed caseloads are highest from December to March, remain fairly high through to June and are relatively low in the summer months (July to September). As Figure 5 shows, weekday volumes are higher than those at weekends. Total

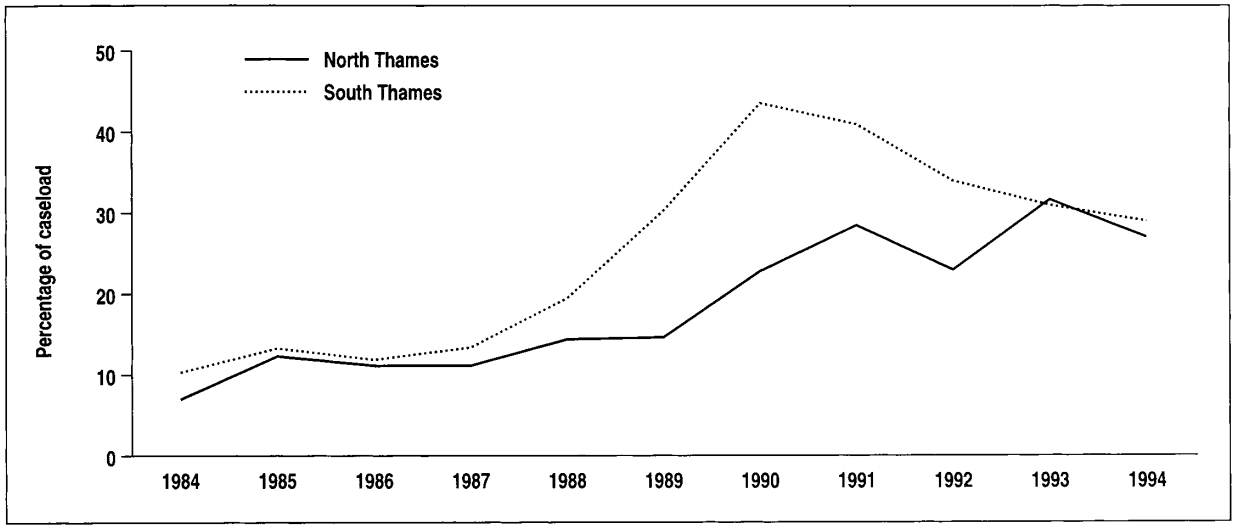

Figure 3 Proportion of medically refereed cases, 1984–1994

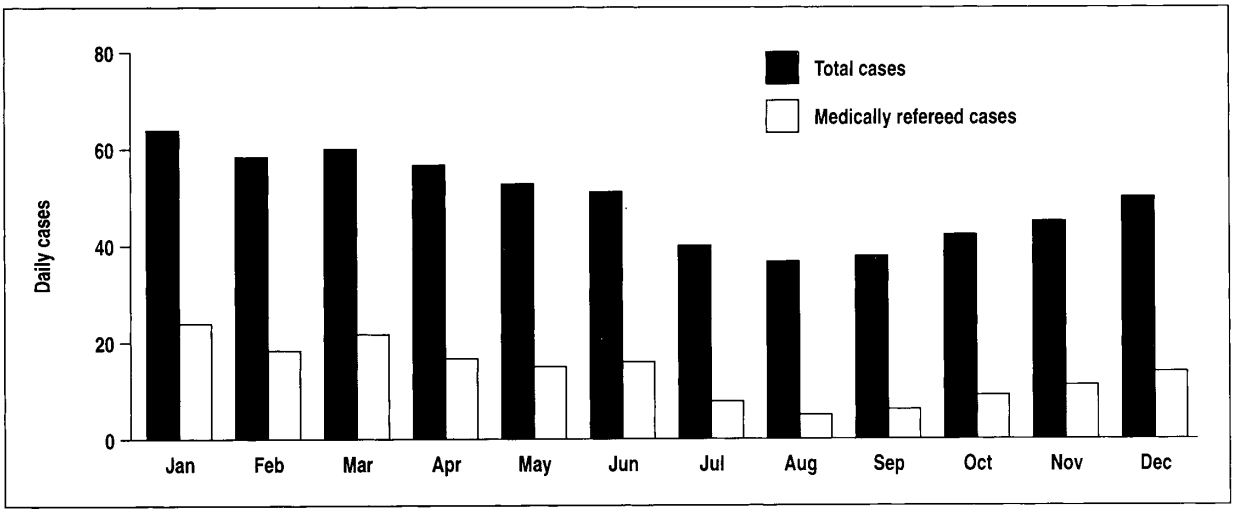

Figure 4 EBS average monthly caseload, 1994

caseload is highest on average on Mondays, gradually dropping during the week, and lowest on Saturdays and Sundays. The medically refereed caseload has wider fluctuations, but shows a similar pattern on average during the week. Total caseload and the number of medically refereed cases on any particular day appear to be positively related.

District variations

There is considerable variation between districts in the use of the EBS. Figure 6 shows caseloads by district health authority (DHA) for 1994 in descending order by total caseload: the ranking would change somewhat if it were ordered by the number of medically refereed cases. Utilisation of the EBS varies from New River DHA with the greatest caseload of 2,742 to Kingston and Richmond DHA with 167. Districts outside London, in Essex, Surrey and Kent, have a small EBS caseload.

In 1994 the highest use of the core service was in the east of London, especially the north-east, while the lowest use (in London) was in the west. However, further analysis showed that the use by district has also varied considerably over time. This analysis was on the basis of the new district

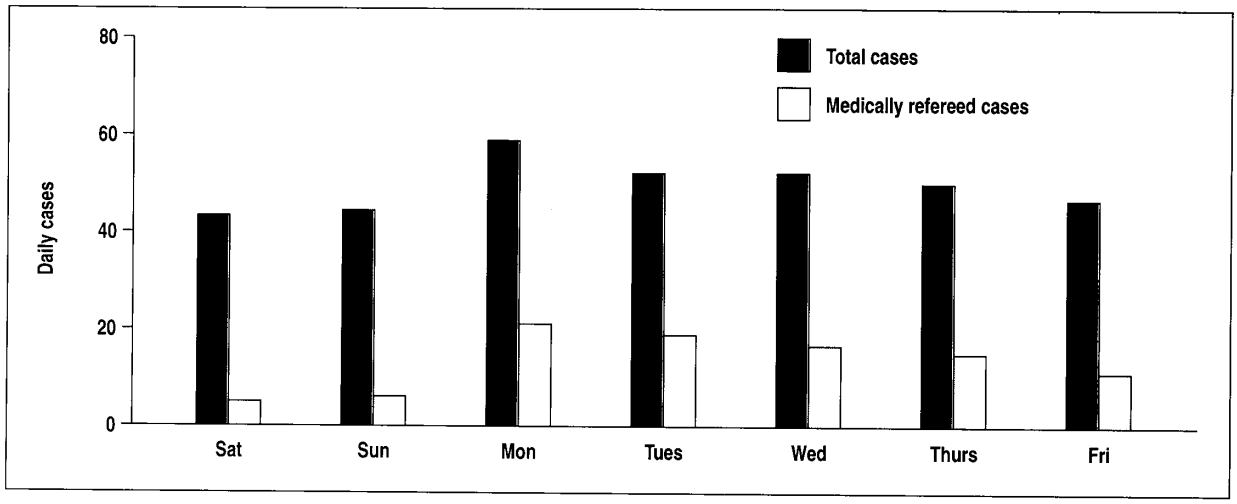

Figure 5 EBS average daily caseload, 1994

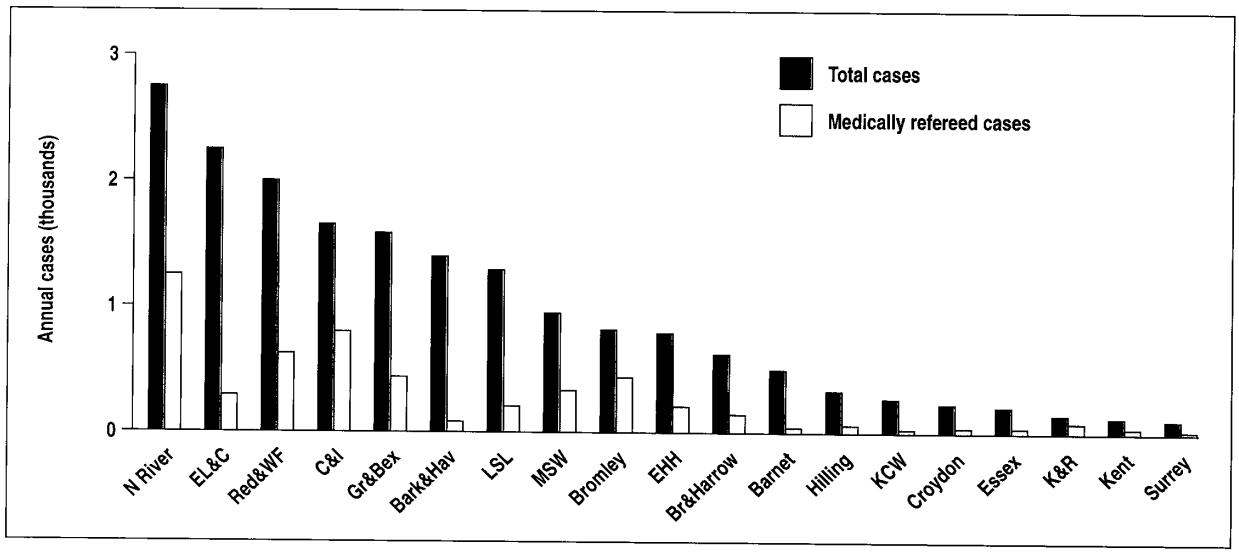

Figure 6 EBS annual caseload by DHA, 1994

boundaries with an approximate retrospective allocation of cases. Of particular note were:

- an accelerating increase between 1992 and 1994 in the caseload originating from New River DHA, with a relatively high proportion of medically refereed cases;
- a fairly sharp fall between 1992 and 1994 in Lambeth, Southwark and Lewisham DHA's caseload, and a sharp drop in medically refereed cases;
- a peak in caseloads at Camden and Islington DHA in 1993;
- relatively low caseloads (for an inner London DHA) at Kensington, Chelsea and Westminster DHA;
- a large percentage increase in both the total and medically refereed caseloads in Bromley DHA in 1994, although the caseload is still relatively small.

More detailed investigation would be required to find local factors that offer at least a partial explanation of these variations.

The extent of restrictions by hospitals

The EBS records manually the restrictions notified to it by hospitals. The following analysis is based on monthly summaries of EBS-recorded restrictions for 1994. It considers the number of days hospitals were restricted to the EBS, where a restricted day is defined as 'a day on which a pre-emptive restriction was notified to the EBS, covering one or more specialties, for part or all of the day'.

The distribution of restrictions for all hospitals in the EBS area for 1994 is shown in Figure 7. The more common combinations of specialties are shown. Other less common combinations are grouped together as 'Other MRO Combinations' or 'Other ODO Combinations'. Definitions of MRO and ODO are given in a box on pages 94–5. In 1994, out of a potential maximum of 17,155, i.e. if all 47 hospitals had some restriction on all 365 days, 8,606 restrictions were notified to EBS. Therefore, on an average day, half of the hospitals notified the EBS of some restriction.

The most severe restrictions are 'MRO All Cases' and 'ODO All Cases'. These accounted for 5.7 and 29.7 per cent of restrictions respectively. Similarly, 'MRO All Adults' and 'ODO All Adults' are severe restrictions. These accounted for 15 per cent and 10.3 per cent of restrictions, respectively. In aggregate, these severe restrictions accounted for over 60 per cent of the total. Looked at another way, on average in 1994, *30 per cent of hospitals in the area were restricting all cases or all adults to MRO or ODO only.* In addition, it should be noted that 'Other MRO Combinations', which accounts for a further 13.5 per cent, can include some severe restrictions.

Further analysis showed the presence of seasonal effects, with the most restricted months being

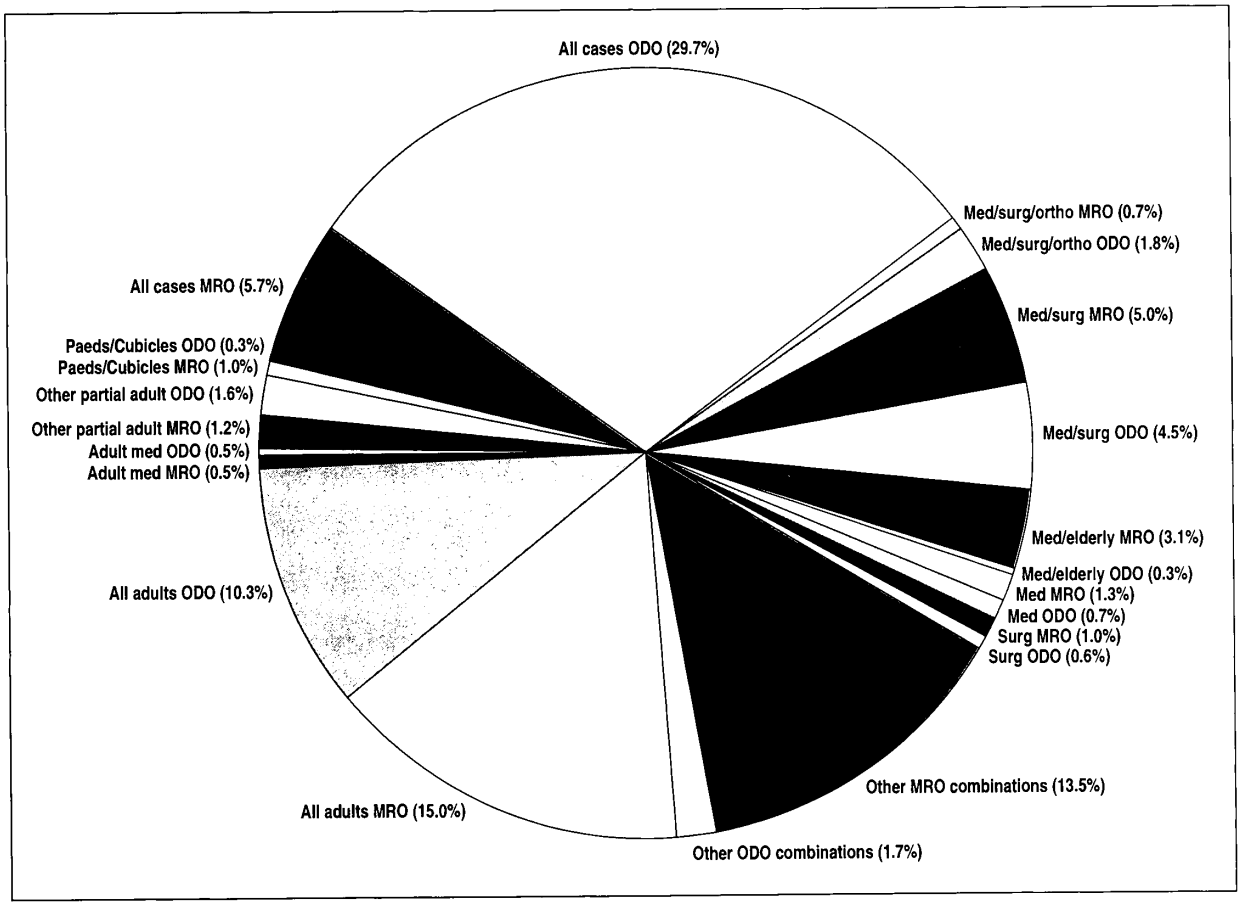

Figure 7 Daily restrictions to the EBS, 1994

January to March, and the least, July to September, broadly in line with the EBS caseload. Most of the broad categories show some variation across months.

The use of restrictions varies considerably between hospitals. Some hospitals advise the EBS of restrictions on most days, while others advise of very few. This effect does not appear to be related to those hospitals known to be under some pressure. It is likely that variation between hospitals is explained by factors such as the relationship between the hospital and GPs in its catchment area, procedures/protocols set up within the hospital concerning notification, and the knowledge and responsibility of the person notifying. A detailed study of these factors is beyond the scope of this article.

The neonatal intensive care service

This service has been provided by the EBS for some years, and is essentially an information service for hospitals. It covers North and South Thames and involves the EBS calling all of the neonatal intensive treatment units (ITUs) in the Thames regions (21 units as at 9 August 1995) twice a day regarding their spare capacity. The demand on this service has reduced considerably from a high of around 800 enquiries to about 250 in 1994. Sometimes the EBS receives enquiries from outside the Thames regions, e.g. from Anglia & Oxford RHA.

The intensive care service

This service, introduced on 17 April 1995, had been planned for over a year, and was modelled on the neonatal service. It is based on calling all of the ITUs in North and South Thames participating in the scheme (some 78 as at 9 August 1995). They are called routinely twice a day, at around 9am and 4pm, each round of calls taking about an hour. The sub-group of nine neuro-ITUs are called routinely three times a day, the additional call being around midnight. The EBS sometimes does a series of extra calls, particularly if one part of the area has little or no spare capacity.

As for the neonatal service, the area for this service in terms of units covered is wider than for the core service, comprising the whole of the Thames regions. Enquiries come from a slightly larger area too, including Bedfordshire (which is part of Anglia & Oxford RHA) and Hampshire (part of South & West RHA). Units are asked, 'How are you placed to accept a transfer from another hospital?'. The EBS can then provide enquiring hospitals with information on spare capacity in terms of clinical group and location.

In the first 75 days of the service (from 17 April to 30 June), there were 284 enquiries with requests for transfer, an average of just under four enquiries a day. At the time of writing, ITU beds had been found for every call.

The EBS follows up to find where the patient was sent to. Over that period, 183 transfers actually took place, of which 85 per cent (155) had been sent to the hospital suggested by the EBS, and 15 per cent (28) to other units. The remainder of the enquiries were not transferred, generally for clinical reasons.

The EBS records the main diagnosis for these enquiries. As would be expected, most enquiries concern diagnoses such as cardiac arrest and pneumonia or respiratory failure. About 10 per cent have been neurological. Another significant diagnostic category has been suicide attempts, also at about 10 per cent.

An issue for the provision of this service is whether hospitals will declare their 'last' intensive care bed, since to do so requires trust on behalf of the individual hospital that it will be able to find a bed elsewhere if its last one has been given up. The 14th of June was the first and only day since the service was set up (to the end of June) in which no neurosurgical beds were declared throughout a call-around. Currently, this does not result in any subsequent action by the EBS, although the service is still subject to fine-tuning.

Other services

The EBS provides the following services (on a 24-hour basis, unless otherwise indicated):

- *St Joseph's Hospice.* The EBS holds the waiting list for the hospice, organises admissions for terminal care and handles associated tasks. In 1994 there were 727 referrals to the waiting list (867 in 1993), resulting in 504 actual admissions

(583 in 1993). Since August 1994, the EBS has also been dealing with referrals to St Joseph's community palliative care service, and in the five months to December 1994 handled 258 such referrals.

- *Psychiatric Services Information.* The EBS holds definitive information about the pattern of psychiatric services and attendant catchment areas. In 1994 there were 6,935 requests for information (6,400 in 1993).
- *General Service Information.* The EBS received 355 general enquiries about service provision in the London area in 1994 (500 in 1993).
- *Major Incident Procedure.* The EBS has a role in the NHS response to major incidents in and around London and played a part in the three declarations in 1994 (there were two in 1993). The EBS follows agreed procedures and has two main responsibilities: providing communications to relevant organisations (e.g. the Blood Transfusion Service, hospitals and regional offices); and protection from other admissions, including medically refereed cases, of the hospitals designated by the London Ambulance Service as the responsible or supporting hospitals.
- *Out-of-Hours District Nurse/Specialist Nurse Contact Service.* Following a successful pilot scheme towards the end of 1994, the EBS is now providing a service to Optimum Health Services Community Trust, taking out-of-hours calls from clients to pass to the relevant duty nurse. In the early part of 1995, the volume was around 400 calls per month.
- *Medic Alert Foundation/Red Cross.* One thousand and thirty-two calls were taken on behalf of the Medic Alert Foundation (900 in 1993) and 205 out-of-hours calls handled for the Red Cross (175 in 1993).

Future issues

A number of factors are likely to have influenced recent patterns of use of the EBS. Relationships between GPs and their local hospitals are changing as they develop closer working links. It has been suggested that some hospitals have adopted a policy of automatically accepting referrals from local GPs. To the extent that GPs are aware of such policies, the effect would be to reduce initial calls to the EBS, and consequently to reduce the need for the medical referee procedure.

It is not clear whether GP fundholding has had an impact on the use of the EBS. Fundholding is still at a relatively low level in London, particularly inner London. Future developments regarding out-of-hours services provided by GPs and the use of deputising services may also affect the way the EBS functions.

Arrangements within hospitals have also been changing in terms of how beds are managed; in particular, the management of admissions and discharges and the flexibility of bed use between specialties and between emergency and elective care. For example, more hospitals now have an internal bed manager. In such cases, the bed manager tends to contact the EBS daily regarding bed availability, in addition to EBS calls to the bed manager.

No definitive statement can be made about the impact of the introduction of the internal market, and in particular contracting behaviour, on the use of the EBS or on hospital acceptance behaviour. A wide range of factors are at work. The pattern of service provision across London and in particular the range of services provided at each unit will affect the demand for the EBS. Such changes will affect the balance between the demand and supply of emergency care, influence the development of hospital catchment areas (sometimes differently for different categories of patients), and at least during an interim period could make GPs uncertain as to where to refer patients.

In summary, there are two key factors influencing the ongoing need for a bed bureau mechanism in London and its size and scope. These are:

- the flexibility that hospitals develop, both individually and as a network, to cope with daily and seasonal variations in the demand for their services;
- the relationships between GPs and their local hospitals. These relationships have been and will be affected by factors such as the evolution of the internal market and changes in contracting, the development of the primary-care-led NHS and the initiatives of health commissioners.

There are a number of stakeholders in the future development of the EBS. However, it is likely to be health commissioners in the first instance who have the task of ensuring that the future role of the EBS is fine-tuned to fit the needs of London in the context of an evolving NHS.

HOW THE CORE SERVICE OPERATES

On receiving a call from a GP, the EBS completes a two-page case note, typically taking four to five minutes. Information recorded includes diagnosis, GP examination findings (the current condition of the patient), hospital history, medication and whether an ambulance is required. The address and postcode of the patient's current location are noted, and local hospital determined according to catchment (described further below). Certain GP details are recorded, such as name, telephone number and whether the GP call is a deputising service. Since January 1989, certain information from the case notes has been coded into a database, which was used for the analysis presented here.

Whether the GP has made attempts already to get the patient into hospital(s) is usually asked but not routinely recorded. The EBS manager believes that about 30–35 per cent of the GPs that call have tried previously to get a patient into hospital (or another patient earlier that day), although it is not possible to verify this from the data collected. The time taken to find an accepting hospital varies according to the urgency of the case and is generally within the time indicated by the GP.

The EBS selects a hospital or sequence of hospitals based on (not necessarily in this order):

- catchment and knowledge of availability (restrictions notified by hospitals, earlier EBS calls, etc.);
- type of referral (e.g. older people are subject to more rigid catchment areas);
- recent hospital history (for continuity of care);
- convenience of location to patient.

The EBS contacts the appropriate person in the hospital (there may be several contacts within a hospital) and 'offers' the case to the hospital. This process is repeated several times until a hospital accepts. It is the decision of the supervisor when to terminate the search. Usually up to four or five hospitals will be contacted but in some cases it may be as many as ten.

The doctor contacted within the receiving hospital should notify the hospital entry point of anticipated admission. The EBS contacts the London Ambulance Service (LAS), if required, with details of the type of journey, destination and time available (there is a direct EBS-LAS line). About 80 per cent of EBS referrals are transported by ambulance and about 20 per cent by private car.

The EBS notifies the GP about the arrangements made. Some GPs then notify patients, but not necessarily, and a possible weakness of the system is that patients are not routinely notified. Conversely, some GPs give the EBS number to patients, who then contact the EBS regarding progress. The EBS does not routinely follow up cases.

The medical referee procedure

The medical referee procedure is invoked if an accepting hospital cannot be found (in EBS terminology, the case is 'stuck'). The details of the case are given to the EBS duty doctor (the medical referee). The EBS has a rota of several doctors (practising and semi-retired GPs/hospital consultants), who are in the office from 10.30 am to 5 pm and otherwise on call at home. It is up to the EBS doctor on duty to judge whether the

(Continued opposite)

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patient should be referred to hospital 'to see with a view to admission'. The referral is automatically to the relevant catchment hospital and is in terms of 'this patient is now your responsibility'.

Thus, the key to the London bed bureau model is the definition of catchment areas of hospitals within the EBS area. The catchment areas determine the 'hospital responsible' based on where the patient is when the call is made. These were first devised in 1974, and change from time to time due to changes in the pattern of service provision. Catchment areas are agreed between the purchasers, Trusts and EBS and can vary by specialty, since not all hospitals provide a full range of services.

Generally, there is one 'EBS' hospital in each catchment area, although in some cases there are two hospitals with a shared responsibility, usually part of the same Trust. Generally, hospitals are fairly central to their catchment area but a few are either near the edge of the catchment (e.g. Queen Mary's, Sidcup) and one is outside its catchment area (Northwick Park). The relationship between district health authority (DHA) boundaries and catchment areas is not a straightforward one and needs to be reviewed regularly in the light of DHA boundary changes and changes in the pattern of service delivery.

Yellow/red warning system

The EBS operates a yellow/red warning system indicating a hospital's ability to receive emergency admissions. This system should not be confused with the same terminology ('red and yellow warnings') used within most hospitals.

The decision to impose a yellow or red warning on hospitals in inner and outer London is based on the following measures reaching certain pre-determined levels, having adjusted for seasonality:

- EBS caseload, i.e. demand for GP emergency admissions through the EBS;
- medical referee rate, i.e. the proportion of the caseload where the medical referee procedure has been used;
- reported difficulties from hospitals.

It should be noted that EBS warnings are relatively rare. The EBS has not issued a warning since 1993.

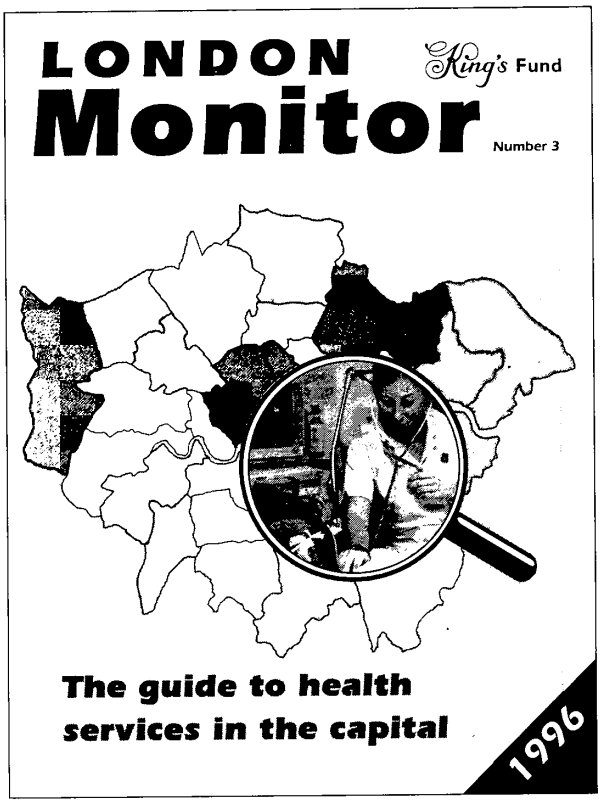
EBS restrictions

All hospitals in the EBS coverage area may advise the EBS when they need to place restrictions on emergency referrals. These restrictions usually apply for that day, but occasionally vary during the day. Restrictions can apply on a blanket basis to all cases, to adults only, to males or females only, and/or only to certain broadly-defined specialties.

The restriction will either be:

- **MRO** (medically refereed only), i.e. 'A hospital unable to listen to any requests for acute admissions. Able to accept only those cases which are medically refereed'; or
- **ODO** (own district only), i.e. 'A hospital unable to consider requests for admission for patients outside its defined catchment area'.

The specialty groupings used for restrictions are: surgery, medicine, elderly, orthopaedics, gynaecology, paediatrics and paediatric cubicles. Restrictions may be in terms of any combination of the above and often are. For example, a hospital may decide to restrict cases to paediatrics (MRO) and medical/surgical/orthopaedics (ODO).



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ISBN 1-85717-104-7