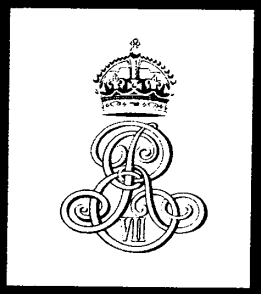
THE KING'S FUND



ANNUAL REPORT 1991

KING EDWARD'S HOSPITAL
FUND FOR LONDON

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1991

Patron
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THE KING'S FUND

ITS ORIGINS AND HISTORY

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

These words from the 1907 Act of Incorporation have been the guide to the Fund's practice for more than three-quarters of a century.

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

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

Grantmaking ranges from sums of a few hundred pounds to major schemes costing more than £1m, such as the Jubilee Project which was the Fund's commemoration of the Silver Jubilee of Queen Elizabeth II. That project helped ten London hospitals to renovate some of their oldest wards. The problems of health care in the inner-city areas is the concern of the London Primary Care Programme, for which, to date, some £1,520,000 has been made available. Other new ventures concern the assessment and promotion of quality in health care and the London Acute Services Initiative.

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

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

The **King's Fund Institute** was established at the beginning of 1986. The Institute is located at the King's Fund Centre in Camden. The Institute seeks to improve the quality of public debate about health policy through impartial analysis.

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Chief Executive's Introduction

In 1991, the National Health Service operated under the shadow of major political events. The changes stemming from the NHS and Community Care Act 1990 began to come into effect in April 1991. The first 57 NHS Trusts went into action at that time and the first general practitioner fundholders received their initial budgets. April was also the start date for operating the first contracts between 'purchasers' (district health authorities, GP fundholders, etc) and 'providers' (NHS Trusts, directly managed units, voluntary bodies and the private sector).

These changes were highly controversial, not only between Government and Opposition, but in the public at large, within the professions and within individual institutions. Whatever the pros and cons of the changes, it was sad to see bitter rifts within institutions, and to sense a substantial degree of public disquiet about the wisdom of the changes, and the integrity of the Government's intent.

The other major public event that overshadowed the year was, of course, the general election, even though that did not actually occur until the spring of 1992. The National Health Service was a major electoral issue throughout the previous 12 months and one where the Opposition seemed to hold the political advantage. Not surprisingly, therefore, the Opposition hammered away at the Government on health, emphasising that it would reverse the changes introduced by the 1990 Act, while the Government sought to minimise its exposure to 'bad news'. The managerial messages within the National Health Service were about avoiding embarrassment.

We now know the end of this particular story. Mr Major's new Government has a five-year term ahead, so that the process of implementing the changes stemming from the 1990 Act will continue. Health has moved out of the national headlines, at least for the moment, but that does not mean that the misgivings about the idea of a managed market have actually died away. Structurally, however, we can now expect consistency in the direction of change for the next few years, so that energy can be directed into another set of questions that need not be confrontational and divisive, and are crucial to the performance and objectives of the National Health Service. They include:

- Preparing for the implementation of the community care part of the Act in April 1993, and establishing the substance (as opposed to the rhetoric) of health and social care in community settings.
- Humanising health care, with informed patient choice based on disinterested professional advice. This is a theme picked up in the Selected Issues section later in this report.
- Improving health by all the means available, including cross-sectoral policies. Presumably a Government white paper, based on *The Health of the Nation*, will be published early in the life of the new administration and will propose a broadly-based strategy for health.
- Tackling health inequalities and inequities in a society where deprivation is only too real and entrenched.
- Getting the best value we can for patients and for communities from whatever resources are available to the NHS. This will include trying to make the government's changes work, and arguing for adaptation and further change on the basis of sound evidence.

These priorities will rank high on the Fund's agenda in the next few years. As always, we must act with others, helping or intervening when we perceive real chances to move the agenda forward.

King's Fund Centre

The highlights of 1991 for the King's Fund Centre included the recognition of nursing development units as a major initiative in nursing, and Organisational Audit becoming sufficiently established to be a freestanding King's Fund initiative (see page 12).

The Nursing Developments Programme has supported four nursing development units with funding from the Sainsbury Family Charitable Trusts. The units are now recognised as an important means of developing nursing practice for better patient care, and also for developing nurses. We were delighted when the Secretary of State announced a further £3.2 million for the establishment of 30 more NDUs, with funds to be managed by the King's Fund Centre. By the end of the year bids for the first round of awards for NDUs had been received and selection took place in January 1992. The success of the Programme owes a great deal to Jane Salvage, who left the Centre in July to become Head of Nursing, Midwifery and Social Work at the WHO Regional Office in Copenhagen. In 1991 we welcomed her successor, Barbara Vaughan, to the Centre.

These achievements have brought changes to the Centre – changes which are an opportunity to look at the Centre's work as a whole, especially the internal organisation. We are working hard at shared activities between teams and also at sharing learning, internally and externally. The contributions of our Communications Unit and Publications Unit have been increasingly effective in enabling project staff to communicate their work more successfully and in ways which encourage wider take-up and support for good practice. Much development work is quite long term, and a continuing question is how much to change our project work in a constantly changing environment while not losing our sense of direction. Much of what is described below will need some time before it is adopted widely beyond the initial project areas.

Community care

The Carers Unit service development projects continued in Doncaster, Nottinghamshire and Oxfordshire Social Services Departments and we initiated a region-wide project in Yorkshire. The Unit also produced *Focus on Carers*, giving guidance to local and health authorities on what they can do to support carers. Alongside this, a *Checklist for Carers* was also published. During the year proposals were drawn up for a National Carers Service Development Team in collaboration with the Carers Impact Group, and for a new service development project to help GPs improve their support to carers. By the end of the year a new service development project had been initiated in Lewisham on services for black users of mental health services and their carers – the first joint project with the Community Living Development Team.

The field work of the Community Living Development Team grew during the year with Better Futures, a project to develop comprehensive services for people with severe and long-term mental health problems, and Living Options, in collaboration with the Prince of Wales Advisory Group on Disability, developing services for people with physical disabilities. The team also produced some important publications: *Service Evaluation by People with Learning Difficulties* on how people with a learning disability can evaluate services for themselves; *Meeting the Challenge: Some UK perspectives on community services for people with learning difficulties and challenging behaviour*; and *Making it Happen: Employment opportunities for people with severe learning difficulties.*

Primary care

A key thrust of the team's work this year has been to keep community health services on the agenda as an essential part of the network of primary care services complementary to general practice. The team is working with provider units helping to

clarify what the services can offer, and with purchasers who want to develop a strong and cost-effective primary health sector. The team is also working on how information from general practice can be used in needs assessment. In October the team published *A Case Study in Developing Primary Care: The Camberwell report*, based on a major development programme from the department of general practice in Camberwell. This was also the focus of a celebration in December to mark ten years of the Fund's work on London's primary and community health sector.

Clinical care

The medical audit activity continued to develop with support from the King's Fund Centre in setting up an association for audit assistants and a newsletter. Work was also undertaken on clinical quality measures which could be used in service agreements. The team began to focus on how users can be involved in clinical care, both in determining their treatment and in assessing their own health status. By the end of the year, grants were made to four centres to use the medical outcomes survey which is a patient-assessed outcomes questionnaire. The purpose of the experiment is to see if this questionnaire can be used in managerial applications, for example in purchasing and in provider units, perhaps through the audit process.

The medical education work also met with considerable success in 1991, with the publication of *Critical Thinking* and with the establishment of a network of people engaged in innovation in undergraduate teaching.

Information resources

With a new name and mission, the Information Resources (formerly Library and Information Services) department began to move into a new phase of activity as discussions are held about a national health information strategy, and as we see how this team can be more engaged in service development work in the information field. This team's Fund-wide role has also broadened from the initial library automation project through to its involvement in planning a Fund-wide database rationalisation project.

User involvement

The Centre places considerable importance on user involvement in all aspects of care, from the individual user/professional interaction to service planning. In 1991 we began to coordinate this work more successfully across teams and, with the publication of the Patient's Charter, began to work on our particular contribution which we see as being mainly clinical care and in user consultation for developing service specifications in contracts. Through our consumer feedback resource we published a number of publications and leaflets during the year on how to obtain the views of patients.

Health and race

Again, this is a theme which runs throughout the Centre and in 1991 we launched SHARE, a health and race information exchange. Work with purchasers on how to consult their black populations and improve services through contracts also began to take shape, particularly in Ealing and Parkside.

The Centre has an important role to play in providing an impartial setting where groups of service providers and users can come to debate with us on new developments or among themselves on how to meet new challenges and learn from each other's experiences. This is another way in which we can facilitate developments in the field. The meeting and conference facilities we provide are appreciated by users and many staff are directly involved in providing this service. Fifteen years on from when we moved into the current Centre building we are planning some refurbishment to ensure that we can provide as good as service in another 15 years.

King's Fund College

During 1991, members of the College faculty were actively working with clients in the field and in the classroom on all aspects of the changes begun as a result of the NHS and Community Care Act of 1990. Our work involved us in supporting young managers and the most senior managers in provider units as they dealt with the enormous change agenda. And, as the year went on, managers of commissioning authorities and FHSAs joined our programmes at Palace Court. A comparative leadership programme for Welsh health service and private sector managers was also launched in 1991.

Work continued on management programmes for doctors, increasingly with those in clinical leadership positions seeking help to make significant changes in the services they direct. Faculty also provided management development and organisational development for the medical staffs of acute units to begin to develop a new organisational culture that supports effective clinical resource management. As the new challenges to nursing for clinical and executive leadership became clearer, the College's nurse leadership programmes have been well subscribed as have staff-wide nursing development programmes in selected hospitals.

A new set of programmes was developed to address the many challenges of service commissioning and the relationships between commissioning authorities and provider units. Managing through Contracts brought together managers and clinical directors to develop more effective purchasing strategies. Management and Medicine in the 1990s provided an opportunity for clinical directors and consultants to focus on links between clinical audit, resource management and quality assurance systems. Purchasing Dilemmas gave an opportunity to develop frameworks for priority setting for purchasing decisions. In Public Health and the Purchasing Role, public health directors and purchasing directors explored their roles and strategies for purchasing to improve population health.

In the primary care area, much of the College's work was based in workshops on local patches or in ongoing consulting relationships with unit managers in community health care services, FHSAs, and with GP fundholders, their business managers and GPs themselves. Significantly, several regions also used the College to help them adapt to their new central role in the development of primary health care and in promoting the integration of primary and secondary care. All these efforts were focused on implementation of the reforms in this critical sector – increasing managerial capacity, helping explore mechanisms for more effective community needs assessment and intervention from the primary care practice base, and working on projects to build partnerships among primary care providers, acute units and local authorities. Two educational programmes for independent medical advisers in FHSAs focused on the rapidly changing interface of medicine and management in primary health care.

In the area of social care we have been working with policymakers, politicians, managers and professionals to explore and try to address the many issues involved in the implementation of Caring for People. There has been some substantial direct influence at the political/managerial level through a community care learning set which has informed the work of the Audit Commission and the Social Services Inspectorate.

As many local authorities began to make the changes necessary to implement the Act, the College has actively worked on longer-term relationships with local authority social services on management and organisational development issues. College faculty has facilitated an increasing number of patch-based 'partnership building' efforts with local authorities, FHSAs and DHAs to develop the joint policy and management capacity and, in several instances, joint service agreements that will be important in the future. Programme offerings on Systems for Care Management and Implementing Services for

Elderly People have provided opportunities for work with the teams who will be responsible for delivering interdisciplinary service development.

The College's international work in 1991 involved continuing to build relationships with WHO, EC, World Bank and British Council. A European Health Leadership Programme for top executives in health services in Europe is being jointly sponsored with SENSIA (Stockholm) and EADA (Barcelona) and will extend throughout 1992 and into 1993. Institutional partnerships have been developed with the Technical University of Wroclaw, Poland, to support development of a health services management centre for that region. Towards the end of the year, the College, in partnership with Nuffield, was successful in winning a major tender from the World Bank for a comprehensive health policy review in Romania, the outcome of which will guide the restructuring of their future health care system. Management development programmes for physicians, financial directors, and health service managers have also been held in Poland and Czechoslovakia in 1991.

Finally, the content for these enormous changes in 1991 has been an 'election year' atmosphere. Because the College works with and seeks to support managers and professionals in management roles in the health and social services, we have seen the effects of a strong politicisation of the management process. Some individuals with demonstrated expertise and commitment to service delivery in the NHS have had their careers threatened by elected officials of one party or another who see their actions as partisan. Issues identified as of immediate political importance, such as waiting lists, receive massive infusions of resources and managerial attention, while critical medium- and long-term issues, such as developing the infrastructure for primary care and community care, go relatively unattended.

The environment in the NHS, at its most extreme, leads managers to seek the 'quick fix' while overlooking issues that call for longer-term strategies. The stress leads to burn out, to questioning values and to questioning whether the NHS is a place for long-term personal and professional satisfaction. These are serious problems for politicians, senior managers and those who work with them. It is hoped that 1992 will find us all working together towards joint solutions to the delivery of effective high-quality health and social services that can result in greater long-term health benefit for the public.

During the year, the College has sought to clarify its own response to the future needs of the Service, and to support managers and health professionals in a year of high demands, high accomplishment, and intense stress.

The College has engaged in a strategic planning exercise to identify priority areas for its own development in the future. We have identified the following areas of emphasis:

- Health Professionals in Management: enhancing the contribution of health professionals.
- Strategic Commissioning of Health and Social Care: the separate roles, development needs and interactions of those charged with the strategic direction and purchasing for the NHS and those with operational responsibility for provider units.
- General Management Development: for NHS career development of general managers.
- Working at the Interface: creating systems of care that work for clients across traditional health service and social service boundaries.

Cutting across each of these priority areas are four key themes: health gain, user empowerment, quality, and the comparative perspective that comes from our work in the private sector and internationally. Faculty will be devoting a portion of its time to development work in these key areas to shape the future work of the College. We look forward to 1992 as a year of continuing change for the health service and for the College that will lead to even greater effectiveness in the future.

King's Fund Institute

The Institute's key achievement in 1991 was to strengthen its staff by making a number of strategic appointments. Ray Robinson and Linda Marks rejoined the Institute and three new researchers were employed. This enabled the Institute to pursue more research-based studies and begin to invest substantial time and effort in the analysis of such diverse data sets as the health service indicators package, the public health common data set, the health and lifestyles survey and a survey of Londoners' living standards.

London

During 1991 the Institute made a substantial contribution to the Fund's Commission on London. Michaela Benzeval and Ken Judge were joined by a new member of staff, Mike Solomon, to investigate the health status of Londoners, and Sean Boyle worked with another new researcher, Chris Smaje, on acute health services in London. Both pieces of analysis used a comparative framework to compare London with similar areas in the rest of England.

The Health Status of Londoners examined the relative health status of Londoners using two national surveys of mortality and morbidity. It then investigated the factors which affected health and discussed the implications of its findings for policy. The report had two clear messages: Londoners' health is no worse than residents in comparable areas; there is a consistent and significant relationship between deprivation and health.

Acute Services in London showed that London is not over-resourced in terms of beds and staff against equivalent parts of England. However, London is a high-cost provider of services, particularly in teaching districts. While Londoners use a higher proportion of hospital services than the national average, it is no different to comparable areas. Finally, in a detailed analysis of patient flows within the capital, the work showed that deprived areas of London are net exporters of care to people in other parts of the capital and beyond.

In addition, *Homelessness and the Utilisation of Acute Hospitals in London* was produced in conjunction with two inner London health authorities.

NHS reforms

The King's Fund made the independent assessment of the NHS reforms the focus of a major grant initiative, and is supporting seven research projects. The seven projects, coordinated by the Institute, are: monitoring managed competition; the NHS reforms and hospital costs; medical audit in hospitals; general practice fundholding; the changing face of human resource management; evaluating the impact on elderly patients; patient choice and changes to the referral system.

The aim is to bring together academic researchers and practitioners, in an effort to combine first-class evaluative methodology with practical problem solving. The dissemination of information arising from the projects is seen as particularly important. In view of this, the Institute produced a Bulletin which provides information on the work in progress.

In addition the Institute has published the interim report of one of the projects. *A Foothold for Fundholding* by Professor Glennerster and colleagues at the LSE is based on the in-depth analysis of ten practices and suggests that fundholding has produced some clear benefits for patients. It also highlights some of the weaknesses of the scheme which need to be addressed.

1991 census

For the first time since the beginning of this century the 1991 census included a health status question about limiting, long-standing illness. The Institute decided, therefore, to involve itself as early as possible in the debate about how best to utilise the 1991 census. It began by making use of the OPCS Omnibus Survey to obtain early feedback about the likely responses to precisely the same health question which was included in

the census. The Institute intends to examine how the census can be used in areas such as assessing health status and needs, resource allocation and the distribution of hospital and family practitioner services.

Primary and secondary care

During 1991 the Institute published two reports on primary care. *Home and Hospital Care: Redrawing the boundaries* shows how acute hospital stays may be reduced and admissions prevented through the development of intensive nursing schemes and home-based high technology care. Linda Marks reviewed different ways of organising hospital care at home and its potential benefits and causes for concern.

Developing Primary Care: Opportunities for the 1990s reviewed evidence from projects funded by the DoH, Nuffield Provincial Hospital Trust and the King's Fund as part of the primary care development fund. This highlighted the role of the new contract for GPs in developing appropriate action for care in areas such as health promotion, and the potential for FHSAs to establish local primary care objectives and target resources to areas of greatest need.

NHS estate

In 1991 the Institute published the first report by one of its visiting fellows, Richard Meara. *Unfreezing the Assets: NHS management in the 1990s* investigated how well health authorities have managed to develop the more commercial approach to estate management recommended in the Ceri Davies report.

Ray Robinson also examined the issue of capital charges in a joint publication with NAHAT. *Cutting through the Confusion: A review of capital and capital charges in the NHS* describes the background to capital charges; how capital charging will work; funding and transitional arrangements; implications for NHS Trusts and other unresolved issues.

Future strategy

The Institute now has four key strands in its programme of work: investigating the future of acute hospitals; monitoring health and health care in London; evaluating access to health care in the new NHS; and continuing to contribute to a range of King's Fund initiatives.

Institute work in relation to the future of acute hospitals is closely bound up with the joint health policy review with the Milbank Memorial Fund. However, Institute staff are intending to make further contributions to analysis of the shifting boundary between acute hospitals and other forms of health and social care.

During 1991 the Institute laid the foundation for its effort to monitor the health and health care of Londoners. There are now two priorities. We will continue to support the Fund-wide London initiative while, at the same time, consolidating the growing reputation of the Institute for expertise in this area. The Institute has begun a comparative investigation of primary health care and other community services in the capital, and an analysis of consumers' views.

An emerging theme is to consider issues about access to health care. We intend to bring together a number of detailed projects on ethical issues about rationing, resource allocation, purchasing and utilisation of health services. Our aim is to develop a coherent analysis of the extent to which access to health care in the new NHS conforms to different notions of fairness and justice.

During the next year the Institute will also start to make new contributions to areas of growing interest in the Fund, such as health and health care in Europe and for black and ethnic minorities.

Grantmaking/ Organisational Audit/ Commission On London

Grantmaking

Compared with the early 1980s there have been big changes in the Fund's grantmaking. At that time, many of our grants were designed to help hospitals and institutions such as nursing homes to improve their facilities.

Towards the end of the 1980s the Fund began to concentrate much of its grant giving in major allocations. Early examples included the COPE project, which considerably improved the service for orthopaedic patients needing hip replacements, and a project showing how the management of venous ulcers in a community setting could greatly improve the patients' lot. Subsequent evaluations by Professor Nick Bosanquet showed financial savings and service benefits in both these innovations which could usefully be emulated in many general hospitals. The Fund's next major grant was used to show that the health care of the homeless could be improved. Here we have worked closely with the four Thames regions and with many authorities and voluntary agencies; on the whole, we have achieved considerable success.

The results from these major grants were encouraging and three further major initiatives followed. The first involved the objective evaluation over three years of the Government's health care reforms and this is still in progress. Last year's major grant scheme was concerned with improving services for elderly people. Seven projects were funded totalling £402,601. The projects are located around the country and explore the hospital/community interface, support in people's homes, needs assessment, and enhancing old people's quality of life.

The 1992 major grant initiative is designed to support two programmes of work on improving services for black people. The first will be a study to assess the feasibility of establishing a Black Foundation as a potential organisation to promote black people's issues. One hundred thousand pounds has been set aside. The second initiative involves improving access and reception for black people within the health service. This will be a competitive scheme, in two phases. The first will select ten projects, and give them time for more detailed planning and consultation. A final selection will be made of three of these projects for eventual implementation. Three hundred thousand pounds has been set aside.

The Fund, of course, still makes many more modest grants. These are listed on pages 27–35. The range supported is wide.

The Fund is encouraged by the results of its recent initiatives. The annual totals we have available for distribution, perhaps £1.5m to £2m, are very small compared with the huge costs that the Government faces in maintaining Greater London's health care services. However, we believe that carefully selected initiatives can often point the way forward, and illuminate current policy debates. We expect to continue to play an exciting part in the achievement of better patterns of health care delivery in the London area.

Organisational Audit Programme

The Organisational Audit Programme became independent of the Quality Improvement Programme in September 1991. This was followed by a move from the King's Fund Centre to Palace Court in November.

Nineteen ninety-one was the first full year of activity for the Programme and, during it, 23 acute hospitals were surveyed. In addition, a further 42 hospitals joined the Programme in the spring in preparation for surveys in 1992. By the end of the year over 100 hospitals had signed up to take part; of these approximately 70 per cent are NHS and 30 per cent independent.

Continuing informal evaluation of the Organisational Audit Programme by participating hospitals has confirmed that they judge it to provide the following benefits: multidisciplinary, systematic review; improved communication; validation of documentation; and identifying an agenda for action.

Much of the success of the organisational audit process is due to the calibre and expertise of the senior health care professionals who act as surveyors. During 1991, we held two surveyor training sessions and now have 90 surveyors. The core survey team comprises a chief executive (unit or general manager), a consultant and a director of nursing. In addition, the opportunity to become a surveyor has been extended to senior members of the Professions Allied to Medicine. The recruitment of surveyors will continue to be a priority in 1992 and we shall seek the support of the professional organisations in this process.

Extending the programme

Now that the acute survey programme is well established, we have been able to turn our attention to extending the range of our organisational audit activities. In the autumn a working group of consumer representatives was established to help define the standards for use by consumer groups. This work complements and builds significantly upon the aim of the Patient's Charter 'to provide services that meet clearly defined local standards in ways responsive to people's views and needs'.

The Organisational Audit Programme is now set to build on the success of the acute hospital programme. A new project will run over the next two years. This aims to extend the organisational audit approach into the community setting, specifically within health centres and GP practices.

The aim of the project is to develop a framework of standards which can be applied to the organisation of wide ranges of services. Organisational audit would become the objective way of monitoring compliance with these standards.

King's Fund Commission on London

The Commission met eight times in 1991 in order to continue its work on health care in the capital. In addition, members of the Commission made visits to the University of Nottingham School of Medicine; the Nuffield Department of Clinical Medicine and Institute of Molecular Medicine, University of Oxford; and the Lambeth Community Care Centre.

The early part of 1992 saw the publication of 12 working papers on health and health care in the capital. These were the first fruits of the Fund's London Initiative research programme, which was established to inform the work of the Commission. The first six to be published centre on facts, figures and views on health and health care in present-day London. They include papers on the health status of Londoners; the resources used on acute health services in London and their efficiency; acute medical specialties in the capital; independent health care in London; users' views on health care in London and three essays on health care in the capital by a senior clinician with management experience.

The second six are more speculative, and focus on likely future trends and directions for health care in the early years of the next century. They cover the future of acute services and of medical education in London; the balance between primary health care and acute services; management structures; health care labour markets in London; and the extent and condition of the NHS estate in the capital.

The Commission's intention in publishing the working paper series in advance of its own report was to stimulate an informed debate on the future of health services in London. In this it was successful: the working papers attracted a very considerable amount of attention in the media, and have also been widely distributed among senior NHS managers and clinicians in the capital. The hope is that this exposure to the basic facts about health service provision in London will pave the way for the Commission's own strategy for health services in London which will be published in the summer of 1992.

Public services: what can users expect and how can they be involved?

Nineteen ninety-one saw the introduction of the Citizen's Charter and its offspring, the Patient's Charter. This latter spelt out patients' rights, added some new rights, plus some standards. The Charter will be dismissed by some as political rhetoric, but the mere statement of rights can be empowering to the individual user. There is a long way to go with some of these rights, though. For example, it is welcome that patients should have a right to know about their condition, treatment and care, and the alternatives available to them, but to make sure this really does happen in the NHS (or any other health service) is another matter.

Despite these welcome signs of intent the great challenges still remain. How can public services be made more accountable to the public and to the individual user? What standards can the public expect, and how can these services be encouraged to continue improving their quality?

There are signs that the NHS is becoming responsive to its users. Purchasers of health care are seeking the views of user groups and the community to help specify the services that they intend to purchase. An example of this is shown in Box 1. Four districts were given grants by the King's Fund to improve services for their black populations through the purchasing process. A requirement was that they should consult their local community on what services they wanted.

Both purchasers and providers are seeking out the views of people who have received care. Finding out is not enough – managers must act on the findings, but this too is beginning to happen. Where consumer involvement is only just starting is in the individual patient/doctor interaction. Some doctors are good at explaining what is happening and what the options are; many are not. For patients to feel able to take part in these decisions they will need a great deal more information. A current challenge is to find good ways to get that information to patients in a form that they can understand and use (see Box 2). Experiments are just beginning with a US-designed patient interactive video system, setting out the risks and benefits of treatment options for particular conditions. Recently patients' views about their own health outcomes from treatment have begun to be assessed. This is important because, while the condition may have been diagnosed

1.

Purchasing services for ethnic minority populations

Parkside Health Authority, in one of the four King's Fund projects, focused on four care groups to pilot its activity. These are: elderly people, AIDS/HIV patients, maternity and disability. The district covers all or part of three London boroughs: Brent, Westminster, and Kensington and Chelsea. Given that many community and voluntary organisations depend on the Health Authority for funding for some of their activities, a series of consultations was organised in each of the three boroughs. Thus in each case the consultations were with groups interested in, or involved with, the care of any of the four care groups. One of the objectives of the consultations was to:

'. . . enhance the role of the Health Authority as "patient advocate" by responding to the views of the consumer and challenging the dominance of health professionals and managers in determining priorities.'

As a result of these consultations a number of quality standards have been identified as key performance indicators that providers are expected to meet, namely:

ethnic monitoring
interpreting and translation
access
diet
religious provision
staff training

For each of these indicators there is a series of standards that have been negotiated with local providers and act as a guide to the expectations of the purchaser.

2.

Understanding patient preferences

Choices are often made between different operations or medications provided for patients, yet commonly these choices are made *for* patients instead of *by* patients. Reasons normally given for deciding on behalf of patients are: the patient not wanting to know the full implications of treatment, or, the issues are too complex, or, that there is not enough time to explain all the possibilities. Lack of information can generate a paradoxical situation in which health care is both appropriate and effective, yet a patient is dissatisfied because the condition and its treatment were inadequately explained.

The Patient's Charter echoes a call from patient and professional groups for more information to be given to those using health care services. Emphasis towards services based upon 'need' requires health authorities to take proper account of the views of those using services. Consensus is gathering among the purchasers, providers and users of health care services that information to patients has to be improved. Deciding what information is provided and the means through which it should be conveyed is more difficult. Information given through leaflets and pamphlets can be impersonal. Problems exist in balancing the breadth necessary to inform patient groups (heterogeneous in respect of symptoms, age, educational level and ethnic origin) with the focus to reach a specific individual at the time of his or her need to decide which treatment to choose.

Ideally patients should have access, if they wish, to detailed information about their condition, tailored to their individual circumstances, and also the opportunity to hear from people who previously faced similar treatment decisions. Logistic and financial restrictions make direct staff and past-patient contact a difficult, although not impossible, means for informing patients in this way. Advances in computer and video technology have provided a more practical alternative, using **interactive video**. The King's Fund Centre is currently supporting and evaluating a development project using **interactive video** to provide patients considering prostate surgery with improved and more detailed information about their condition.

This **interactive video** system takes information obtained from outcomes research in prostate surgery to 'set the scene' for the decision that patients face. Role models, who have been patients faced with similar decisions, share their experiences on the video. The interactive video thereby provides information to help patients determine their own preferences about treatment. It supports their eventual decision and does not act as a decision algorithm which decides for them. The system was developed in the USA and has been well accepted by patients and clinicians. The King's Fund Centre is concerned with the immediate implications of introducing this innovation, but also in setting it within a broader context of other means of informing patients, so determining patient preferences for the health care services they receive.

and treated to the doctor's satisfaction, patients may have a very different view of their health and wellbeing, perhaps feeling worse because of the side effects of the treatment. In looking at what health care is achieving, information from both groups of people is needed.

But what about the quality of services being delivered? In the health service it will be a long time, if ever, before patients can really judge all aspects of their care. They will need others to assess quality on their behalf, or at least to provide them with information on which to base their judgments. Ultimately patients might be provided with information about the outcomes of care so that they can make judgments about how well a hospital is performing for example and decide where they want to be referred. Our knowledge of health outcomes is limited at present. Outcomes depend on the patients' state on entering the system, whether the treatment they receive is effective and appropriate for them, and how well the procedures were performed. We need a lot more information then, to be able to judge the quality of services by their outcome.

Instead, we are usually left to judge the processes of care. The King's Fund Organisational Audit Programme reviews organisational policies and procedures, against predefined standards, and

medical audit is beginning to tackle issues in clinical care. The Audit Commission is now operating in the NHS and beginning to take particular issues, such as day surgery, and to assess how well a hospital or unit is doing compared with others in the country. The important issue in all these activities is that they must build on the enthusiasm of people in the NHS who are firm in their resolve to make improvements. There are plenty of professionals and managers in the NHS who want to know how well they are doing, whether there are standards they should be meeting, and whether there are ideas from elsewhere they could adopt.

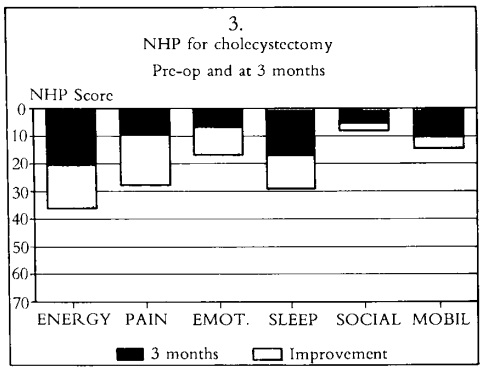
This argues for quality activities in the NHS which emphasise development rather than inspection.

This philosophy fits in well with total quality management and similar approaches. It seems likely that in the next few years many people working in the health sector will want to take on these ideas.

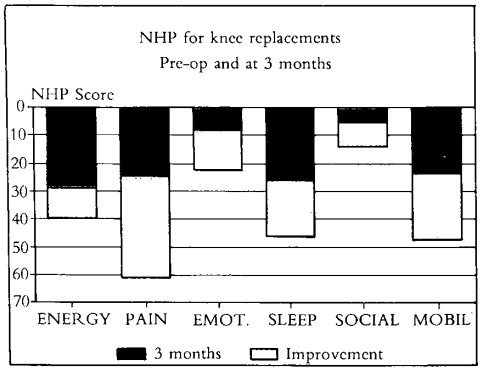
Many people are working to increase the influence patients can have about the delivery and assessment of their treatments. The CASPE Research Unit has been at the King's Fund for many years and, for instance, has worked on the measurement of outcome in a number of conditions at the Freeman Hospital in Newcastle. The study considered a number of dimensions of outcome. As well as recording clinical improvements, it also examined patients' own perceptions of their own lives both before operation and three months after. The graphs (box 3) show that some areas of the patients' lives had improved considerably, although there was still some residual pain, lack of energy, and so on, reported. The graphs show significant differences between conditions. They provide a useful reminder that technical success in the operation, as defined by the surgeon, is not necessarily synonymous with a complete cure as expressed by the patient.

A further issue is about what the NHS does and does not do, which treatments are available and to whom. We are used to rationing in the UK, whether done implicitly by GPs or more explicitly through waiting lists. As new therapies are developed, others may have to be reduced to make way for them. Purchasers are beginning to look at these questions. Are we going to decide that some treatments will not be covered by the NHS? If so, how is the public going to have its say in these decisions?

Improvements in patient perceptions of health status after surgery



Mean NHP scores and change in NHP score to 3 months after cholecystectomy.



Mean NHP scores and change in NHP score to 3 months after knee replacement.

NHP: Nottingham Health Profile (Ref: Hunt SM, McEwen J, McKenna SP. Measuring health status. Beckenham, Croom Helm, 1986.)

Source: Bardsley M, Coles J, et al. CASPE/Freeman Outcome Study, Final Report, November 1991.

The NHS and Community Care Act: progress in 1991 and issues for the future

In reviewing 1991, two major issues dominated the National Health Service. First, it was the year of 'going live' on the implementation of the NHS and Community Care Act. Second, it was a pre-election year and the NHS has been a lightning rod for the two major political parties. Both these facts have played a major role in shaping the implementation of the reforms and the consequences of the implementation for managers and professionals in the NHS.

Going live

In 1991, except for postponement of the implementation of Caring for People (the community care component of the legislation), the effects of change began to be felt in all segments of the health and social care system.

The biggest demands for change in the NHS have probably been made on hospital and community health services. The impact of the purchaser-provider split has begun to be real. On the provider side, the movement towards trust status has exceeded most initial projections. Following on the 57 first wave trusts, 103 more will join the ranks in 1992. Over 75 per cent of all provider units are likely to be under trust management by the middle of 1993.

There are clearly problems: lack of good management information systems· the relative immaturity of a general management culture in the Service in the face of demands for new management strengths in finance, human resource development and clinical resource management to name a few; the uncertainty of many health service staff about the wisdom and ultimate intent of the reforms; questions about whether money will really follow patients to avoid the old efficiency trap; and continuing lack of clarity about the capital allocation process. However, there does seem to be considerable support among general managers (and increasingly among health professionals) for the basic thrust of the changes as they affect provider units – decentralisation and delegation of both authority and responsibility to the unit level; increased individual and organisational accountability within the unit; ability to tackle local problems of efficiency and effectiveness using locally relevant solutions; and an increasing culture of responsiveness to patients and other 'users' such as general practitioners (GPs).

On the commissioning side, the change in approach has been dramatic. New organisations have had to develop rapidly as district health authorities (DHAs) have split to address their new roles. While this process has been difficult in many authorities, there have been notable exceptions which have begun to show how a health authority can shape health services in a geographic area. The NHS Management Executive began to place emphasis on enhancing purchasing in mid-1991 and this has paid off in increasing the credibility and attractiveness of commissioning for NHS managers. There are still enormous numbers of unanswered questions as to how effective purchasing authorities can be as the future strategic management spine of the NHS. They face several challenges. One is increasing the sensitivity to local needs in the face of a trend towards mergers of authorities which are being promoted as a way of strengthening their purchasing power and their leverage over providers. Another is developing mechanisms for delivering on health care priorities and resource allocation.

In general practice, dramatic changes have been taking place as a result of the implementation of the new GP contract, the emergence of family health services authorities (FHSAs) and, of course, GP fundholders. GPs have responded well to the financial incentives to enhance their role in prevention. They have also become increasingly conscious of their power to influence change in the traditional practices of hospitals in order to gain better responsiveness and quality for their patients. The FHSAs have

emerged as more effective management units in primary care, with real potential for impact on community health needs assessment and intervention through general practice. There is, however, continuing confusion about whether their future role is as sole purchasers of primary care, or as joint purchasers with DHAs, or as provider managers, developing the capacity of their GPs to coordinate care and leverage influence. Similar inconsistencies are still apparent in the management of community health care services.

The GP fundholders have truly been the 'wild card' in the reforms. In some parts of the country, they have become major purchasers of care and have used this power to improve the responsiveness and quality of acute hospitals in dramatic ways. Their success has clearly stimulated non-fundholders to exert themselves more in their relations with DHAs. Fundholders have also used their new freedoms to provide more services to their patients within their own practices rather than buying them from hospitals. This trend will increasingly challenge the traditional boundaries between primary and secondary care as well as the skill mix within general practice itself.

There are, however, unanswered structural problems. DHAs have the responsibility for ensuring that health service resources are directed to improve the health of the population. GP fundholders have no such direct responsibility, but may increasingly pull purchasing power away from the districts. This inconsistency must be addressed through more effective joint working between regions, FHSAs and GP fundholders on strategies for health gain. There are also potential problems of differential access to care for the patients of fundholders; for continued variation in standards of practice; and concerns about potential incentives not to register certain patients. All these should be addressed in future work on financial allocation strategies or regulatory frameworks for the overall market. The continuing uncertainty over the current and future role of regions makes addressing these broader issues very difficult.

The proposed community care reorganisation continues to pose enormous potential problems for patients dependent on these services. Success or failure in implementing cross-sectoral working to develop effective community based case management will have fundamental effects on the success of de-institutionalisation initiatives, and on the primary care sector's ability to cope with likely reductions in hospital utilisation and increases in services closer to the patient. While there is a strong history of senior management and policy level collaboration in processes of formal joint planning between health and social services, this is often not translated into the kind of effective middle and junior management cooperation that will be necessary to implement the desired reforms. Different organisational cultures, timetables, accountability structures are all issues to be addressed. Financing – how much is available, who pays, and who is therefore accountable for service outcomes – are overriding issues.

The election year

The fact that there was an impending general election has had a major impact on the environment in which these massive changes have occurred. The NHS has been an arena for debate about the differences between the Labour and Conservative parties. Any change as massive as those called for in the past two to three years must have positive and negative effects. The same will apply to any future change, if it is, in fact, a radical departure from the current service structure or operation. The pre-election environment has 'politicised' both the successes and failures of the reforms to date.

It is clearly the job of ministers and politicians to chart a policy course that reflects their views of how the public services should operate, and to decide what resources these services will

receive. It has been the traditional role of managers and professionals to try to ensure the provision of services to as high a standard of quality as possible within the policy framework and resource constraints. There has been a considerable blurring of these roles in the last year and a politicised atmosphere that has often prevented those who are experts in managing and providing services from working honestly and openly with the politicians of whatever party to find the best way to operationalise their policies.

The ability to act on real managerial concerns about the pace of change in organisations and its effects on staff, the freedom to identify and support changes that have resulted in real management improvements and abandon those that have not, the need to focus on the potential effects of service systems changes on the quality and responsiveness of the care provided to patients and communities, are all critical to an effective NHS. If managers or professionals are afraid to express their views about such issues lest they be accused of playing partisan politics, the level of debate and problem solving that is needed cannot occur. No political party can expect to provide quality services to the people without the support of those who manage and deliver those services. That support is earned through substantive debate, joint problem solving, developing trust and mutual concern for the patient and citizen.

Hospital design

What ought hospital buildings to be like? Does Britain have appropriate hospital buildings? If not, what can be done?

In the King's Fund we started thinking systematically about these questions in 1989, following an approach by Professor Richard Beard of St Mary's Hospital, London, to our President. Professor Beard felt that British hospital design does not meet the demands for an environment that is aesthetically acceptable for patients and staff. Broadly we agreed, although the buildings of which we complain most strongly (Figure 1) are typically products of the thinking of the 1960s and early 1970s, rather than more recently. The 1960s concept of the district general hospital of 600 beds or more, planned as a single entity, unfortunately coincided with a taste for high rise buildings, quite a brutal and intimidating functional style, and rigid, centralised approaches to cost control. This proved to be a lethal combination.

However, fashions have fortunately changed. For a whole variety of reasons, since about 1980 hospital development schemes have become smaller, are much less likely to be high rise, and are more human in scale.[1] Nucleus designs are the fashion (Figure 2) and are in general far better than what went before. There are also many more day unit, day centre and hospice schemes than previously, and even community hospitals (Figure 3), all of which are on a much more human scale than the district general hospital.

Nevertheless, that does not mean that everything is perfect. For example:

- Without wanting to detract from the real advance that nucleus represents, the results are frequently still at odds with their local

Figure 1

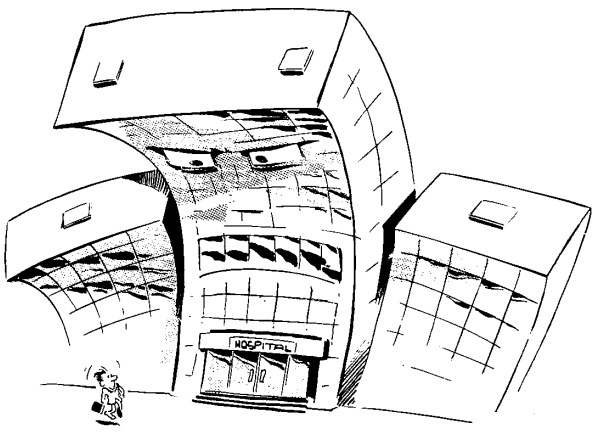
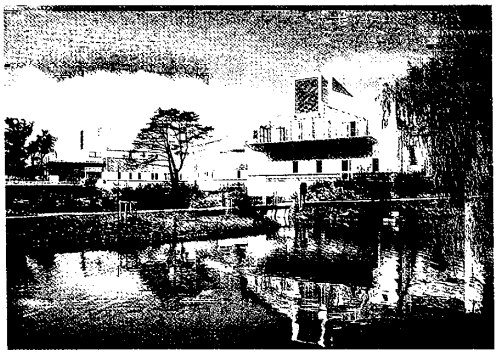


Figure 2 St Mary's Hospital, Isle of Wight



environment. They are also often (though by no means always) lego-like in their predictability, and have not always escaped from the rival dangers of planning delays, cost over-runs and enforced, short-sighted economies in construction.

- Quite apart from the challenges of new construction, the NHS is in general appallingly neglectful about maintenance. Even when they are relatively new and built to a high standard, hospitals require regular maintenance and sympathetic adaptation. They simply do not receive either in most of the National Health Service. Standards of maintenance are notoriously low and this shows. Moreover, requirements are changing continuously. Before any modern hospital building is complete, the requirements have moved on. All too often the NHS response is to put annexes into any vacant space that exists, almost regardless of the impact on the rest of the building. The result is sites with no overall coherence that have lost any generosity or grace that they possessed originally.
- Not long ago we assumed that much of the inherited building stock of British hospitals would be scrapped reasonably soon, simply because it is so old, dating back to the turn of the century and beyond. This is no longer a sensible assumption, on grounds of cost and value for money, even though much of it is in poor repair.[2] We need to be thinking harder about renovation and modification of the existing buildings, provided they are (a) suitable settings for care by today's standards and (b) in the right places (Figure 4).
- Designing for today's requirements is not enough. Patterns of care are changing, for example, away from big institutions for care of mental illness and mental handicap, and away from inpatient settings for a considerable proportion of elective surgery and diagnostic investigation. The general hospitals of the future will be smaller, with fewer inpatient beds and much more outreach.

Figure 3 Lambeth Community Care Centre – an urban community hospital in a garden

Figure 4 Queen Mary's Hospital, Hampstead – built as a maternity hospital in 1921 and recently reopened as a hospital and day centre for elderly people

Four guiding propositions on hospital design

Hospitals should:

- do nothing that can be done equally well outside them
- provide an atmosphere that is conducive to healing; that is, one which:
  - is pleasing and reassuring to patients
  - protects privacy and confidentiality
  - includes social spaces (for patients, staff, visitors) that are as normal as possible
  - works with the healing powers of the natural environment (light, greenness, etc)
  - is attractive to staff as a place to work
- be operationally efficient in design and configuration
  - for patients, visitors and staff
  - providing spaces that are appropriate for technical functions, as well as spaces for care and recovery
  - able to accommodate dramatic unforeseen changes in technology
  - located and designed for ease of access, particularly for those for whom access is likely to be difficult
  - wear well and be robust and economical in use
- be places that communities are proud of, internally and externally.

What the King's Fund is doing at the moment is based on continuing enquiry, research and dialogue. With the Milbank Memorial Fund of New York we are engaged in studies on the future development of hospitals. The King's Fund Centre also has a major focus on future patterns of care, in institutional and community settings. We are willing to fund concise pieces of research, with a view towards a major publication in due course. This will include an attempt to identify and learn from outstanding examples of hospital architecture from any country, culture or historical period and to set explicit criteria for judging excellence (see box). It is also likely to involve one or more competitions to promote excellence in contemporary British designs for health care, within hospitals and outside them.

1. New health building developments in England and Wales over the last 25 years. Rawlinson, Kelly and Whittlestone for the King's Fund.
2. Meara, R. London's legacy: aspects of the NHS estate in London. London, King's Fund Commission on the Future of Acute Services in London, 1992.

Complementary medicine: recognition and regulation

Therapies outside orthodox medicine receive less official recognition in this country than in many others. That applies not only to the National Health Service but to private health insurance also. Whereas in North America and much of Western Europe therapies like osteopathy, chiropractic and acupuncture are respectable, and insurance companies will frequently pay for them, that is rarely the case here. Yet patients feel differently. Many can testify that particular osteopaths or chiropractors have worked wonders with their bad backs when physicians could offer little and surgeons might well do more harm than good. People who have suffered strokes have frequently found acupuncturists and reflexologists more willing to listen, to encourage and to work with them over a prolonged period than the hospitals that have saved their lives. So it is not surprising that despite the lack of official recognition, there is a flourishing and expanding market in complementary medicine on a pay-as-you-go basis. In the mid-1980s this was estimated to involve some 6,000 practitioners and to be used by 1.5 million people annually at a cost of some £250 million.[1]

In 1989 the King's Fund established a Working Party under the chairmanship of Sir Thomas Bingham, a Lord Justice of Appeal, to consider the scope and content of legislation to establish a statutory register to regulate the education, training and practice of osteopathy. The Working

Party reported in December 1991[2] and a draft Bill was immediately introduced into the House of Lords by Lord Walton, a leading physician who had served on the Working Party. When Parliament dissolved for the general election, the Bill had completed the Committee stage in the Lords, with substantial all-Party support.

The argument for regulation is essentially to protect patients. Currently in Britain anyone can hold himself or herself out to be an osteopath regardless of training. This might not matter if osteopathy were a placebo therapy with no effect, but it generally involves physical manipulation of a powerful kind that can (when delivered by an unskilled practitioner) do substantial harm as well as good. Most patients are entirely unaware of this lack of protection. Responsible osteopaths acknowledge that it is not good enough and all the recognised osteopathic bodies gave their support to the proposed legislation.

While the Bill failed on this occasion for lack of time, both the main political parties have undertaken to consider government-backed legislation in the new Parliament. The Labour Party had given this undertaking for complementary medicine in general and the Conservative Party for osteopathy in particular, during the House of Lords debates.

The case for registration and regulation seems overwhelming when the following criteria are met (as they are for osteopathy):

- that there is or is likely soon to be a substantial practice in Britain in the therapy concerned;
- that the therapy concerned can do significant harm as well as good;
- that there is a body of knowledge and skill underpinning the therapy that is recognisable by those outside the therapy concerned and is open to scientific enquiry.

Sir Thomas Bingham is currently chairing a further King's Fund Working Party on chiropractic. That is as far as the Fund itself is likely to be able to go in this field. Whether other branches of complementary medicine do or do not currently meet the criteria set out above is a matter to be considered therapy by therapy: the case for statutory recognition and regulation is not as strong for some as for others.

Thanks to Lord Walton, there is now a model bill for osteopathy that has received very close attention from the Department of Health and the parliamentary draftsmen. We hope that the new Government will honour the pledge given in the Lords and will find a way to take this matter forward early in the new parliament.

1. Private medicine and public policy. Health Care UK, 1987.
2. King's Fund working party report on osteopathy. London, King Edward's Hospital Fund for London, 1991.

Financial Review

The following pages (24 and 25) contain abridged financial statements extracted from the full accounts of the King's Fund which are available on request.

At 31 December 1991 the valuation of the Fund's net assets was £104.8m, an increase of £4.4m over the year. Stock markets in general showed improvement during 1991 although the property market in the UK remained depressed. The Fund continued to maintain a high level of liquidity following the previous sales of property and also while exploring the possibility of moving its activities to a single site, which did not turn out to be feasible.

The overall value of securities and cash assets was £71.4m at the year end, an increase of £2.9m over 1990, and other net assets which include bank balances rose by £2.0m to £9.2m. The value of holdings in property was £0.5m lower and this was after the inclusion of one new investment costing £2.8m.

After transfers affecting General Fund, net income for 1991 was £5,423,000. This was an increase of £776,000 over the previous year and in part reflected the high return on holdings of cash assets.

Net general expenditure of the Fund before grants was £3,371,000 (1990 £2,130,000) and grants allocated were £2,091,000 (1990 £2,531,000). Net expenditure shown under the Centre and Special Projects takes into account specific contributions from other bodies and the corresponding figures for 1990 have been adjusted accordingly. The overall deficit for the year of £39,000 was met from General Fund.

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

Bankers:
Bank of England
Baring Brothers & Co Ltd
Midland Bank Plc

Auditors:
Coopers & Lybrand

Solicitors:
Turner Kenneth Brown

ABRIDGED STATEMENT OF ASSETS AND LIABILITIES

AT 31 DECEMBER 1991

	Valuation	
	1991	1990
	£	£
CAPITAL FUND		
Investments		
Listed securities and cash assets	30,970,000	23,701,000
Unlisted securities	485,000	497,000
	31,455,000	24,198,000
Net current assets	703,000	4,103,000
	32,158,000	28,301,000
GENERAL FUND		
Fixed Assets		
Equipment	589,000	526,000
Investments		
Listed securities and cash assets	39,582,000	43,971,000
Unlisted securities	338,000	295,000
Properties	13,943,000	11,916,000
King's Fund premises	10,195,000	12,725,000
	64,647,000	69,433,000
Net current assets	7,961,000	2,643,000
	72,608,000	72,076,000
SPECIAL FUNDS		
Investments		
Listed securities	20,000	18,000
Net assets	£104,786,000	£100,395,000

Abridged Income and Expenditure Account

YEAR ENDED 31 DECEMBER 1991

	1991			1990		
	£	£	£	£	£	£
INCOME						
Securities and cash assets		4,768,000			4,173,000	
Properties		645,000	5,413,000		460,000	4,633,000
Profit (loss) on realisation of General Fund Investments		(120,000)			5,119,000	
Less: transferred to General Fund		120,000	—		5,119,000	—
Income from securities and cash assets in Property Reinvestment Fund		2,197,000			1,912,000	
Less: transferred to General Fund		2,197,000	—		1,912,000	—
Donations			10,000			14,000
			£5,423,000			£4,647,000
EXPENDITURE						
Grants allocated		2,091,000			2,531,000	
Less: grants lapsed		6,000	2,085,000		45,000	2,486,000
King's Fund Centre		3,196,000			2,543,000	
Less: Contribution from DoH	585,000			558,000		
Conference fees etc	478,000			433,000		
Grants from other bodies	1,214,000	2,277,000	919,000	976,000	1,967,000	576,000
King's Fund College		3,505,000			3,080,000	
Less: Fees and service charges		2,547,000	958,000		2,775,000	305,000
King's Fund Institute		505,000			471,000	
Less: Receipts		53,000	452,000		78,000	393,000
Publications		—			186,000	
Less: Sales		—	—		54,000	132,000
Special Projects		814,000			665,000	
Less: Grants from other bodies		600,000	214,000		665,000	—
TOTAL GRANTS AND SERVICES			4,628,000			3,892,000
Other expenses:						
Head Office – Staffing	384,000			366,000		
Other	184,000	568,000		171,000	537,000	
Professional fees, etc		163,000			116,000	
Maintenance of King's Fund premises		103,000	834,000		116,000	769,000
			5,462,000			4,661,000
EXCESS OF INCOME OVER EXPENDITURE OR (EXPENDITURE OVER INCOME) FOR THE YEAR TRANSFERRED TO (FROM) GENERAL FUND			(39,000)			(14,000)
			£5,423,000			£4,647,000

Contributors in 1991

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

Baring Foundation Ltd

N H Clutton
A H Chester

V Dodson
K Drobig

S M Gray
The Gloucester Charitable Trust

J M Hargreave
Lord Hayter KCVO CBE

Jensen & Son

Roger Klein

R Maxwell
W Maxwell McGuire
Morgan Grenfell Group Plc

G Pampiglione

Albert Reckitt Charitable Trust
Sir Thomas B Robson

O N Senior
Sussman Charitable Trust

The Wernher Charitable Trust

Legacies received in 1991 (£1,784)

Robert Shephard Large Deceased

GRANTS MADE IN 1991

Management Committee

Responsible on behalf of the General Council for the Fund's general policy and direction. The Committee receives reports from each of the other expenditure committees, and deals with any business that does not fit within their remit. From time to time it initiates major new projects such as the London Acute Services Initiative and the Organisational Audit Programme.

	£
Sir Donald Acheson towards administrative costs associated with Sir Donald's work with the Fund	15,000
Brook Advisory Centres to meet a shortfall in the cost of purchasing an advisory centre in East London	15,000
Disability Matters Ltd to part sponsor a personal development course for disabled people	12,250
Educational bursaries for nurses and others to continue the scheme for a further year	40,000
Institute of Education, Social Science Research Unit to help start up a project to investigate consent to health care and health research	20,237
King's Fund Annual Reports Competition to continue the competition for 2 years	11,000
King's Fund Art in Hospitals Scheme towards the continuation of a scheme aimed at introducing contemporary art into London hospitals, and training arts coordinators within hospitals	24,000
King's Fund Hospital Design Project towards continuing work on this project	50,000
King's Fund Medical Education Grant Competition to support innovative developments in medical education	59,000
The London and Barts Centre for Clinical Ethics to support developmental work in the field of clinical ethics	25,000
National Advocacy Network Steering Group towards the cost of establishing the group	25,000
Northern Regional Multidisciplinary Head Injury Working Group towards the cost of a project on the audit of head-injured patients	20,231
Royal College of Physicians towards the cost of a senior lecturer in medical audit, to work particularly in the field of outpatient audit	25,000
St Mary's Hospital Medical School towards the cost of a project on outpatient-based teaching at St Mary's and the Central Middlesex hospitals	25,000
Testing Consumer Opinion in the NHS to commission research on public opinion of the NHS, as part of the King's Fund London Acute Services Initiative	100,000
Travelling Fellowships for Doctors to continue the scheme for a further year	25,000
Women in Special Hospitals towards the cost of an administrative worker	20,000
Small grants	
ADFAM towards the cost of a regional training scheme for families of drug users	2,500

ALICE
towards the cost of recording an adaptation of Alice in Wonderland for health service staff on quality in hospitals 2,086

AM Pictures
towards the cost of producing a photographic publication on homelessness 2,000

Association of Directors of Social Services, Community Care
towards the costs of facilitators at the European Family Conference, Paris 2,000

British Council of Organisations of Disabled People
towards the cost of a project to promote and support disabled people's self-operated personal assistance schemes 1,000

to enable two representatives to attend the Disabled People's International World Congress 3,200

Reverend T Bush
towards the cost of attending an international conference about integrative employment opportunities for people with learning disabilities within the EC 500

Centre for the Greening of the NHS
towards the cost of literature about greening the NHS 1,000

College of Anaesthetists
towards the cost of a seminar on progressive patient care 2,500

The Council for Music in Hospitals
towards the cost of new premises 10,000

Faculty of Public Health Medicine
towards the cost of refereeing the King's Fund Annual Report Competition 5,000

General Managers Association
to help establish a GMTS Network 1,000

Sholom Glouberman
to facilitate the planning and organisation of the French International Seminar 7,000

towards the cost of a conference on care, cure, control and the community in health care 3,000

Health Care Arts Centre
towards administrative costs 2,500

Health Service Journal
to provide sponsorship for the health management award scheme 6,000

Health Visitors' Association Special Interests Group for Homelessness
towards the cost of a development worker to improve access to health care services for homeless people 10,000

Sarah Hosking
towards the cost of publishing *The Hospitality of Hospitals* 1,500

Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death
towards the running costs of the working party 3,000

Institute of Nursing, Oxford
to complete a project on patient-centred nursing in practice 7,500

King's College London, Centre for Physiotherapy Research
to meet the shortfall from a meeting on higher degrees for therapists 113

King's Fund College Senior House Officer Learning Set
towards a second pilot of the learning set 3,000

King's Fund Homelessness and Health Initiative
towards administrative costs 6,000

King's Fund Institute
to cover the cost of three questions in the OPCS Omnibus Survey concerned with the utilisation of health services 2,700

King's Fund Institute
to supplement an Audit Commission grant on extra-contractual referrals 3,000

King's Fund International Seminar
towards the cost of a planning meeting 5,000

King's Fund/National AIDS Trust
to meet the costs of a planning meeting for a proposed conference on AIDS 327

King's Fund Seminar and Dinner on Reshaping Nursing for the 1990s
towards the cost of a seminar and publication on nursing development 2,130

Vivien Lindow
towards the cost of attending and making a presentation at the European Congress of the World Federation for Mental Health 400

The Marce Society
towards the cost of producing distance learning materials 10,000

Merseyside Racial Equality Council
Healthy Cities Conference 3,000

National Association for the Welfare of Children in Hospital
towards the cost of relaunching NAWCH 1,000

National Carers' Survey
towards the cost of producing a publication regarding a research project on attitudes towards caring for the elderly 4,000

Nurses Welfare Service
towards the cost of a caseworker with specific responsibility for London and the home counties 10,000

Dr Peter Pritchard
towards the cost of attending a conference in Oslo to make a presentation on knowledge-based decision support for general practice 200

Geraldine Quinn
to complete an MA in Management Learning at Lancaster University 3,000

Royal College of Nursing
to underwrite accommodation costs to enable the Standing Committee of Nurses of the EC to be established in Brussels 3,000

towards the cost of producing a new nursing thesaurus 10,000

Salford Health Authority, Public Health Research and Resource Centre
towards the cost of organising a seminar on public health and social research in the NHS 1,500

Jonathan Shapiro
to attend KF College Top Management Programme 2,000

SW Herts Community Health Council
towards the cost of a seminar for CHC members on the introduction of development plans 1,750

Tenants' Resource and Information Service
towards the cost of preparing a booklet, *Taking Action on Cold Homes* 3,250

The Terrence Higgins Trust
towards the cost of producing booklets on children and AIDS 2,000

towards the cost of producing leaflets on AIDS/HIV for prisoners 1,885

Toxoplasmosis Trust
towards the cost of developing an administrative base 1,000

David Towell
towards the cost of a visit to Czechoslovakia to assist in changing services for people with learning difficulties 1,000

University of Bath, Centre for the Analysis of Social Policy
towards the cost of a publication on the implementation of the white paper 5,000

University of Bristol and 'Community Care'
conference on training opportunities for people with learning difficulties in Czechoslovakia and the UK — 1,200

Windsor Fellowship
half sponsorship of two management training schemes in the health sector — 8,700

Women's Health and Reproductive Rights Information Centre
towards the cost of leaflets about getting the best out of GP/NHS services — 6,907

Geoffrey Wykurz
towards the cost of attending an international conference of the network of community-oriented educational institutions — 550

688,616

Grants Committee

Promotes the better delivery and management of health care in the statutory and voluntary sectors. Grants are awarded mainly in the Greater London area, although projects of national relevance are also considered.

AIDS Care, Education and Training — £
short-term bridging to help with service costs in London — 5,000

Africa Research and Information Bureau
towards a report, workshop and conference which will discuss the findings of a survey on the extent of HIV/AIDS among the African community in London — 9,800

Anand Mandal, Islington
volunteer expenses for a project which caters for housebound, non-English speaking elderly Asians — 1,000

Anorexia and Bulimia Nervosa Association, Tottenham Women and Health Centre
towards setting up a drop-in counselling group in Bethnal Green — 1,000

Association for All Speech Impaired Children
training for professionals in the London area working with children who have speech and/or language impairments — 2,500

Association of Black Social Workers and Allied Professionals (ABSWAP)
to support a development worker in mental health — 25,000

Bexley Social Services
furnishings and equipment for a housing project for adults with chronic mental health problems — 2,500

Bromley Health Authority/King's College London
to document and evaluate a hospital discharge scheme for elderly people 'at risk' offering a 2–4 week programme of individually tailored support — 42,424

CASA Alcohol Services
furnishings for a new day centre in North London — 2,434

CHARIS at Tower Hamlets Mission
furnishings for CHARIS, a new treatment unit for homeless men with alcohol problems — 2,500

Camberwell Supported Flats
furnishings for one flat for this scheme providing independent flats in the community for people with mental health problems — 2,725

Camden Society for Mentally Handicapped People
publication of a report on a quality assurance project which provides services for people with learning difficulties — 2,080

Changing Faces
to start up a new service for people with a facial handicap providing personal advice and social skills/confidence building workshops — 10,000

Dr Gillian Dalley
to prepare an evaluation proposal for the Fund's 1991 Major Grant on Services for Elderly People 3,000

Drink Crisis Centre
to support an evaluation and quality assurance programme (total grant awarded £49,578) 33,989

Friends of Wensley Close
contribution towards a play area for children with learning difficulties in South East London 2,000

Gateshead Libraries and Arts Department
to develop 'elderly arts' by appointing a writer in residence, arranging tours by Living Memory Theatre around day centres, and producing health promotion material with and for elderly people in primary health care settings 57,000

Greater London Association of Community Health Councils (GLACHC)
towards a conference on 'A Health Service for London' 2,500

Holloway Prison
to evaluate the effectiveness of art therapy in Holloway Prison 20,000

Independent Living Alternatives
for a full-time volunteer coordinator to place volunteer workers with people who have severe physical disabilities to enable them to live independently in their own homes 17,000

Inner City Centre
towards a training course on counselling skills for African, Asian and Caribbean workers 14,103

Innisfree Housing Association
towards the salary of a project/support worker working with young Irish people with mental health problems 14,000

Institute of Child Health
towards the cost of running community genetic counselling courses 10,000

Irritable Bowel Syndrome Network
towards computing and other administrative costs 2,000

Ms Savita Katbamna
attendance at a Healthy Cities symposium in Barcelona to present the work of an Asian Parents Health Project in Camden 500

King's College Hospital Dental School
to evaluate peer group support for denture wearers with longstanding difficulties in coping with their dentures 500

King's Fund Major Grant 1989
towards annual residential workshops associated with the 1989 Major Grant scheme on Monitoring Changes to the NHS 9,000

King's Fund Major Grant 1990
towards workshops and expenses associated with the 1990 Major Grant scheme on Community Care 8,000

King's Fund Major Grant 1991
towards workshops and expenses associated with the 1991 Major Grant scheme on Services for Elderly People 10,000

King's Fund Initiative on Black People and Health
towards the cost of holding a consultation day in preparation for the Fund's 1992 Major Grant 2,425

Lambeth Consortium
to support a Job Coach for Abbevilles Restaurant, a training project for people with learning difficulties 15,000

Lewisham Social Services and Lewisham and North Southwark Health Authority
to recruit evening carers to provide a service for elderly people when they go to bed 40,000

London Hospital Whitechapel, Department of Child Psychiatry
to enable a Sylheti researcher to produce a report on an evaluation of Tower Hamlets child psychiatry services 4,200

Maudsley Outreach Support and Treatment Team
towards an economic evaluation of the team's work 6,000

Motor Neurone Disease Association
for a direct care adviser who will provide more direct contact between patients, carers and health professionals 30,000

National Association for the Care and Resettlement of Offenders (NACRO)
towards a conference on the experience and requirements of black mentally disturbed offenders who end up in court 1,000

North Manchester Health Authority
to appoint a development worker to identify local needs by talking to elderly people, community leaders and professionals, focusing on the needs of the Afro-Caribbean population 55,442

Oasis Trust
a contribution towards the costs of developing a walk-in medical clinic for homeless people in Southwark 25,000

Ormond Road Workshops
to develop a ceramics workshop in Islington for people with mental health problems and with a mental handicap 1,000

Oxford Social Services and Oxford City Housing Department
to provide a service for elderly people during the night, involving turning, sitting and toileting, which can be planned in advance or provided in an emergency 80,000

Partially Sighted Society
towards the establishment of a London Sight Centre 5,145

People to People, Southwark
to cover the costs of a training programme for staff and volunteers helping people with learning difficulties to make friends and become involved in leisure activities 500

Re-Solv
for a Liaison Officer for London and the South East Region 22,034

St Ann's Hospital
to carry out a case control study of psychoses in British Afro-Caribbean people 21,435

St Bartholomew's Hospital, Department of General Practice and Primary Care
to support a needs assessment exercise to explore the best way to ascertain the health priorities of the lay public 24,000

SHANTI Women's Counselling Service
to enable the completion of an evaluation of this women's mental health counselling service in Lambeth 21,000

Sickle Cell Anaemia Research Foundation
towards a Research and Development Worker's post 20,000

Dr Conamore Smith
towards the cost of a visit to the Mormon Hospital in Salt Lake City to investigate the use of information technology 620

South Tyneside Social Services and South Tyneside Crossroads
to enable the Crossroads Care Attendant scheme to work together with the Local Authority domiciliary care team to provide a flexible and responsive service so that elderly people who might normally go into residential care can remain in their own homes 60,000

Southwark Day Centre
a contribution towards the capital costs of a new medical centre for homeless people 20,000

Strathclyde Regional Council
to provide home based support to elderly people by workers at a Centre for the Elderly (on contract by SRC) and for a youth organisation to develop carer support networks — 67,735

Thames Regional Health Authorities/King's Fund Homelessness Grant 1989/90
towards a conference on homelessness and health with reference to the Fund's Homelessness Grant in 1988/90 — 1,300

The Rainbow Centre
to provide education and support services to professionals working with children with cancer and other life-threatening illnesses — 1,000

Peter Thorogood
to fund a trip to New York to study the services provided in alcohol crisis centres for homeless people and underprivileged groups — 1,000

Twentieth Century Vixen
resources for work with children who have disabilities and who are at risk of sexual abuse — 10,000

United Medical and Dental Schools of Guy's and St Thomas' Hospitals
to support five research studies looking at different aspects of acute inpatient admissions and discharges in London (total grant £130,060) — 10,938

Unity Centre of South London
to support a medical adviser's post — 19,175

University College London, Department of Psychiatry
towards a study into women prostitutes and their access to London's health care facilities — 10,000

University of Loughborough, Department of Social Services
to investigate the detention of patients under the 1983 Mental Health Act — 20,716

Values into Action
publication of a report which highlights the need for a fundamental reassessment of the way services approach community care, with particular reference to services for people with learning difficulties — 4,500

Wandsworth Family Service Unit
towards final publication of research into the problems experienced by Afro-Caribbean psychiatric patients of British social and psychiatric services — 2,500

Ms Alison Wertheimer
towards the cost of a visit to the USA and Canada to look at different ways of providing support for people bereaved by suicide — 1,000

917,220

Details of projects funded using money set aside in 1990 but earmarked for a 1991 London's acute hospitals grant scheme:

	£
King's Fund Institute third and fourth year funding of the London Health Monitor	95,000
United Medical and Dental Schools of Guy's and St Thomas' Hospitals to support five research studies looking at different aspects of acute inpatient admissions and discharges in London (total grant £130,060)	119,122
	214,122

King's Fund College Committee

	£
Overseas travel and work connected with the King's Fund College	40,000

King's Fund Commission on London

	£
Salaries and other expenses in connection with the work of the King's Fund Commission on the Future of London's Acute Health Services	100,000

London Primary Care Committee

Promotes primary health in the inner city with particular attention to services for disadvantaged groups.

	£
Amount not previously allocated (at 31.12.90)	10,167
1991 allocation	105,283
	115,450

Barking and Havering FHSA
to support a complaints consortium of nine FHSAs in order to develop standards for the handling of complaints, audit and quality assurance and training and support for members and staff 9,950

Community Nursing Development Work
to support a programme of work on community nursing development 15,000

Jenner Health Centre
a contribution towards integrating management between general practice and the CHS staff 1,000

National Community Health Resource: Black Health Unit
to continue the work of the unit for a third and final year 23,000

Needs Assessment and Primary Care
to appoint a development worker with the Health Services Research Unit, University of Oxford, to lead work on community-oriented primary care 50,000

Primary Care in London: Riverside
to purchase a computer to run the information network database 1,500

Riverside Community Health Council: Complaints Study
to part-fund, with North West Thames Regional Health Authority, an analysis of complaints and people's experiences of the complaints process 5,000

Commissioning Agency (SELCA) and Lambeth, Southwark and Lewisham FHSA
to appoint an accident and emergency contracting coordinator 10,000

115,450

King's Fund Centre Committee

	£
Better Futures Project to continue support of comprehensive community services for people with long-term health problems	60,000
Manchester Afro-Caribbean Mental Health Project funding for a second year	25,000
Mental Health Services, Lewisham towards a two-year development project for better services for black mental health service users and their carers	70,000
NAHAT/King's Fund Centre publication: *Where are all the good women* towards the cost of producing and launching this publication	4,075
Patient Interactive Video to evaluate a US-produced video disc to convey information about the nature of choices for treatment for benign hypertrophy of the prostate	29,942
St Bartholomew's Hospital: medical education project additional funding to complete the project	8,002
Survivors Speak Out to develop the capacity of this organisation to act as an effective resource for service users involved in mental health advocacy and self-advocacy	27,981

Small grants	
Alzheimers Scotland	1,000
Assessment of Psychiatric Services	500
Black and Ethnic Minorities	1,000
Black Mental Health Group	1,000
Bridge Park	500
British Society for Population Studies	500
Camden Carers' Forum	200
Caring Costs	1,000
Centre 70 – Mental Health Project	500
Complementary Therapies – National Conference	100
Concept Photography	1,000
Genetic Interest Group	500
Impact of Advocacy on Quality Conference	184
Islington Mental Health Forum	1,000
MIND	336
National Consumer Council	1,000
National Oncology – Social Workers' Conference	200
North Manchester Black Health Forum	500
Nottingham Health Promotion	500
Rushcliffe Council for Voluntary Service	400
SHAMA – Women's Centre	200
Southwark Disablement Association	500
L Ward – Norah Fry Research Centre	500
University of Dundee	1,000
Wycombe Practice Team User Group	880
	240,000
TOTAL GRANTS MADE IN 1991	£2,091,119

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