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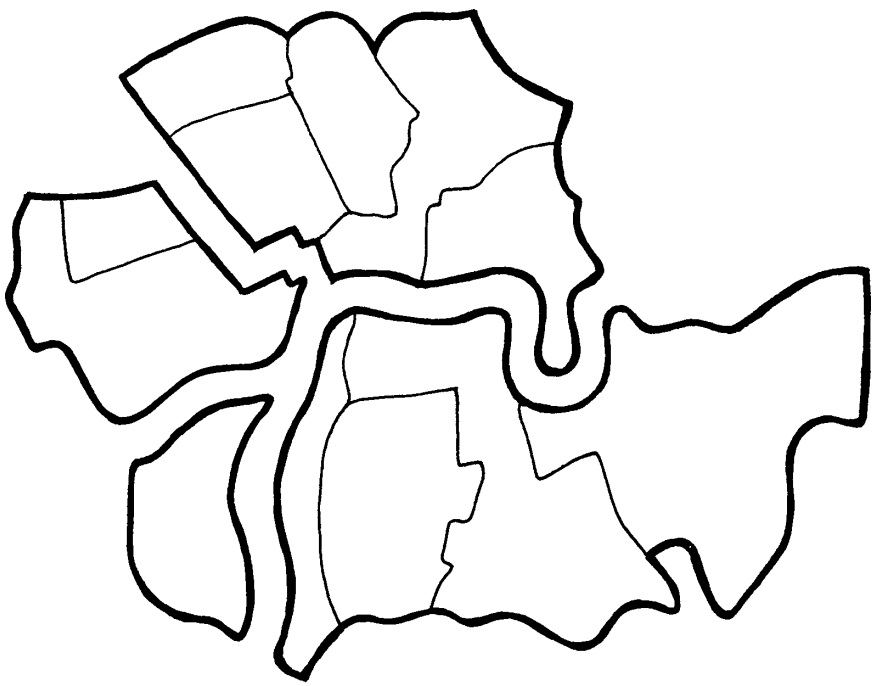
HEALTH SERVICES FOR INNER LONDON



Back to back planning

Report on the Regional Plans for Inner London's Health Authorities

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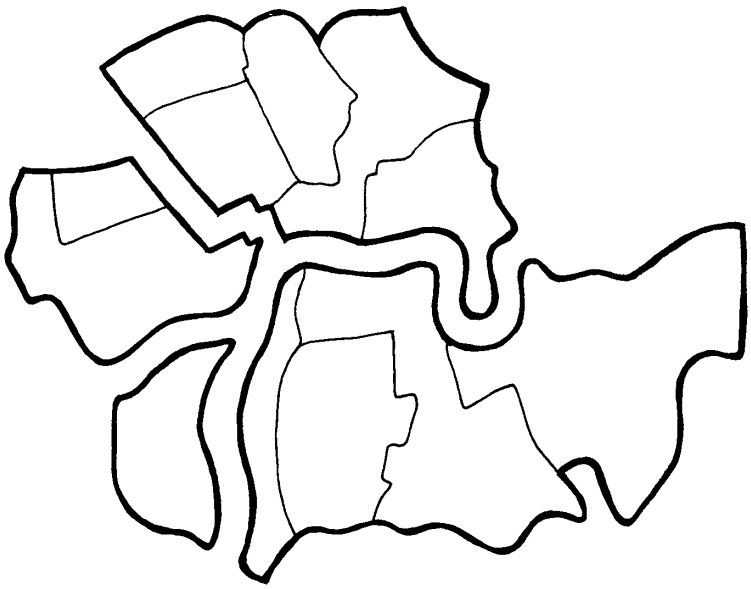

Back to back planning

Report on the Regional Plans for Inner London's Health Authorities

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PLANNED HEALTH SERVICES FOR INNER LONDON

CHAIRMEN'S FOREWORD

The pressures on London's health services have been widely recognised as an increasing problem, causing concern to Health Authority members, to the staff who provide those services, and of course to the wider public who receive them. What has been lacking, however, is a systematic factual basis against which to judge these concerns, or even to assess the London-wide implications of the plans of the four Thames Regional Health Authorities.

For this reason the Chairmen of the 12 District Health Authorities covering inner London commissioned the King's Fund to prepare a factual report, describing the current plans for inner London's health services. This report, which is a descriptive analysis rather than a critique, draws on the published Regional Strategic Plans, but also reviews the main service and financial changes which have taken place since the Strategic Plans were issued.

The key finding is remarkable:

- *It is not in fact possible to draw a coherent and comprehensive picture of inner London's future health services from the published plans of the four Regions, nor indeed from the unpublished documents to which we have had access.*

These difficulties have arisen because of variations in planning data and differences in methodology between the four Thames Regions. The finding itself is significant because it questions the many authoritative statements which have been made about "London's Health Services", and it demonstrates that despite their best endeavours Regions have not been able to coordinate their approach to planning on a London-wide basis. The tendency for planning horizons to be effectively constrained by the Regional boundaries is the basis for our title "Back to Back Planning". This finding needs to be seen in the context of the many difficulties which face the Regions in their planning task, which include the financial pressures on them, the demand for an expansion of health services and the poor quality of information systems. These factors actually emphasise our concern about the adequacy of our approach to planning for London.

It is worth highlighting a number of further findings which emerge from the report:

- *Regional plans for inner London Districts require a reduction of £109m (12.9%) in the period 1983/84-1993/94; this is equivalent to the combined annual cost of St Thomas', St Bartholomews and the Royal Free Hospitals;*

- *this in turn involves a reduction of between 7% and 31% in each District's spending on local acute services, and overall a reduction of 1487 (15.7%) local acute beds;*

- *these reductions were anticipated to accompany a 15% decline in the number of hospital admissions in inner London by 1993/94;*

BUT a review of changes which have occurred since 1983 reveals that:

- *the number of hospital admissions has not declined, but has in fact increased by 2.5% (reflecting a national pattern);*

- *1100 local acute beds, representing 74% of the planned 10 year bed reductions, have been closed in the first two years of the strategic period (also reflecting a more general trend);*

- *these reductions have yielded £30.9m, representing only 34.5% of the planned 10 year reduction on local acute service spending.*

Thus, in the first two years of the planning period, one third of the planned revenue has been saved but three-quarters of the beds targetted for reduction over the ten year period have already had to be closed. This is of all the more concern in view of the London districts' record in achieving major cost improvements. We are bound to ask what this means for health services in London during the remainder of the planning period: will services have to be reduced much further to meet the revenue targets? or will these targets have to be revised, and if so how and with what implications?

We are conscious that some might wish to dismiss this report as special pleading for London; but this is in no sense our intention, and indeed all of us would wish to subscribe to the principle of equity which has led to the RAWP approach to resource allocation adopted by successive governments over the last decade.

But we believe that the findings summarised above raise important questions about the effect of planned changes on inner London's health services, and about the lack of consistency between planning intentions and the changes actually taking place. These are clearly serious matters for London; but they are also significant in a national context, because of London's role in providing educational and training facilities for such a large proportion of the country's health professionals, and in providing a range of specialist services which are quite logically concentrated in the metropolis, and which are not available elsewhere.

All of us are working with our Regional Health Authorities in an attempt to meet national and regional strategic objectives in a way which safeguards the quality of the services for which we are responsible. The difficulties we face in this task have received recognition by the Government's recent decision to allocate for the metropolitan districts an extra £30m spread over two years; we welcome this recognition, but would have to point out that such a sum (which is not a recurrent grant) could not, nor was ever intended to do more than ease the transitional problems arising from the implementation of the Regional strategies.

We believe that it is now urgent that together with our Regions we review our approach to planning in London, in particular to ensure that we understand the London-wide implications of the changes proposed. Equally it is important that we seek to reconcile the inconsistencies which have emerged from this review. Our conclusions need to be fed into the next round of strategic planning. For our own part, we would like to continue the work we have begun in particular by improving the information we have about the health services in inner London as a whole, and by examining with the medical schools the implications for teaching, of future changes in health service provision.

12 Chairmen of inner London Health Authorities

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INTRODUCTION

1. This report provides an overview of what is intended to happen to Inner London's health services as described in current planning documents and policies of the four Thames Regional Health Authorities. The terms of reference for this study call for a description of what is envisaged in the Regions' documents; this report does not attempt to analyse the possible impact of any proposed changes.

2. The report concerns the planning period from 1983/84 to 1993/94, although different planning documents sometimes entail different time scales. These and many other variations in planning data have made it difficult, and in some cases impossible, to make direct comparisons between Regions of even the major intended changes to health services. In addition, data which are available frequently are aggregates or averages which can mask the impact of actual changes in individual services or districts. Thus, it is not possible to draw a coherent and comprehensive picture of Inner London's future health services from the published plans of the four Regions nor from many of their unpublished documents. This in itself is an important finding and a surprising one in light of the many supposedly authoritative arguments which have been advanced about "London's health service". It is evidence that to date, the Thames Regions, in addressing the considerable problems in planning their services, have not been able to coordinate an overview of their plans' impact on inner London's health services taken as a whole. Hence our title "Back to Back Planning". Furthermore it raises the serious issue about whether the public has adequate coordinated and readily understood information about the planning of the capital's health services.

3. District Health Authorities who have commissioned this report and who together manage services in inner London, are located in four Regional Health Authorities as shown overleaf.

BACKGROUND

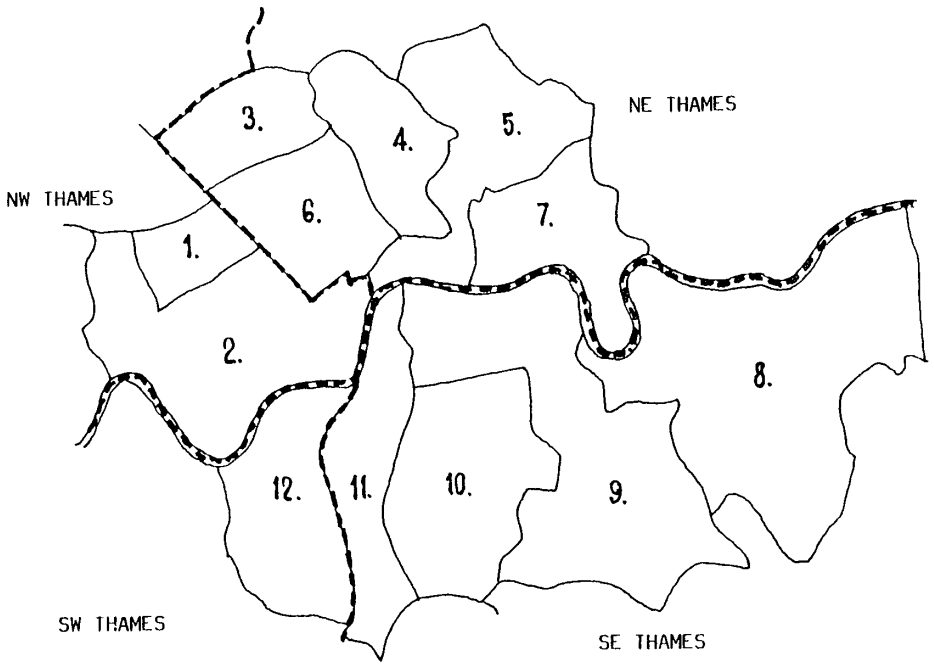
4. Comprehensive planning of health services which is population-based and priority-led has existed in the National Health Service only since the mid-1970's. Its introduction represented a major change in the management culture of the NHS, principally because it called for three substantial modifications to the service:

   . geographical redistribution of resources

   . functional redistribution of resources, i.e. between services

   . full integration of policy-making, planning, funding and operational activities with other agencies providing complementary services to the same or similar populations.

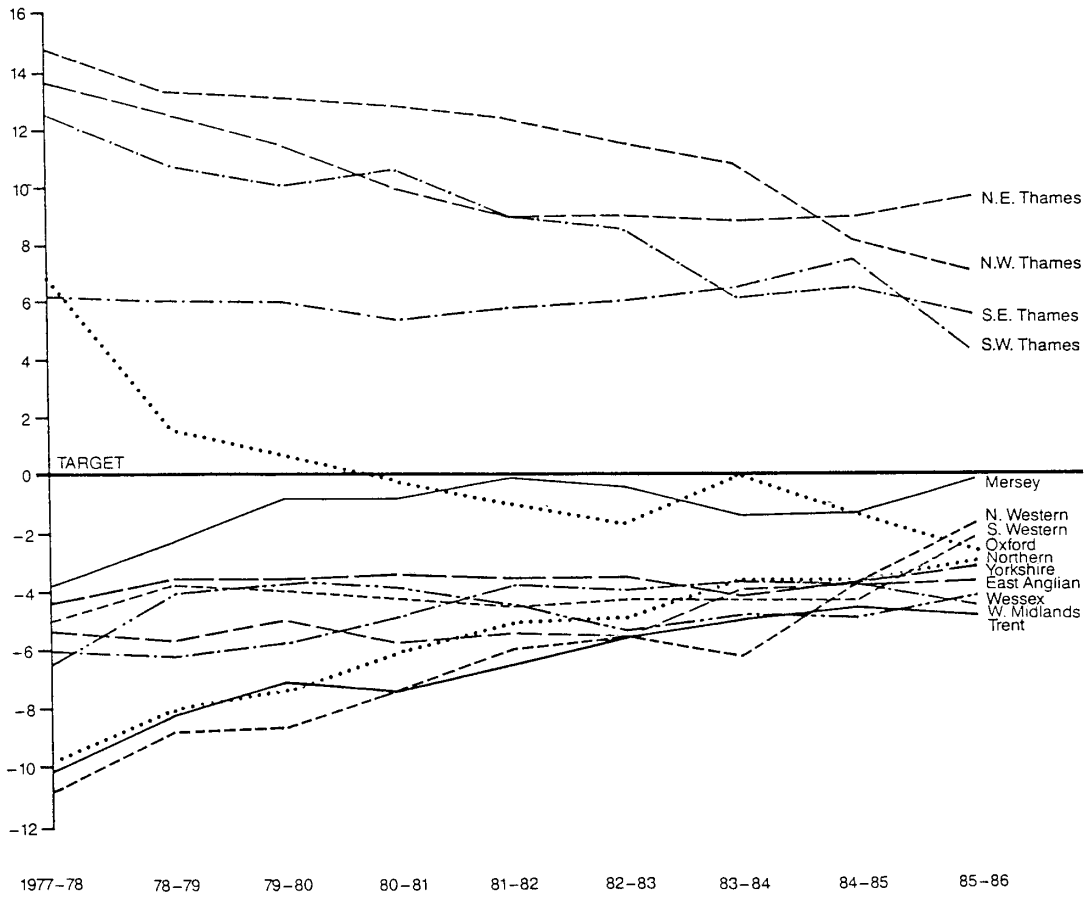
Fig 1: Health Authorities comprising inner London and their distribution within the four Thames Regional Health Authorities



1	Paddington and North Kensington HA	North West Thames Regional Health Authority (NWTRHA)
2	Riverside HA	
3	Hampstead HA	North East Thames Regional Health Authority (NETRHA)
4	Islington HA	
5	City and Hackney HA	
6	Bloomsbury HA	
7	Tower Hamlets HA	
8	Greenwich HA	South East Thames Regional Health Authority (SETRHA)
9	Lewisham and North Southwark HA	
10	Camberwell HA	
11	West Lambeth HA	
12	Wandsworth HA	South West Thames Regional Health Authority (SWTRHA)

5. Comparisons, using statistical methods which have developed from the work of the Resource Allocation Working Party (RAWP), show that the Thames Regional Health Authorities have more resources relative to the populations they serve than the rest of the country (Figure 2).

Fig 2: Regional Health Authorities' Resource Allocation relative to their Target Allocation since the RAWP Report (1976)



Source: Annual Report on the National Health Service 1985. HMSO

Within the Thames Regions, comparisons using similar methods show that much of this apparent over-provision is focused geographically upon Inner London, and functionally upon the group of services known as Local Acute Hospital Services and, in some districts, upon other services as well, such as those for the mentally ill and handicapped.

THE REGIONS

6. For the Thames Regions, these calculations and the application of RAWP formulae to NHS revenue allocations have had four principal implications:

. First, there has been a reduction in growth increments as well as a loss of efficiency savings, which are intended to reduce each Region's annual revenue allocation towards its RAWP target. This has meant that during the period 1983/4 to 1993/4 the four Thames Regions must plan to reduce their spending by £84 million per annum (2.9%) on a total revenue allocation of £2,855 million (Figure 3)

Fig 3: Planned Thames Regional Revenue Reductions 1983/4 - 1993/4

NORTH WEST THAMES	£29.7m	4.4%
NORTH EAST THAMES	£25.6m	3.0%
SOUTH EAST THAMES	£17.6m	2.3%
SOUTH WEST THAMES	£11.1m	2.0%
Total	£84.0m	

. Second, it has meant that each Region has been obliged to develop an even-handed rationale for redistributing resources between its districts - originally applying a version of the RAWP formula for sub-Regional purposes.

. Third, it has meant that similar rationale have had to be devised for releasing resources from Local Acute Hospital services for deployment to services designated as priorities.

. Fourth, it has meant that within the planning resources available to them, the Thames Regions have found it increasingly difficult to support the development of plans through to implementation. Strategies have not helped to identify the management practices which are needed to achieve the substantial change in services which are necessary to meet the planned changes in resource distribution.

7. In addition, Regions' real spending powers are being continually eroded, according to reports of the Parliamentary Select Committee on Social Services(*) and others(**). This erosion is occurring on many fronts which range from the nationally agreed staff pay awards, which have not been fully funded by the Government, through to additional service requirements, such as for victims of Acquired Immune Deficiency Syndrome (AIDS), and those suffering from renal disease. In addition there are central government requirements for Health Authorities to develop new support services and to introduce major new information technology. The additional programmes which Regions have had to accommodate within their cash and manpower limits since 1983 are summarised in **Appendix I**, taken from DHSS Planning Guidelines.

8. The Select Committee report suggested that the Government would need to make available real growth of 2% per year for the next 3 years in order to meet the additional service demands of the elderly (1%) to keep pace with advances in medical technology (0.5%) and to make progress in priority areas such as the development of renal services and community care (0.5%). The Government has agreed with this overall assessment, and for 1985/6 produced the required 2% increase in resources by including in its calculation 1.5% gleaned from the Service through cost improvement programmes, a saving which nationally amounts to £153m(***). The savings from cost improvement programmes submitted by districts and Regions in 1985/6 are shown below (Figure 4). Some of this revenue contributes to a national growth pool from which Regions receive back revenue for new developments. For the Thames Regions the difference between contributions and receipts helps to bring them toward their (RAWP) revenue targets.

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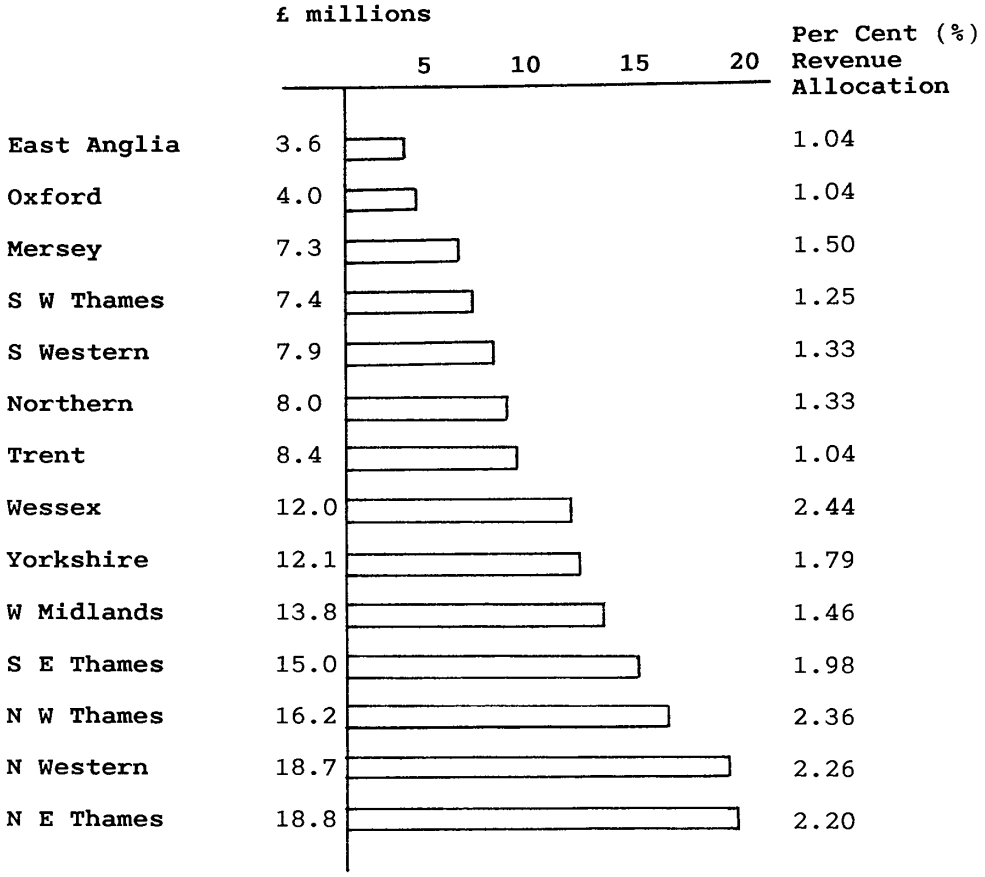
* Fourth Report from the Social Services Committee Session 1985-1986. **Public Expenditure on the Social Services.** Vol I. HMSO London (pp viii-xvii)

** Bosanquet N; **Public Expenditure on the NHS: Recent Trends and Outlook;** Report commissioned by the Institute of Health Service Management. October 1985

*** Jones T; **The 2 per cent debate;** The Health Service Journal, March 27 1986

Fig 4: Regions' published "cost improvement programmes"

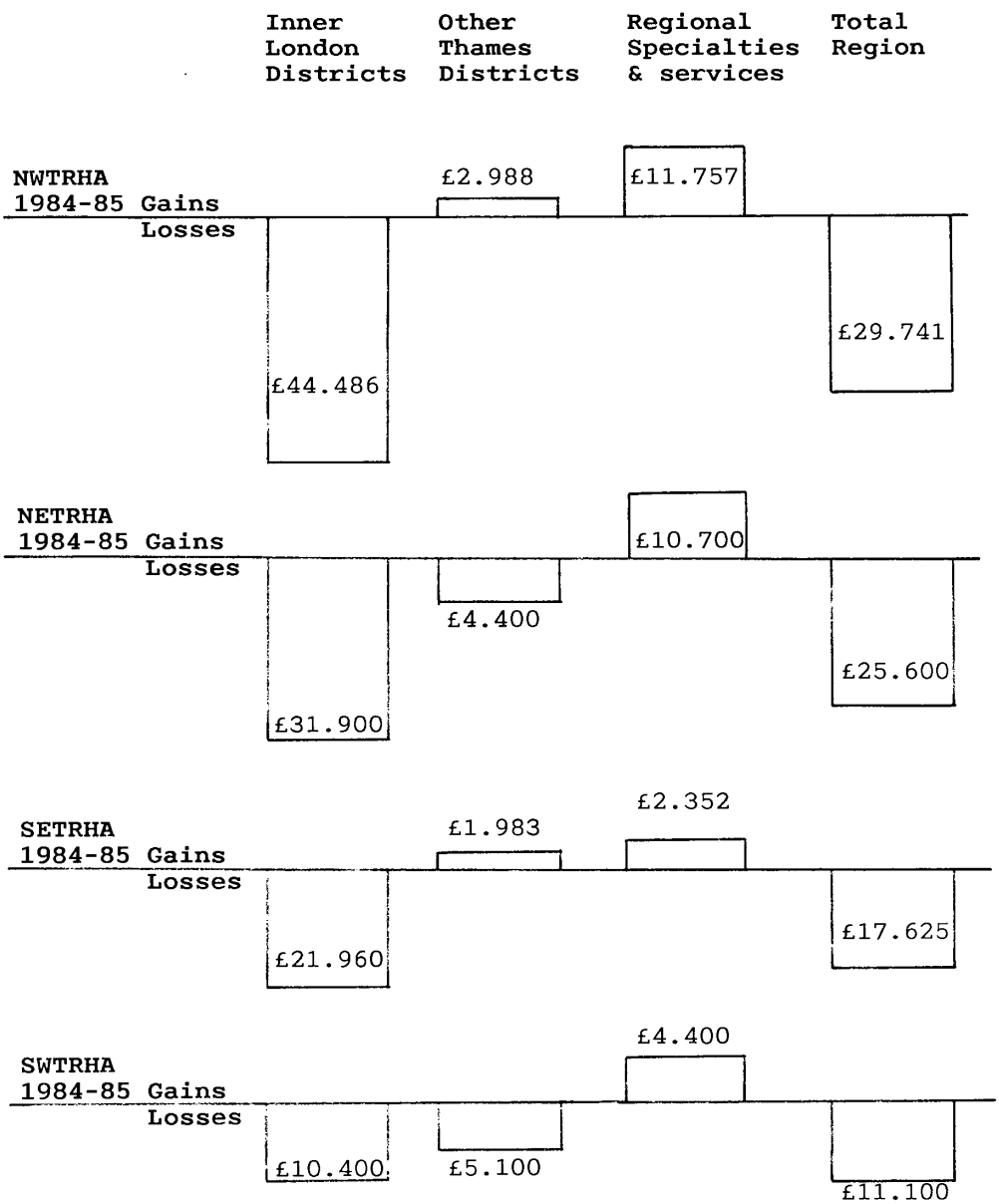


Source: Published Cost Improvement Programmes and DHSS Regional Revenue Allocations

9. In order to accommodate centrally-imposed reductions in purchasing power, the Thames Regions have been obliged to pass their revenue losses on to those districts which are funded at levels apparently above their statistical targets. At the same time, because of their own financial predicaments, Regions have been constrained in the support (for example, bridging loans or capital investments) they could provide to districts which might need interim developments in order to make the required modifications to local services.

Figure 5 shows the published figures which identify by how much each of the Thames Regions' revenue allocations will reduce by 1993 and where the Regions in turn will deploy their resources compared with 1984/5 levels.

Fig 5: Thames Regions' Planned Revenue Redistribution by 1993



OVERALL	-£108.746m	-£4.529m	+£29.209m	-£84.066m

THE DISTRICTS

10. For District Health Authorities in Inner London, this has had two major implications:

- First, like the Regions, each District has had to maintain and develop services within cash limits which have represented successive annual reductions in purchasing power. In order to do this, Districts have had to develop and agree detailed service plans, and to coordinate these with other agencies to restructure local service provision and achieve the required revenue reductions.

- Many Districts have also invested considerable effort in attempting to analyse the rationale offered by their Regions in order to justify revenue reductions. In some cases, they have tried to refute those rationale when they have believed them to be inappropriate. Much of this work has focused on the relative economic and social deprivation of many of the resident populations of Inner London Health Authorities and the extent to which this relative deprivation leads to greater demands upon health services.

Fig 6: Districts in the highest 10% of scores on a national distribution for a sample of indicators of socio economic status taken from 1981 Household Census

	% ELDERLY ALONE	% 1 PARENT FAMILIES	% UNSKILLED	% UNEMPLOYED	% OVERCROWDED	% ETHNIC	JARMAN 8	DOE, SOCIAL INDEX
PADDINGTON	✓	✓	✓		✓	✓	✓	✓
HAMMERSMITH & FULHAM } RIVERSIDE	✓	✓			✓	✓	✓	✓
VICTORIA }	✓							✓
TOWER HAMLETS		✓	✓	✓	✓	✓	✓	✓
ISLINGTON		✓	✓		✓	✓	✓	✓
HAMPSTEAD	✓	✓					✓	✓
CITY & HACKNEY		✓	✓	✓	✓	✓	✓	✓
BLOOMSBURY	✓						✓	✓
CAMBERWELL		✓	✓		✓	✓	✓	✓
WEST LAMBETH		✓	✓		✓	✓	✓	✓
GREENWICH		✓						
LEWISHAM & NORTH SOUTHWARK		✓	✓				✓	✓
WANDSWORTH		✓			✓	✓	✓	✓

11. Data in Fig. 6 show that the populations of districts in Inner London are relatively socially and economically deprived compared with many other parts of the country. These particular indicators draw substantially from 1981 household census data and consequently do not reflect additional problems associated with the relatively large homeless and transient populations of inner cities. Regions are considering more sensitive methods for representing the needs arising from social deprivation, which include rural factors in deprivation, GP assessments of health needs by political wards and more detailed aspects of the work of Professor Jarman. However, as even more comprehensive measures become available, the technical difficulties of validating the effects of a particular socio-economic characteristic of a population upon its relative morbidity, escalate. These difficulties are compounded when several factors are combined to produce indices or weightings. To date, the controversy surrounding these technical difficulties has meant that social deprivation factors have had little impact on the individual District revenue targets set by Regions. A summary review of current work in this field is included as **Appendix II**.

12. The four Thames Regions' strategic plans show that Inner London's health services must contract considerably by 1993/94. In revenue terms, the plans show the twelve Inner London Health Districts losing approximately £109 million (12.9 per cent of 1984/85 revenue levels). Of this amount, approximately £24.7 million (or 23 per cent) is intended for reallocation within the Regions; the remaining £84 million is intended for redistribution nationally.

13. The overall planned reductions in revenue for Inner London Health Districts for 1993/94 average approximately £9 million each, but the planned changes range from a reduction of £33 million (28.7 per cent of 1984/85 revenue) in Riverside Health Authority to an apparent increase of £0.1 million (0.3 per cent) in Camberwell Health Authority. However, these figures, which are taken from the Regional Strategies, include significant service changes and can give a misleading impression. For example, whilst Riverside Health Authority is planned to lose 28.7% of its revenue, it is at the same time, expected to cease providing mental health services on behalf of several districts; this loss in service provision will account for a significant part of Riverside's revenue reduction. Similarly, in Hampstead Health Authority, an overall reduction in revenue of 7.0% masks a further significant planned reduction in revenue associated with the closure of long stay hospitals in which the Authority has provided services to a number of districts in the Region.

Despite the fact that the published figures often contain service changes of this kind, they are still useful as broad indicators of the scale of change faced by most inner London districts. The published revenue reductions for the remaining inner London districts are: Paddington and North Kensington HA, 20.0%; West Lambeth HA, 18.1%; Bloomsbury HA, 13.0%; Wandsworth HA, 12.2%; Greenwich HA, 10.4%; City and Hackney HA, 8.1%; Islington HA, 7.8%; Tower Hamlets HA, 6.6%; Lewisham and North Southwark HA, 6.4%; and Camberwell HA, +0.3%

LOCAL ACUTE SERVICES

14. In addition to the planned reduction in the absolute size of inner London districts' revenue allocation, the Local Acute Hospital services are targetted in Regional plans for greater proportional reductions to enable Inner London Districts to develop new priority services such as for the elderly and for people with mental illness and mental handicap.

15. Despite their prominent position in the plans of Regions and districts, there is no agreed definition of what constitutes Local Acute services. Broadly they are provided in a group of medical and surgical specialties where periods of diagnosis and treatment usually occur in short 'acute' episodes. The term 'local' denotes the expectation that these specialties should be present in each Health District (in contrast with supra district or Regional specialties which are managed in one location for use by several Districts).

The exact constitution of the group varies considerably from Region to Region and does not comply consistently with the definition used in the work of the London Health Planning Consortium, whose methodology for predicting bed requirements in 1979, underpins several Regional approaches. This variety of definition has meant that a picture of the caseload, bed provision and finance relevant to discussion of planned Local Acute services in inner London's districts has been difficult to derive.

This report has considered data for those specialties consistently included in Thames Regions' definitions of Local Acute services which are:

General Medicine
Paediatrics
Chest Medicine
Dermatology
Rehabilitation
Rheumatology
General Surgery
Trauma and Orthopaedics
Urology
Gynaecology
General Practice Medicine
Preconvalescence
Genito-Urinary Medicine.

16. In each of the Thames Regions taken separately, planning Local Acute services has received much attention. Complex modelling techniques have been developed which are different in each Region and which reflect different planning philosophies. However, all seek to provide a rationale for redistributing resources in geographical and functional patterns which are consistent with equality of access and national priorities.

17. These rationale include assumptions about the number of patients that a given population will generate, the number of patients which can be treated per available hospital bed; and the costs which will be incurred for each patient. The models generate target numbers of cases, beds, and revenue that districts should have in 1994 if the Region were to make acceptable progress towards its goals for geographic and functional redistribution of resources. The assumptions in these models therefore underpin the plans of the Regions to release resources, principally, from inner London districts and Local Acute services, in accordance with national policy. See **Appendix III**.

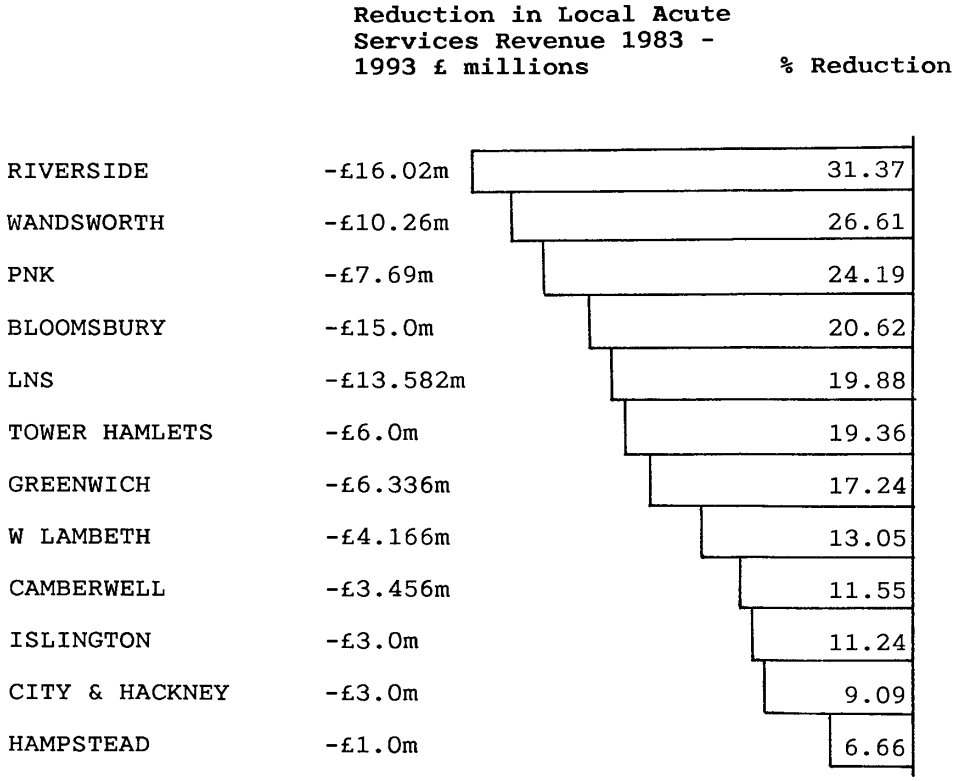
18. The planned geographic and functional redistributions of resources would result in:

- a reduction in revenue allocation for all local acute services in the Inner London Health Authorities of £89.6 million by 1993/94; the actual change in revenue allocation ranges from 28.6 per cent of 1983/84 allocation in North West Thames Regional Health Authority to 15.7 per cent in North East Thames Regional Health Authority.

- an average reduction in revenue allocation for local acute services of £7.47 million in each of the Inner London Districts. The actual changes in revenue allocation for local acute hospital services range from a reduction of £16.02 million (31.4 per cent of 1983/84 allocations) in Riverside Health Authority to £1.0 million (6.7 per cent) in Hampstead Health Authority (Figure 7).

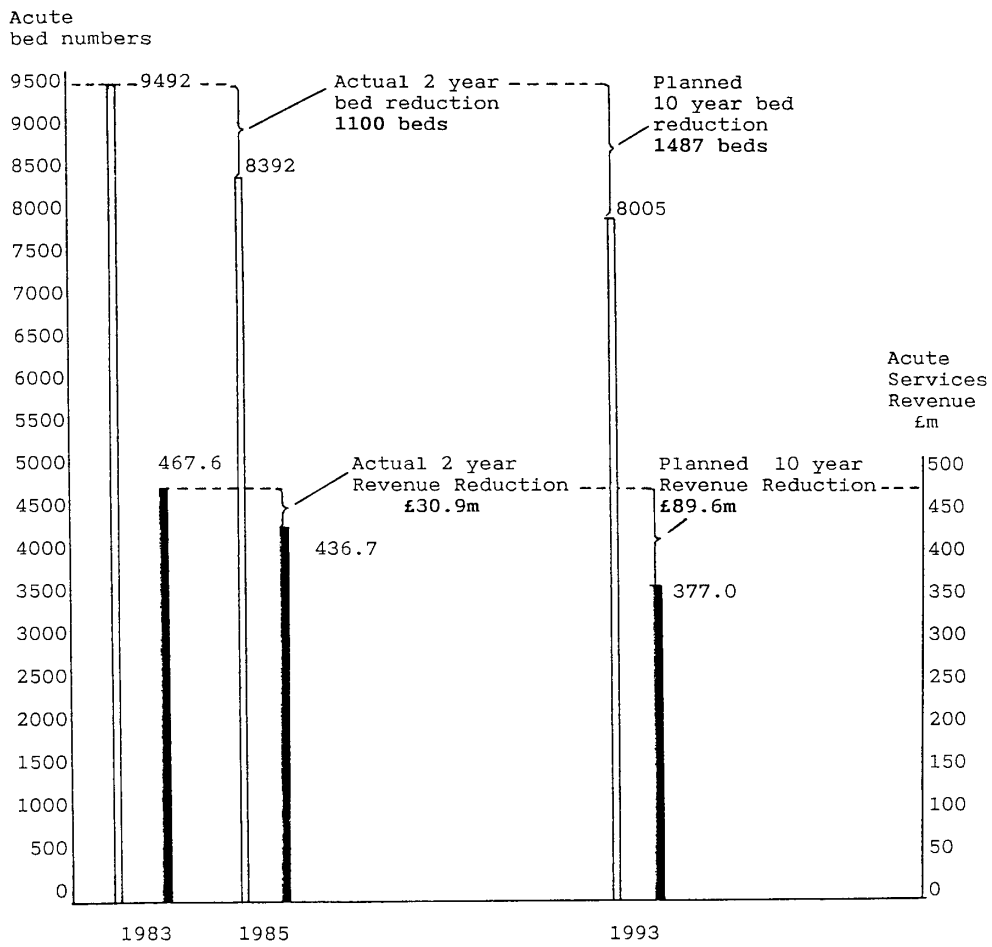
- an equivalent reduction of 1,487 local acute hospital beds in the Inner London Health Authorities by 1993/94 from 1983/84 levels. This would leave a total complement of 8,005 local acute beds for Inner London residents, representing a 15.7 per cent reduction over the ten year period.

Fig 7 The distribution of the planned loss of revenue to the Local Acute services of Inner London's districts, both as a cash figure and as a per cent reduction



19. From the King's Fund survey of Inner London Health Authorities, it is apparent that nearly three quarters of the Regions' planned reductions in local acute hospital beds (1100 beds of the 1,487-bed reduction) had been made in Inner London by the end of 1985. This 74% movement toward the planned number of Local Acute beds for 1993 has not released a similar proportion of the £89m revenue. (See Figure 8). Moreover, these figures are in addition to the substantial bed reductions which had occurred in inner London's Local Acute services prior to 1983. This finding suggests that, either more than the planned reduction in Local Acute service beds will be required to release the required resources, or revenue reductions may have to be extended to priority services.

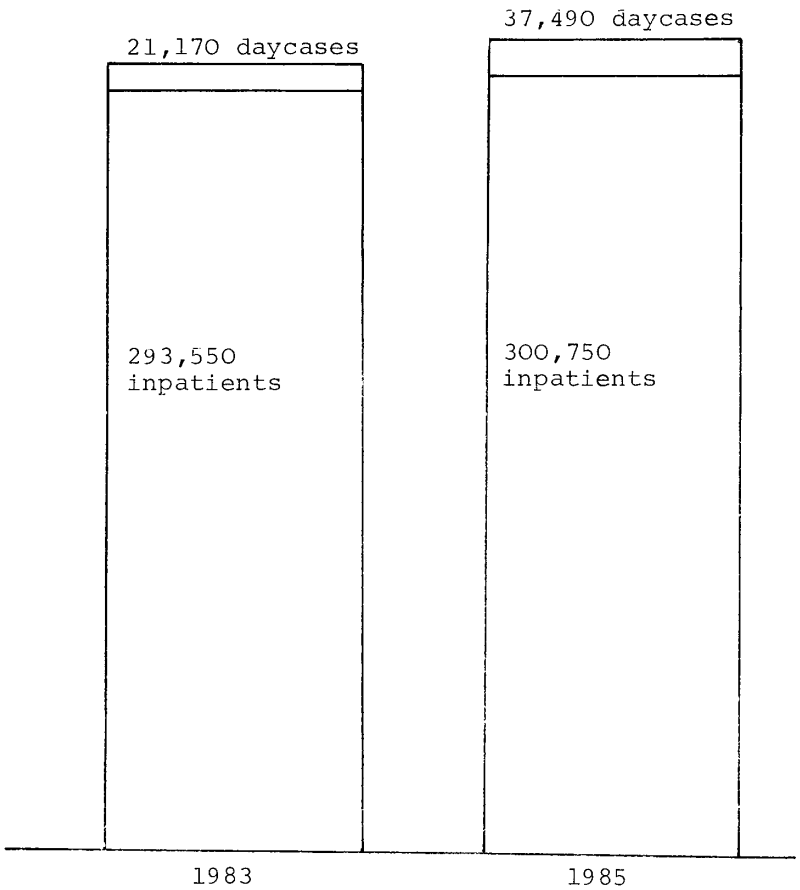
Fig 8: Inner London Local Acute Beds and Revenue 1983, 1985, and 1993



20. As a corollary to the reduced supply in local acute hospital beds, Regional plans anticipate a decline in inpatient caseload in inner London district hospitals from 366,500 patients in 1983 to 310,800 patients in 1993/94. This 15% decline is seen as a combined result of (a) the reduction in the supply of local acute hospital beds, (b) the development of new acute services elsewhere in the Thames Regions, and (c) a reduction in the rates of hospitalisation in inner London.

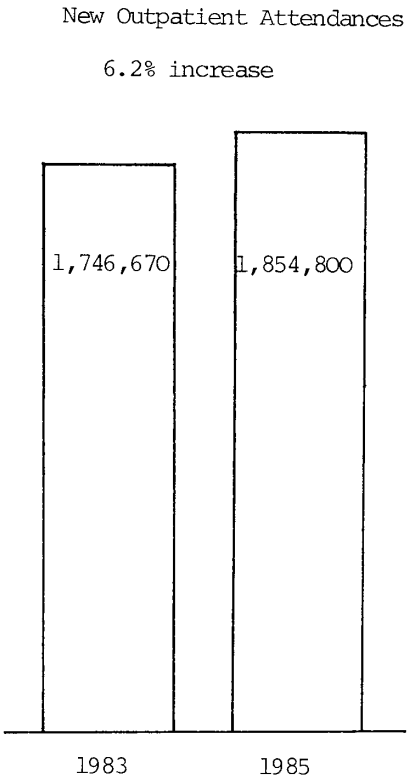
21. This planned reduction in caseload, is not taking place. Indeed, during the period 1983 - 1985, utilisation of local acute services in inner London districts has actually increased for inpatients and day cases (Figure 9), for new outpatient attendances and for new Accident and Emergency cases (Figure 10). Should this trend continue and/or utilisation decline at a slower rate than anticipated, the planned reduction in caseload will be significantly less than forecast. If this does occur, it is unlikely that inner London Health Districts will be able to effect the reductions in acute beds required to meet their reduced revenue targets, without having a detrimental effect on waiting lists.

Fig 9: Inner London Districts Local Acute Inpatients and Day cases 1983 and 1985*

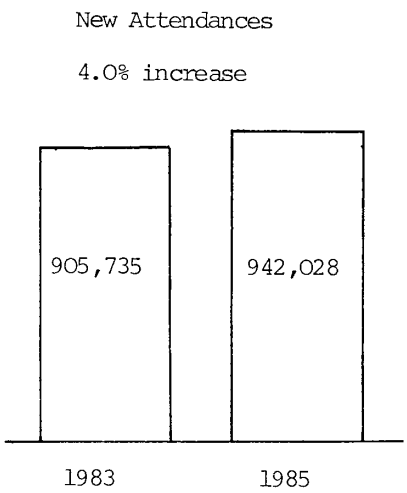


* Data in Figures 9 and 10 have been derived using SH3 published sources and the standardised list of specialties contained in paragraph 15.

Fig 10: Inner London Districts Local Acute New Outpatients Attendances - 1983 & 1985

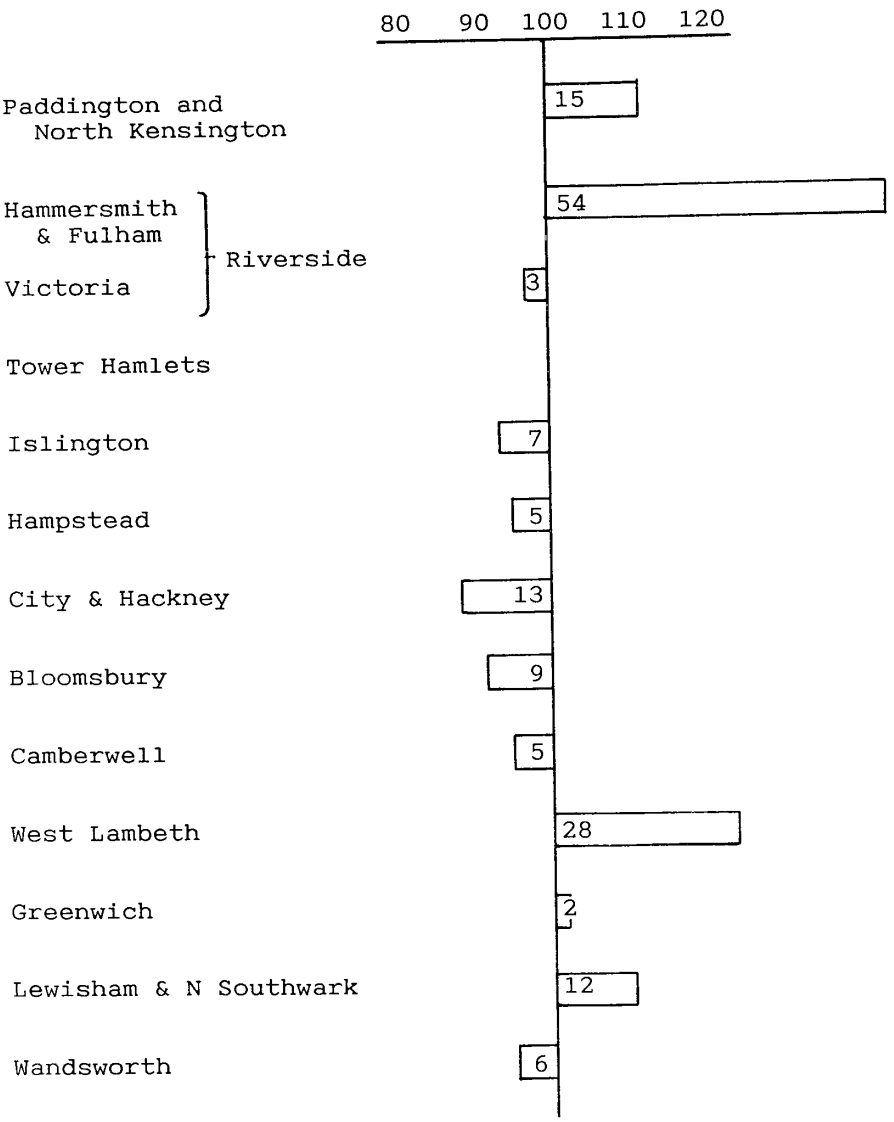


Inner London Districts Accident and Emergency caseload - 1983 & 1985



22. In terms of workload, DHSS Performance Indicators for 1984/5 show that for Acute services, the London districts do not perform consistently as a group even when caseloads are weighted to take account of the broad types of diagnoses they contain. For example, Figure 11 below shows that while four districts have a significantly higher bed throughput than might be otherwise expected when balanced for caseload, the other eight districts are broadly in line with or below expected bed use. This baseline however, is derived from a sample of all NHS districts. A fairer comparison would be between the inner London districts and a national sample of teaching districts: it is likely that such a comparison would suggest that the bed throughput levels in inner London are substantially higher than might be expected for comparable teaching districts with similar caseloads.

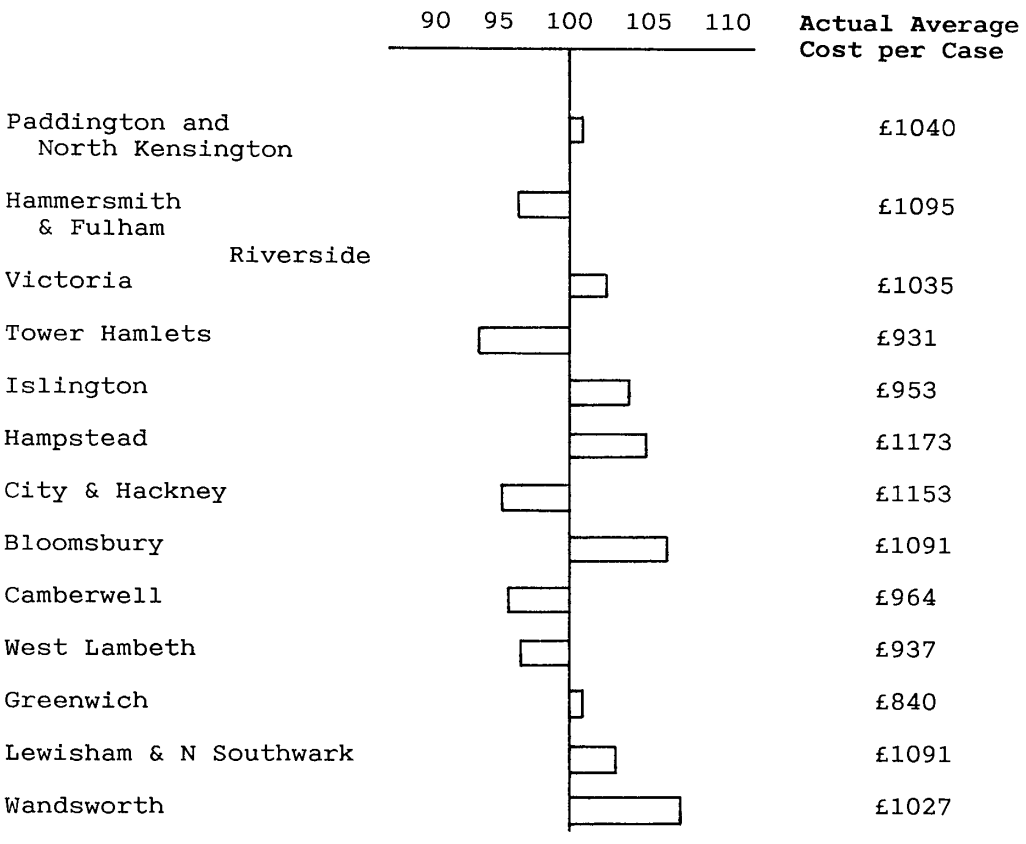
Fig 11: Actual throughput as percentage of expected thro'put balanced for caseload (DHSS)



23. Another target set for these districts to achieve is an economic performance based upon national costs per case. The DHSS performance indicators also include data which compare actual cost per case with an expected cost in which case mix in broad categories has been taken into account. The diagram below shows how the inner London districts compare on this statistic for their acute services. All districts fall within +7% of their expected cost per case on this statistic but the actual costs per case (shown in £ on the figure) substantially exceed the national average cost of £788.

24. The comparisons shown in Figures 11 and 12 are particularly significant in understanding the problems which confront most of the inner London districts. Within the constraints of the Regions' planning models, whenever a district fails to achieve one of the assumptions in the model - such as performing at the national average throughput or costs - this has implications for its capacity to stay within its revenue target. That is to say, the revenue targets set for all districts reflect in part, the assumption that they will be able to bring bed throughput and case cost into line with national averages or some adjusted index based on national comparisons. However, the mechanisms for managing clinical practice in the service are as yet not sophisticated enough for districts to control these factors. As a consequence, many districts have been forced to fall back on bed closures and other crude cost-cutting measures in an effort to stay within their spending limits. This phenomenon almost certainly accounts in part for the earlier observation that bed closures are running significantly ahead of progress toward resource targets.

Fig 12: Actual cost per case as % of expected cost balanced for case mix (DHSS 1986)



PRIORITY SERVICES

25. For priority services, that is, for services for the elderly and for people with mental illness or handicap, or physical disability, similar descriptions of the plans for inner London need to be compiled. The difficulties in identifying what is intended across the districts of inner London have proved to be even greater in these services than for Local Acute Services. Gaining such a comprehensive picture is likely to become more difficult as the range of facilities provided for each priority group increases, with private, Local Authority, acute and long stay hospital and community-based support services each playing a part. In future, it will be increasingly difficult to compare the quantity and appropriateness of services between geographic locations.

26. Services for elderly people: A clear picture emerges of the norms for bed provision which each Region has adopted. These suggest that while the population aged 75+ years will increase in inner London districts by only 4.3% from 1983-1993, the planned bed provision for inner London districts will increase by 14% (376 beds) in the same period. This represents an improvement in the bed provision from 18 beds to 21 beds per 1000 population aged 75+ years, and approaches the Regional norms published by N.W. Thames and N.E. Thames Regions of 17-21 beds and 23.5 beds per 1000 population aged 75+ years respectively. S.E. Thames Region predict a 16% increase in day patients and a 15% increase in outpatient clinics across the Region, while S.W. Thames Region anticipate an increase of 20% in day patients and an increase of less than 5% in inpatients during the strategic period.

27. These forecasted increases in activity apply to overall changes in Regional totals and do not necessarily reflect the intended or achievable changes in each district. The financial resources available will be a major determinant of whether proposed increases in services can be achieved in inner London, and it is not clear what the impact of reduced Local Acute Services (an estimated 40% of which are used by the population aged 65+ years) will be upon the available and proposed new facilities for the elderly. In addition, measures of social deprivation which relate specifically to the elderly, namely, percent of the population who are pensioners living alone and percent of the population who do not have private, indoor toilet facilities, are substantially higher in inner London districts than other parts of the Thames Regions and this may be reflected in the very high intensity of use of currently available beds for the elderly (95% occupancy in 1983; 96% occupancy in 1985).

28. Services for the mentally ill: The planned provision for these services in inner London districts is extremely difficult to determine. Published data (for 1981) from N.W. Thames Region concur with an earlier report from the London Health Planning Consortium (LHPC) to suggest that admissions to hospital arising

from mental illness occur significantly more frequently from inner London districts populations than from other district populations. The LHPC report associated this increased demand for psychiatric services with the poorer social and environmental conditions which occur in inner London districts. Current service provision is dominated by hospital inpatient services most of which are located outside inner London. This pattern of service provision is planned to change, but it will not be possible to compare the level of new services provided (which will include some acute hospital beds, residential and community-based services provided in cooperation with Local Authorities, private and voluntary agencies) directly with those which have formerly been available in the large hospitals. Considering changes in hospital bed numbers for acute, elderly and long stay services alone, data from three Regions suggest that hospital bed provision available to inner London districts will decline by some 40% (1900 beds) over the strategic period. New locally-based alternative forms of care are proposed in each of the Regions but the extent to which they will match or enhance services available in 1983 is unclear. Districts in inner London will face two principal problems:

- Those who have formerly had no significant services for the mentally ill, other than those managed by other districts, will need to identify resources (finance, locations, clinically and managerially skilled personnel) to begin developing facilities.

- Those who have managerial responsibility for large facilities must develop their own locally based services, but also must maintain their large hospitals to an acceptable standard for the remaining residents

In both circumstances, pressure is likely to be exerted upon the Regions' revenue bridging loan facilities and their capital programmes. Some details of the Thames Regions' financial proposals for services for the mentally ill are included as Appendix IV. Planning support for the management of these transitional processes is not prominent in the Regions' strategic documents.

29. Services for the mentally handicapped: DHSS estimates suggest that between 10-12,000 residents in inner London will require access to specialised mental handicap services throughout the period 1983-1993. Currently only 28-32% of the Regions' population requiring access to mental handicap services receive hospital inpatient care at any one time; the remainder receive support from community services, Local Authorities, voluntary or informal caring networks. N.E. Thames Region's provisional planning norms for providing residential places suggest that the present balance of care will shift further towards the mixed pattern of locally based services with only 16-19% of care being provided in hospital inpatient facilities.

On the basis of these norms and inner London's population, between 1600-2280 residential hospital places should be planned for inner London districts. At present inner London districts manage only 371 hospital beds for people with mental handicap. In financial terms, all Regions have identified the increase planned for this area of care and the combined Thames Regions estimate a total expenditure of approximately £154 million at 1984/5 prices. On the basis of the proportion of the projected 1993 populations for the Thames Regions, this would suggest that inner London districts should identify resources to provide 16% of the total Regions' services, amounting to £24.7 million. A survey of the inner London districts in 1986 showed that spending in 1985/6 on mental handicap services including community services amounted to only £9.2 million at 1984/5 prices. Some details of the financial arrangements planned in each Region are included as Appendix V.

CONCLUSIONS

30. The magnitude of the planned reductions in resources for Inner London's Health Services is indicated in part in this report. Other parts making up the complete picture of the future services available to people living in Inner London are not within the scope of this report, but they include:

- the capacity of the Inner London Local Authorities to contribute to new community services, both for priority groups and in order to alleviate the demand on local acute hospital services;

- the responsiveness of Family Practitioner Services to the new levels of hospital service provision in inner London, and their capacity to maintain patients outside hospital facilities and to direct patients to where new facilities are developing;

- the capacity of the resident population to support in the community more of its members who need care and support;

- the extent to which better liaison between public, private and voluntary agencies can improve the efficiency with which available resources can be used.

31. Gaps and inconsistencies in available information, together with the difficulty of finding comparable data amongst the four Regional strategic plans, mean that it has been impossible to construct an accurate and comprehensive picture of the planned health services for Inner London. The partial picture that does emerge, however, suggests that the planned reductions and redistributions in revenue pose formidable challenges to Inner London Health Authorities over the Regions' strategic planning period. These include:

- a 12.9 per cent reduction in total revenue allocation, which requires

- a reduction of between 6.7 and 31.4 percent of each District's acute service revenue allocation, which equates to

- a 15.7 per cent reduction in the number of local acute hospital beds in Inner London.

These significant reductions in revenue and facilities are planned to accompany an anticipated 15 per cent decline in future inpatient caseload by 1994. Recent data show however that, to date, workload in acute hospital services in Inner London has increased rather than decreased. At the same time, current cost efficiency and performance indicator comparisons between Inner London and other Districts within the four Thames Regions show that, in relative terms, many of Inner London's acute services are already under pressure.

32. Part of this pressure on inner London's districts arises from their need to resource and manage changes and developments in their own priority services. These areas have only recently become a focus of major Regional planning effort and the data which describe services in these priority areas are not as readily available as for acute hospital services. A comprehensive picture of planned services in these areas is therefore not available and cannot be derived from published Regional strategies. Gaining such a perspective in the future will become more difficult since, in each of these areas, diverse locally based services will be the responsibility of a number of different agencies. The capacity to describe comprehensive services in the priority areas must therefore be developed quickly if any comprehensive overview is to guide future planning.

33. At the beginning of the strategic planning period, the four Thames Regions' plans indicated that facilities and workload equivalent, approximately, to one large Health Authority, need to be withdrawn from the capital and redistributed to other Regions in the country and other districts within the Thames Regions. In order to meet this target, Inner London Health Authorities have already made three quarters of the planned reductions in local acute beds. Yet the decline in local acute services utilisation is far less than anticipated. Many districts which are more than half-way through their planned reduction in bed numbers have not been able to reduce caseloads or costs to achieve necessary reductions in revenue requirement. These observations highlight some key issues: What will happen if acute bed reductions continue and utilisation continues to decline at a slower rate than expected? Will Inner London Districts find it possible to stay within their cash limits without significant increases in the waiting time for non-emergency treatment in local acute specialties? What will be the effect of proposed changes upon the capacity to teach medical and nursing staff? Will inner London districts find it possible to direct revenue to priority services development? How will residents' future health needs be met? Without a coherent and comprehensive picture of the future pattern of Inner London's health service, the answers to these questions remain unclear. They cannot be gleaned from today's Regional plans. This is perhaps the single most significant finding of this study.

APPENDIX I

Policy Guidelines for Planning

Each year, DHSS planning guidelines to Regions include provisional revenue and capital allocations that Regions can expect to receive, the timetable to which plans should be produced and the national policies to which service plans should adhere. The following are main elements of national policy introduced since 1983. Regions should:

- attend to buildings and estate maintenance;
- improve services for long-stay residents;
- develop community services;
- increase manpower only in relation to improved volume or quality of service

Health Circular HC(83)4

- carry through sustained and substantial cost improvement programmes;
- develop assessment, rehabilitatiion, long-stay and community services for the elderly;
- develop community services for the mentally ill and handicapped;
- develop services for renal failure, coronary artery surgery, joint replacement and bone marrow transplant;
- concentrate increases in manpower on direct patient care services;
- use "Care in Action" (DHSS 1981) as the general policy guide;

Health Circular HC(84)2

- achieve a target of 40 new renal patients per one million population;
- provide more specific information on cost improvement programmes
- continue manpower restrictions;
- implement the recommendations of the Steering Group on Management Information (Korner) by April 1987 (and April 1988 for Community Services);

Health Circular HC(85)5

- improve cervical cancer screening and introduce computerised patient call and recall systems by 1987/8;
- plan new services for people with AIDS;
- provide services for those involved in drug abuse;
- continue cost improvements and manpower restrictions;

Health Circular HC(86)2

APPENDIX II

SUMMARY OF THE REVIEW OF SOCIAL DEPRIVATION ISSUES

This section of the report summarises a review of current issues in measuring, and responding to, social deprivation as an influence upon the health of populations.

- There is a little dispute with the findings of the Black Report* suggesting that multiple deprivation is associated with poorer health, but there are questions about whether compensated health services are the most appropriate response to this, rather than, for example, better housing or social facilities for old people.

- On a collection of commonly used factors indicating social deprivation, London health districts frequently rank amongst the most deprived in the country. Figure 6

- Two major questions emerge: how can social deprivation weightings be applied in the processes for calculating resource allocation targets? and, how can enhanced health resources be managed to improve the social condition or health of deprived sub-groups within the population on whose behalf these resources are won?

- Most literature and research has concentrated on the first of these questions and upon identifying a statistical weighting which could be built into the allocation formulae used for setting resource targets, both for, and by, Regions. A number of indicators which combine specific social characteristics of the population are being developed eg. Jarman "8", Jarman "10", DOE Social Index and the ACORN system.

- Three problems emerge consistently in this search: Firstly, each of these indicators has to be validated and this has meant demonstrating that it has a high correlation with the incidence of sickness. There is no good measure of the incidence of sickness but three proxies have been used:

  Condition-specific Standardised Mortality Rate (SMR) which are already included in the RAWP formulae;

  Service Utilisation Rates, such as the number of hospital admissions arising per 1000 population, this validation measure is less helpful in Thames Regions and inner London where apparently relatively high levels of social deprivation and service provision exist together and hence high utilisation rates could be said to be service supply-led;

  Subjective Assessments of Health need for example, by a sample of general practitioners.

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* **Inequalities in Health**; Report of a research working group; Sir Douglas Black (Chairman). DHSS 1980

- A second problem concerns the relative weighting given to component factors in compound indicators of social deprivation ie how much emphasis should be given to "the percent single parent families" compared with "the percent unemployed" in the population? Where more factors are taken into account, the assessment of social need becomes more comprehensive but the difficulty of finding a sensitive and appropriate balance for these factors increases.

- The third problem is that of double counting. As more factors contribute to compound indicators of social deprivation, so the likelihood increases, that effects are being counted twice. This would occur for example, where a social factor was linked with a frequently fatal disease, and this factor was used in conjunction with an SMR which also reflected this characteristic of the population. Statistically, this problem can be addressed by using multiple regression methods to identify those factors which together account for variation in the population morbidity.

- These three problems taken together illustrate the technical complexity of attempts to weight the resource allocation process to allow for social deprivation in the population. Beyond the debate about the comprehensiveness and validity of particular indicators, a social deprivation indicator will be valued and used only if it has a significant and widely acceptable net effect upon resource distribution.

- The second issue which featured to a much lesser extent in the literature concerns the actual management of additional resources won on behalf of socially deprived sub-groups of the population. At present there are no processes at Regional or district level for ensuring that additional resources are directed to particular needs, or for evaluating their alleviating effects. Progress in this area would call for explicit judgements and commitment to be made about the relative priority of needs in the Region or district.

APPENDIX III

REGIONAL MODELLING APPROACHES TO SUB-REGIONAL RESOURCE ALLOCATION

Each of the four Thames Regions has developed a model intended to provide an equitable allocation of available revenue to their districts. Each of the models has a number of factors in common as follows:

catchment population	- the population to be served
utilisation rates	- the number of cases arising per 1000 population having particular age sex and socio economic characteristics
caseload	- number of patients to be treated
average throughput	- number of patients treated annually per available bed for major categories of bed provision
beds	- number of beds available
average cost per case	- revenue expenditure per patient episode
£ cash allocation	- total revenue available

Within the constraints of the cash available as a whole, a range of values may be attempted using these models until an acceptable option is denied.

INFLUENCING CATCHMENT POPULATIONS:

District Health Authorities are responsible for providing local services to the resident population within their district boundaries; in some instances they provide particular services to specified populations who reside outside their district boundaries and may also manage services for the whole Region, on behalf of the Region.

In addition to these well defined responsibilities for services there are many instances where patients attend hospital in a district in which they do not reside because they have been referred to a particular clinician, access is more readily available, as an emergency, or to reduce the time on a waiting list.

These flows of patients across District and Regional boundaries follow well established patterns which change only slowly. As a consequence Districts plan to provide services for these net gains and losses to their resident population. Defining the appropriate planning population is a fundamental step in producing service plans. In Inner London, cross-boundary flows of patients between Districts are extensive because of the artificial nature of District boundaries in a densely populated area, because of the highly mobile working population and because of the special facilities traditionally linked with the medical schools and Regional specialties.

A number of surveys have been conducted and models built in attempts to determine what populations districts should plan for. Different approaches are used by each Thames Region and the assumptions which underpin them are not consistent between Regions.

The effects of cross boundary flow upon planning populations are most significant in planning Local Acute Hospital services because flows associated with Regional specialties, Mental Handicap and Mental Illness inpatient services, are either well known and financially compensated or only just emerging as significant as patterns of service change.

The exact extent of cross boundary flows for local acute patients between Districts within Inner London cannot be measured. Whilst each Region produces detailed data showing cross boundary flows between districts **within** the Region, **inter-Regional** flows are grouped together under a single classification. Published estimates of the catchment populations for inner London districts in 1983 show the extent to which inner London's services have been built to serve the demands of many more people than their resident population.

It is clear however that if inner London's Local Acute services are planned to receive substantially reduced resources during the strategic period, this will be achieved partly by increasing the efficiency of available resource use (throughput and cost per case) to maintain services, and partly by dispersing inner London's caseload.

This latter requires reducing the uptake of service from the resident population and reducing the flow of patients into inner London hospitals. At present, and in the forseeable short term, the mechanisms for achieving this change are crude and amount to closing beds and clinics, thereby increasing waiting times and lists, and even closing hospitals to emergency services. Regional strategic plans are currently beginning to address the implications for, other factors, such as the distribution of medical manpower, of a smaller more locally oriented health service for inner London.

APPENDIX IV

FINANCIAL ARRANGEMENTS : MENTAL ILLNESS

S.E. Thames Region's Strategy is explicit regarding its financial strategy in mental illness services and includes:

. an increase in spending over the Region on these services from £77.9m in 1983/4 to £87.8m in 1993/4;

. a potential increase of £8.4m in inner London districts resources arising from the mental illness funding policy, which allocates funds to the districts of residence, and allows host districts to charge these sums of money until patients are returned to the district of residence.

Camberwell	**+ £2.237m**
West Lambeth	**- £0.920m**
Greenwich	**+ £2.175m**
Lewisham and N. Southwark	**+ £4.938m**
	£8.430 million

S.W. Thames Regional Strategy indicates that:

. revenue resources for mental illness services throughout the Region will rise from £76.5m in 1983/84 to £79.7m in 1993/4 (13.5% and 14.3% respectively of the Region's total revenue);

. 30% of the capital programme is allocated to schemes for the mentally ill.

N.E. Thames Regional Strategy is dominated by the closure of two large mental illness hospitals (Friern and Claybury). £50m capital resources are reserved in the capital programme for the reprovision of services from these hospitals. Other elements of the strategy include:

. a further £56m capital for priority services (excluding Friern and Claybury services) out of a committed capital programme of £406m;

. a funding strategy similar to S.E. Thames system whereby districts with patients in other 'provider' districts reimburse the costs of their resident patients;

. a total of £16.6m revenue available across the Region for the development of Priority Care services, including the double running costs related to the run down of large long stay hospitals.

N.W. Thames Regional Strategy includes:

. the closure of Banstead Hospital in 1986;

. the use of the Region's Strategic Development Fund for 'bridging loans' for developments such as the transfer of resources from long-stay hospitals to the community.

APPENDIX IV (continued)

REFERENCES

S E Thames: Regional Mental Health Strategy. 1985-1994
A Consultative document; December 1985

S W Thames: Future Pattern of Services for the Mentally Ill.
Consultative document; June 1983

N E Thames: The Future of Provision of Services for the
Mentally Ill. A Consultative document 1982

N W Thames: Towards a Strategy for Mentally Ill People
November 1983

APPENDIX V

FINANCIAL ARRRANGEMENTS : MENTAL HANDICAP

S.E. Thames Region published its strategy for Mental Handicap services in 1983. This has a number of very clear directives which include:

- an increase in revenue expenditure from £28m to £31-33m (1981 prices);
- £5m for capital developments for districts;
- a definite timetable for closing one major hospital, Darenth Park;
- a process for transferring funds (£9,300 per patient at 1981 prices) as patients are transferred to districts of residence. This transfer allowance includes a contribution from the host district and a bridging element provided by the Region. The receiving district can deploy the money as capital or revenue and can claim the allowances for an indefinite number of years.

A survey of 1985/6 programmed expenditure in the inner London districts of S.E. Thames Region shows the movement these districts still have to achieve.

	1993 target expenditure	1985/6 programme expenditure
Camberwell	1.843m	0.212m
West Lambeth	1.352m	0.100m
Greenwich	1.859m	2.000m
Lewisham and N. Southwark	2.662m	3.477m
	(1981 prices)	(1984/5 prices)

N.E. Thames Region issued their consultative document in 1982. Like S.W. Thames, this strategy involves districts bidding for funds for specific projects. The Region expected to increase its £25m expenditure on services for the mentally handicapped with a revenue increase of £8.4m and capital of £10.2m (1981 prices). Of ten capital projects, sites for six were identified of which one was located in inner London (Tower Hamlets HA).

S.W. Thames Region issued its consultative document in which it showed its 1981/2 expenditure on services for people with mental handicap to be approximately £42m per annum with an expectation that a further £5m per annum would be transferred from Acute services in the strategic period. The Region estimates that 80% of that expenditure is committed to the large hospitals in the Region, which are considered to be underfunded by national standards. Wandsworth, the inner London district, does not manage any of these principal resources.

N.W. Thames Region similarly has its major resources in Mental Handicap services committed in large hospitals outside London, but has established a Regional 'pool' of resources against which Districts can bid with service proposals.

APPENDIX V (continued)

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S E Thames RHA: **Mental Handicap Funding Policy**, 1983

N E Thames RHA: **"The Future Provision of Services for Mentally Handicapped People: a consultative document"**, July 1982

S W Thames RHA: **"The Future Pattern of Services for Mentally Handicapped People"**, June 1983

N W Thames RHA: **"Towards a Strategy for Mentally Handicapped People"**, November 1983

1. Paddington & N Kensington HA
   Chairman: M Hatfield
   16 South Wharf Road
   LONDON W2 1PF

2. Riverside HA
   Chairman: G T Howd
   17 Page Street
   LONDON SW1P 4NB

3. Hampstead HA
   Chairman: W H Wells
   The Royal Free Hospital
   Pond Street
   LONDON NW3 2QG

4. Islington HA
   Chairman: E Moonan
   Whittington Hospital
   St Mary's Wing
   Highgate Hill
   LONDON N19 5NF

5. The City and Hackney HA
   Chairman: E Stone
   District Offices
   St Bartholomew's Hospital
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6. Bloomsbury HA
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7. Tower Hamlets HA
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10. Camberwell HA
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11. West Lambeth HA
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    Lambeth Palace Road
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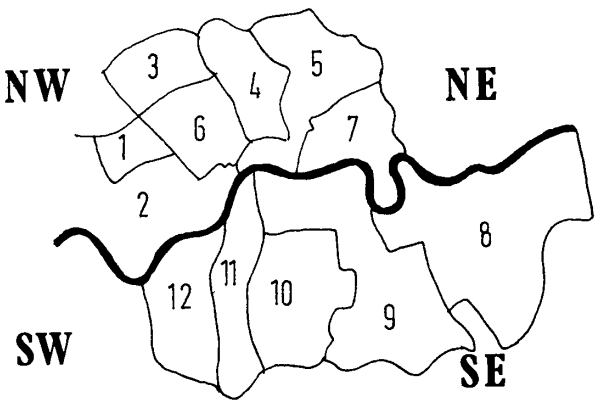
12. Wandsworth HA
    Chairman: D E Cruickshank
    Grosvenor Wing
    St George's Hospital
    Blackshaw Road
    LONDON SW17 0QT



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