King's Fund

Profiles of the King's Fund

Annual Report for the year 1994

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Cover: **David Crepaz-Keay**, Chairman of Survivors Speak Out and an adviser on the King's Fund Mental Health Initiative

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Chief Executive's Introduction

This is the last annual report to be written from the premises of the King's Fund in Camden and Bayswater. As we prepare it, we are also preparing for the move that will bring us into one central headquarters for the first time in half a century.

In the National Health Service, 1994 could be characterised as a year in which, for the first time since 1989, management and Government ceased to be primarily preoccupied with structural change. That does not mean that the radical upheaval stemming from Mrs Thatcher's review is yet complete: still less that its effects can be objectively evaluated.

To date, fundholding affects only about half the total number of GPs; district and family health service authorities are in the process of merging; regional health authorities are disbanding. However, the main elements of the new structures are now in place and they can be tested in practice. We now know from experience what the purchaser/provider split entails; trust boards are established; and, in some places, fundholding is already the dominant mode for general practice.

Partly because the Government was initially opposed to research on the impact of these changes, there is relatively little objective evidence about them. The most complete account remains *Evaluating the NHS Reforms* by Robinson and Le Grand (King's Fund, 1993), stemming from the research programme financed by the King's Fund. It came, with the benefit of hindsight, rather too early to be definitive. Nevertheless, it indicated some features that have remained: the increased transaction costs, for example, in return for better information; the tangible benefits to some patients from fundholding, at a risk of increased inequities among patients; the potential flexibility in personnel matters arising from trust status, along with a danger that many patients actually have less choice about where they are referred under the contract system than they had previously.

Such findings can be disputed, but they are enough to suggest a common-sense conclusion that a set of massive structural changes, like those brought about by the NHS and Community Care Act 1990, have some effects that are intended and some unintended. The NHS has a new framework within which to tackle the familiar, intractable problems of providing the best possible health care for the whole UK population, within defined financial limits.

Internationally as well as nationally the past few years have seen structural and financing reforms, either directed at making large public systems more responsive (as in Australia, New Zealand and Sweden, as well as the UK), or at imposing financial discipline on a publicly funded, largely privately provided system (as in much of continental Europe), or at countering the faults of a market-driven system (as in the ill-fated Clinton reforms in the USA). It remains to be seen whether, when the dust settles, national systems will be converging on a common model, or whether they are simply tacking in different directions against a common headwind.

Perhaps all that can be said at this stage is that the separation of purchasing from provision is one interesting and important idea, familiar to the public insurance-based systems like Germany, but novel in publicly provided systems like the NHS. Another formative idea is that of competing managed-care systems as in health maintenance organisations in the USA.

At least for the present, massive further structural change is not on the immediate political agenda in the UK. Instead, we can concentrate on the standards of health care actually experienced by patients, on its quality in the fullest sense, as well as on the contributions of health policy to people's health. Within such an agenda the King's Fund can seek to help in a whole variety of ways, as illustrated by this year's annual report.

This year's annual report, as has been the custom in previous years, looks back at the work in each of the major divisions of the Fund, and also looks in more depth at some of the specific issues that will continue to be of particular interest and importance to us. In the first half of the report, we summarise our previous year's work under names which will not be immediately familiar. To prepare for our single headquarters we are now referring to the Development Centre (formerly King's Fund Centre), Management College (formerly King's Fund College), Policy Institute (formerly

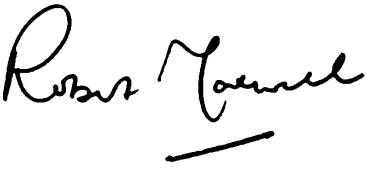
King's Fund Institute) and Organisational Audit (formerly King's Fund Organisational Audit Programme). All will of course be integral part of the King's Fund.

In the second half of the report we have looked in rather more detail at five themes: our work in London; managing in a changing world; new work in the field of mental health; tackling inequalities in health; and, finally, as an example of user involvement in health care the Living Options Partnership, a joint enterprise between The Prince of Wales' Advisory Group on Disability and ourselves, which is now coming to a close after ten years' sustained and successful work.

As this annual report looks forward as well as back, it is opportune for me to mark the beginning of the process to a more integrated King's Fund that the move to Cavendish Square will cement. I have no doubt that Cavendish Square is a new beginning for the King's Fund. It should enable us to increase our impact, combining our efforts to contribute more than we are yet doing. In addition, these new premises are far more than merely a resource for King's Fund staff. We intend to create an environment for education, development, research and debate on a wide range of issues in contemporary health and social care. And we intend that everybody concerned about the future and quality of health services should be welcome.

The Fund's new headquarters are in the heart of London and are thus accessible to the other centres of health policy and practice, as well as being accessible from across the Capital and throughout the country. We look forward to surprising those who already know the King's Fund through just one or two of our activities by the range of services and resources that we offer. We look forward to working with our many friends and colleagues across the whole spectrum of health and social care on the issues that will shape the future of health services.

Above all, we look forward to welcoming you to our new home.



'Our intention is to make the combined activities of the Fund more efficient and more effective by basing them together, without losing our diversity and our accessibility to everyone concerned with health care and health.'

Robert J Maxwell
Secretary and Chief Executive

Ted Ley, foreman, mechanical services, Cavendish Square site. In charge of installing heating, air conditioning and plumbing systems at the new premises of the King's Fund

Development Centre

Our service development projects around the country provide practical experience of better ways of working in health and social care. They are useful testing grounds for new initiatives which, if successful, can be disseminated widely to influence policy on a national basis.

National policy concerns in 1994 included the need to strengthen primary care services in London and other cities; to find ways of empowering patients to participate in decision-making about their own care; to make health services more responsive to Black people; to develop new roles for nurses; and to monitor the effects of the community care reforms. Development staff at the Centre have practical experience of working on all these topics, both at grass-roots and at a strategic level, and we aim to ensure that the knowledge gained is brought to the attention of policy-makers.

Primary health care

The primary care team has been engaged in two major projects this year – the London Health Partnership (described on pages 18–19) and the Community-Oriented Primary Care (COPC) project.

COPC aims to help primary care staff adopt a public health approach to assessing health needs in their local communities and encourages them to collaborate with other local agencies to plan and implement interventions to meet the needs identified. GPs and practice staff attend a training workshop together with local health authority staff, during which they are introduced to basic epidemiological methods enabling them to analyse data from their practice computers and other sources. They combine their knowledge of the local population with their analysis of practice information to set priorities for action. Groups of general practices in a number of localities are implementing the changes they have planned and monitoring progress. A file of teaching materials has been produced so that other groups can learn the basic methodology, and an independent evaluation is being carried out.

Community care

Community care services, like primary care, must be strengthened if service shifts are to be achieved. The Government's community care reforms have radically changed the way in which these services are funded and organised. We have been working with the Nuffield Institute to monitor the effects of the reforms, using our extensive network of contacts among users, carers and service providers to find out how the changes have affected them. A report on the first year after the changes were introduced, *Fit for Change? Snapshots of the community care reforms one year on,* focused on developments in the health and social care divide.

Many people who need long-term care or support to live independently, for example elderly people, people with physical or learning disabilities and people suffering from mental illness, require help from both health and social services. The need to find better ways to improve coordination between health and social care agencies is the focus of our joint-commissioning project. The team is providing practical support for five development sites where serious attempts are being made to overcome the barriers preventing the development of seamless care for elderly people.

Clinical change

While so much effort is being devoted to structural change in the health service, there is a danger that the content and quality of clinical services will be ignored. The main thrust of the clinical change programme is to promote improvements in clinical care, particularly in specialist services. Innovative developments include empowering patients to participate in decisions about their own care by providing them with research evidence on prognosis and treatment outcomes through a variety of media, such as interactive video, CD-ROM, tapes, books and leaflets.

Nursing developments

Nurses constitute the largest proportion of the professional workforce in health care. The reshaping of health services will necessitate the development of new roles and responsibilities for nursing staff, whose potential contribution has often been underestimated. The current

programme of support for 30 Nursing Development Units (NDUs) helps nurses to develop and test new ways of providing patient services in a variety of settings, including hospitals and community units. Supported by the Nursing Development Network, the team has been actively disseminating the experience gained by the NDUs by organising workshops and conferences and by publishing a series of reports. There is considerable interest among nurses in exploring new approaches, and a recent publication, *Clinical Supervision in Practice,* is fast becoming a King's Fund best-seller.

Information resources

Improving access to health care for black and minority ethnic populations and ensuring that services are responsive to their needs are priority themes in our service development work. SHARE, our health and race information exchange, was established to gather together information about initiatives and disseminate good ideas. The staff respond to a large number of telephone enquiries each day, as well as organising workshops and producing a newsletter and special reports.

Electronic links have been developed between our library and that of the Health Education Authority, so that users of either collection can easily search both catalogues. This helps to ensure that resources in both libraries complement each other and greatly enhances the service we can provide to users.

Dissemination

One of our priorities this year has been to consolidate our capacity to communicate the knowledge gained from our development work so that others can benefit from it. The new Communications Unit has greatly enhanced our ability to reach a wider audience by strengthening the design, production and marketing of our books, reports and newsletters, and by developing a professional press and media service. The Communications Unit is now providing this service to all parts of the King's Fund and we hope the result will be a clearer and better coordinated system for getting our messages across. • *Angela Coulter*

'Development staff have practical experience of working on topics of national concern, both at grass-roots and at a strategic level, and we aim to ensure that the knowledge gained is brought to the attention of policy-makers.'

Angela Coulter
Director of the Development Centre

Christine Farrell is director of the clinical change programme at the Development Centre and oversees projects to change clinical behaviour, involve users and improve quality of service

Management College

Nineteen ninety-four was my first year as director of the Management College. It was also the year in which the College began its transformation to reflect the changed circumstances in which it operates.

A new working environment

We had long felt that the nature of our work was changing. As the NHS continued the process of reshaping itself, so the College has aligned itself to the new working environment. Increasingly, the boundaries between our fieldwork and educational activities have become blurred, with many more custom-designed and locally delivered interventions taking place at the workplaces of our NHS colleagues.

Internally, we have reflected this approach by restructuring the way in which we operate. During 1994 the College reconfigured itself into five self-supporting teams. We introduced corporate management portfolios covering the full spectrum of our work; established robust and challenging income and performance targets for the Faculty; restructured our own staff support systems; set up a new College development fund from our own income base to be used in partnership with our clients; and recruited six new Faculty.

Development fund

The development fund represents a unique experiment. By increasing our income targets and setting aside 20 per cent of our income, we have created the capacity to develop important programmes of work within the College, across the Fund and with the NHS itself. During 1995 we will be entering into partnerships where the use of our own resources will be applied alongside those of the NHS to achieve major impact.

The challenges that the NHS is currently facing are many: continued downward pressure on costs; shifts towards primary care; demographic implications; pressure to offer more 'personalised' services; and the impact of technology. The College is dedicated to responding to these key management and organisational challenges and to supporting all who hold or aspire to leadership positions.

Special events

During 1994 we began the first of an annual cycle of special events which would inform the future direction of our work. Every year we will hold a series of consultative workshops involving people from the NHS together with our Faculty and will invite contributors who have something significant to offer in guiding the ongoing adaptation of the NHS. In the autumn of 1994 we held a three-month series of workshops which involved Donald Schon, Henry Mintzberg, Margaret Wheatley and Richard Normann working with Faculty and clients.

During the workshops we explored the concept of new management and leadership in the context of political and social transformation (these are described in more detail on pages 20–1). The outcome of these seminal workshops will be a major publication in the second half of 1995 setting the framework for future change in health service management. In the autumn of 1995 a further series of workshops will take place leading to a publication in 1996.

A new approach

Notable examples of our new approach in 1994 have included our contribution to the London Health Partnership which the King's Fund has jointly sponsored with other organisations to develop new strategies for primary care. We formed partnerships with two groups of authorities in Scotland (both purchaser and provider) to help contribute towards the development of organisations as well as services. We have continued to benefit from our very successful partnership with the NHS Women's Unit in our leadership programmes for women. These in turn have helped us identify new approaches to management and leadership to be explored in the NHS as a whole.

We also began the process of linking acute hospital trusts in a long-term programme of support dedicated to shape acute care to the challenges of the future. Finally, we have consolidated our work with clinical professionals. The new medical directors programme has been a great success and we continued our efforts to support the critical need for nurse leadership development.

The year ahead

Nineteen ninety-five brings significant challenges. Cavendish Square relocation for the whole Fund offers tremendous opportunities for us and our colleagues and clients. Through our development fund and autumn seminars, we will continue to pursue new agendas for the NHS to consider.

Our responses to the needs of the NHS, at a time when the trend appears to be towards increasing independence of organisations, will be to form new partnerships and coalitions to complement this trend. Our overall goal, as ever, is the pursuit of that excellence in management and leadership which will help to shape the NHS for the future. • *Peter Griffiths*

'The College is dedicated to responding to the key management and organisational challenges currently facing the NHS and to supporting all who hold or aspire to leadership positions.'

Peter Griffiths
Director of the Management College

Dr Peter Camm is a consultant radiologist and medical director of West Dorset General Hospitals NHS Trusts, and a participant in the leadership development programme at the Management College

Policy Institute

Public interest in and controversy about health and health care in the UK remain at a high level. The need for independent organisations such as the King's Fund to provide authoritative and non-partisan commentary on policy issues therefore is as great as ever.

During 1994 the Institute continued to pursue its mission of producing and disseminating health policy analyses with the aim of improving the quality of debate and contributing to policy development by:

- continuing to evaluate the consequences of reshaping the NHS;
- making a determined effort to ensure that considerations of equity and fairness return to the centre of the health policy agenda;
- monitoring health and health care in London.

Reshaping the NHS

Change is a constant in the NHS, but the pace has accelerated since the reforms set out in *Working for Patients* began to be implemented in 1991. The Institute has a long-standing interest in these developments and work in this area continues to be its top priority.

During 1994 the main area for investigation was a major review of the changing role of the acute general hospital. This study, which is close to completion, has focused on the appropriate scope and scale of hospital activities and on the development of a framework for understanding critical trade-offs between the quality of services, access to them and the efficiency with which they are provided.

A more specific report, *Seamless Care or Patchwork Quilt? Discharging patients from acute hospital care*, was published at the beginning of the year. The Institute also completed a review of community health services for the Department of Health that identified new possible structures for service delivery. It has also provided advice and assistance where changes in local health services are being considered.

New studies

Analysing the way in which health care is produced and delivered, however, is not the only aspect of the NHS that merits close scrutiny. During 1995 the Institute intends to publish a review of rationing and priority setting that builds in part on policy arguments contained in *A Question of Give and Take: Improving the supply of donor organs for transplantation,* which was published in April. Even more significantly for the future, the Institute has led a national consortium of health services researchers which has been awarded a contract by the Department of Health to evaluate a key element of the current attempt to move towards a primary care-led NHS – *total* purchasing of hospital and community health services by GPs.

Equity and fairness

Improving the efficiency of the health care system so that scarce resources are used to provide appropriate and effective health care remains essential. In recent years, however, there has been an over-emphasis on value for money in the development of health policy; relatively little attention has been given to the traditional values of equity of access to health and health care. The Institute has made a major commitment to redressing this imbalance.

In each of these areas, substantial work was completed during 1994. *Health, 'Race' and Ethnicity: Making Sense of the Evidence* was a very well-received and comprehensive review that covered the rapidly growing public health research in this area and linked it to knowledge about service use and health policy. The first issue of what is intended to be a regular newsletter, *Society & Health,* was produced in collaboration with the Centre for Health and Society at University College, London. More significantly, *Tackling Inequalities in Health: An agenda for action* was the product of a King's Fund seminar chaired by Sir Donald Acheson, former Chief Medical Officer for England. Its analysis and recommendations – some of which are highly controversial – received wide media coverage when it was published in April 1995 (see article on pages 24–5). The Institute also completed various pieces of work on resource allocation closely related to and in part highly critical of the National Health Service Executive's review of weighted capitation. Some of these were published in *Health Economics* and the *British Medical Journal*.

London

The historic purpose of the King's Fund is concerned with the delivery of health care in London, and the Institute has taken the lead responsibility for monitoring changes in health and health care in the Capital (see article on page 18). The second issue of the *London Monitor* was published in February 1995, and other opportunities were taken throughout the year to provide briefing material for particular audiences or occasions. For example, in April 1994, the Institute produced a briefing paper, *London: The key facts,* which was distributed to all MPs and was extensively used by politicians of all parties in a special House of Commons debate about health care in London. One controversial and widely publicised feature of this document was its claim that London's health services are substantially underfunded relative to their needs. To further investigate and substantiate these claims, the Institute has been working closely with the Fund's grants department to manage a group of research projects under the heading *Fair Shares for London*. The results of this initiative will be published in 1995.

Other work

The Institute works on a variety of other topics – often in collaboration with other partners – and some of these are reported in *Health Care UK,* the Fund's widely respected annual review of health policy. Members of the Institute also continue to be in great demand to contribute to the work of agencies such as NHS trusts and commissioning agencies, the Department of Health, the Health Select Committee of the House of Commons, the Medical Research Council, the Cochrane Collaboration, constituent parts of the University of London, the Public Finance Foundation, the Royal College of Physicians and many others.

One final initiative should be mentioned. From 1995 the Institute will provide the editorial base for the newly established *Journal of Health Services Research and Policy.*

• *Ken Judge*

'During 1994 the Institute continued to pursue its mission of producing and disseminating health policy analyses with the aim of improving the quality of debate and contributing to policy development.'

Ken Judge
Director of the Policy Institute

Professor David Mechanic is René Dubos Professor of Behavioral Sciences and director of the Institute of Health, Health Care Policy and Aging Research at Rutgers University in the State of New Jersey, and is visiting the Policy Institute to examine NHS reforms and the rationing of health care

Organisational Audit

King's Fund Organisational Audit (KFOA) is dedicated to improving the quality of health care by the application of organisational standards and a system of peer review to acute hospitals, primary health care and associated health services.

Nineteen ninety-four was an extremely busy year for the unit. The number of acute hospitals and general practices taking part in the process increased significantly over the year. We established two new projects to develop Organisational Audit for nursing homes and purchasing organisations, and we embarked upon the detailed planning of what may turn out to be our most ambitious project to date: Organisational Audit for community and mental health services.

The backdrop to the year's acute activity was the decision taken in the summer of 1994 to launch accreditation for acute hospitals. The decision for introducing accreditation was taken after extensive consultation with our users and with colleagues in the many professional organisations who have an interest in our work.

Early in the year, the NHS Executive commissioned a major research project to describe accreditation activity on an international basis and to evaluate those schemes already in existence in the UK; KFOA formed a central case study in this project. The final report, by Professor Ellie Scrivens of Keele University, was considered by the NHS Executive in the spring of 1995 and will, we hope, result in its support for accreditation as an approach, while recognising the need for some form of regulation of the increasing number of accreditation bodies which exist.

Accreditation – the detail

Professor Scrivens describes accreditation as 'a process used for the assessment of the quality of organisational activity based on a system of external peer review using standards' – its distinguishing feature is that of providing external, authoritative validation. While KFOA had been carrying out external reviews based on standards for a number of years, the decision to pursue the accreditation route had significant implications for us, as its implementation demanded yet higher levels of rigour to meet the needs of authoritative validation. In the late summer of 1994, our standards were completely revised to take account of changes in legislation and practice and to ensure applicability to all services operating within the hospital context. In addition, the standards were weighted to reflect essential practice, good practice and desirable practice. The aim of this was to help hospitals to prioritise in order to meet the standards. The surveyors themselves, now numbering some 200, have all received training in the use of the new standards. In addition, our internal processes have been scrutinised and, where necessary, adapted and strengthened, to ensure that our own quality systems are capable of standing up to rigorous external examination.

The award of accreditation will be made by a committee of the KFOA Council. An award of full accreditation is valid for three years from the date of survey.

Primary health care programme

The work of the primary health care programme has moved forward smoothly. New ways of working appropriate to the more informal environment of general practice have resulted in innovations in the programme which have themselves laid a valuable base for planning the shape of the future management of services, as well as providing information which will be fed into the newly established purchasing project. It has been encouraging to observe the interest shown by these authorities in using Organisational Audit as a developmental tool in their growing relationship with primary care providers.

Project development

The rapid growth of operational activity has encouraged us to take a measured approach to our two main projects in 1994: the development of Organisational Audit for nursing homes and for purchasing authorities.

The nursing homes project, involving ten pilot sites, has progressed steadily, resulting in the production of a manual of standards. The challenge for this project remains to achieve long-term management arrangements which will enable those responsible for the regulation of homes to improve the standard of care offered.

The picture in purchasing has something of the quality of a kaleidoscope, because of the enormous rate of change and learning which is taking place. This makes the development of Organisational Audit particularly relevant, both by providing a mirror to the changes taking place and by offering a framework within which rapidly developing organisations can measure their performance. In the initial planning for the project, primary care purchasing formed a small, if not marginal, part of the picture; as the project develops, it moves to centre stage. We look forward to the continuing progress of this work in 1995 with excitement and a sense of surprises yet to come.

The year ahead

We anticipate 1995 with enthusiasm. The detailed planning and preparation which have taken place to ensure the successful launch of accreditation will be tested in the field as the first hospitals go through the process.

In the early months of the year the community project will be launched and will cover the following range of services: corporate management; mental health services; services for people with learning disabilities; primary/community services; and community hospitals.

The completion of this programme by late 1996 will mean that the major pieces of the jigsaw are in place and Organisational Audit will become available for the full range of health care services. • *Tessa Brooks*

'Organisational Audit programmes have become a benchmark for hospitals, primary health care and associated health services. Our purpose is to provide a rigorous framework by which anyone who aims for quality in their organisation can measure their performance.'

Tessa Brooks
Director of Organisational Audit

Janet Delves is a survey manager for the primary care programme of Organisational Audit, and is one of four managers responsible for the audit of general practice services

Grantmaking

Nineteen ninety-four saw the first full year of operation of the Fund's new grantmaking priorities for its Main Grants programme, agreed through a process of Fund-wide consultation during 1993.

For the first time, the Grants Committee allocated grants within the framework of five priority areas: improving quality in London's acute services; strengthening the voice of the user; equal access to health care; developments in primary and community care; and arts and health.

An analysis of grantmaking activity in 1994 suggests that, even at this early stage, the creation and articulation of a new framework of grantmaking priorities has had a far-reaching effect on the distribution of grant programme funds. The total allocation for grantmaking purposes in 1994 was £2 million, divided among specific programmes.

Improving quality in London's acute services

In this category, the Fund's concern is threefold: addressing questions of resources to London's acute sector; developing quality in hospital-based services; and promoting new styles of multidisciplinary working between professional groups.

The Grants Committee's activity in 1994 was dominated by the Fair Shares for London research scheme, a programme set up to review the Government's formula for resource allocation in the Capital. Jointly managed by the Grants Department and the Policy Institute, the scheme funded three research projects and commissioned academic critiques of aspects of the Government's approach. Other grants in this category were made to projects judged to have innovative approaches to improving the quality of acute services, while one grant went to recognise excellence and innovation in nursing education. Sums committed to grants in this category accounted for 19 per cent of the Main Grants programme.

Strengthening the voice of the user

There was a flowering of projects funded to address user involvement issues in 1994, with grants awarded to six projects. These fall into two broad types: those which seek to model ways in which specific user/patient groups can be involved in planning services and those which look at ways of creating organisational change within health service organisations so that integration of the user perspective becomes part of the operational culture.

The sums allocated to user involvement projects in 1994 was £191,000. This represents 22 per cent of the Main Grants programme.

Equal access to health care

Grants under this category accounted for the largest proportion of the Main Grants programme in 1994, taking 32 per cent, up from 17.2 per cent in the previous year.

By far the largest number of grants went to projects looking at the health needs of Black and refugee communities. Of these, one-third of the sums were committed to Black-led organisations, working with their local communities.

Another group of grants went to mainstream NHS services to support innovations in improving access by Black and ethnic minority users. One grant was concerned with developing an integrated speech therapy service for bilingual clients, while another proposed to employ and evaluate a Bengali-speaking outreach worker in a local audiology clinic.

Other grants were given to develop the work of existing voluntary organisations. One grant was to enable an existing programme, linking disabled people with volunteer carers, to develop its service for disabled people from ethnic minorities and match them with volunteers sensitive to their cultural requirements. Another grant part-funded a clinical director post in a key voluntary organisation, enabling it to strengthen the clinical services it provides to traumatised refugees from all parts of the world.

Three grants with national implications completed the grants tackling Black and ethnic minority health issues. Two were pieces of research, one of them on Asian attitudes to organ donation. People from Asian communities are both in greater need of organ transplants (especially owing to renal failure), but also least likely to donate organs. Given the importance of close tissue matching, the research sets out

to uncover the reasons for the dearth of Asian donors and will provide lessons for transplant services both in London and nationwide. A second research project will look at the impact of minority ethnic communities on the demands on health care services and the implications for allocating resources. Finally, a national project, encompassing information, training and policy development work will address the many areas of overlap between immigration policy and health issues, working both in Manchester and London.

Two grants were made to work focusing on health and homelessness. One will establish a research database at a new hostel and day centre for elderly homeless people in Southwark. The Grants Committee also ring-fenced a sum of £20,000 to undertake a review of the health and homelessness field, to inform their future activities in this field.

Developments in primary and community care

Applications submitted under this category were the most disappointing in 1994, both in terms of quantity and quality. It may be that the attention of London's primary care field has been much taken up with the impact of London Initiative Zone (LIZ) monies, or that energies are taken up with managing externally imposed change, leaving little room for innovation. On the other hand, the 1994 Major Grants monies were allocated to the London Health Partnership, so the Fund's total grants investment in primary and community care issues has been substantially greater than the £86,000 allocated from the Main Grants programme.

Four grants were made during the course of the year. One grant is supporting both the development and the evaluation of a local homeshare scheme, an innovative approach to providing day care to frail elderly people, for whom traditional day care centres are inappropriate. We are particularly interested in whether the project is replicable in areas other than the outer-London borough in which it is currently based. Two grants were made to evaluate projects which seek to implement the *Changing Childbirth* report, which advocated major change in the provision of maternity services, moving services out into the community, under the leadership of midwives. The project teams working in two separate London hospitals have agreed to work closely together on their research, and further sums are being committed in 1995 to establish a network of project teams working on *Changing Childbirth* issues.

The final grant in this category was to meet the costs of networking among the holders of The Prince of Wales Fellowships in Primary Care which have been established under the aegis of the Royal College of General Practitioners.

Arts and health

The only grant in this category was for the continuation and development of the Art in Hospitals scheme, which has been supported by the Fund since 1985. The scheme has sought to stimulate a range of London hospitals to acquire or commission artworks (ranging from gardens to murals, from paintings to stained-glass windows) and to support those working in London hospitals with an interest in developing such initiatives.

The grant given in support of arts and health work in 1994 represented just 5 per cent of the Main Grants programme funds.

Open category

The open category within the Main Grants programme was established as a safeguard against inflexibility and narrowness in the Fund's grantmaking. It is an expression of the Fund's awareness of the need to respond to new or unexpected health needs as they arise. To be considered under this category, applicants must, in addition to meeting our usual criteria, show that their proposed work is new to the UK; will have practical results for the provision or commissioning of health services; and is reliant on Fund support in order to take place.

Six projects were judged to have met these criteria in 1994, from 14 applications considered by the Committee. Between them they reflect a wide range of health issues, suggesting that this category is providing the flexibility and responsiveness which was hoped for.

Grants in the open category accounted for 14 per cent of the Main Grants programme. • *Susan Elizabeth*

Grants made in 1994

Major Grant Programme

London Health Partnership	£350,000

Main Grants Programme

Arts and Health

Public Art Development Trust	£50,000

Strengthening the Voice of the User

Long-Term Medical Conditions Alliance	£40,000
People First	£56,000
College of Health	£30,000
Genetic Interest Group	£50,000
Exeter Community Health Service Trust	£15,000
Afterwards	£35,000

Equal Access to Health Care

Turkish Women's Support Group	£44,000
Timeout Respite Care Project	£36,000
Haringey Somali Community and Cultural Association	£37,000
University of London	£24,722
Independent Living Alternatives	£26,665
Fosse Health Trust	£28,000
University of Luton	£15,000
Greater Manchester Immigration Aid Unit	£42,000
Tower Hamlets Women's Health and Family Services	£25,400
Medical Foundation for the Care of Victims of Torture	£20,000
University of Sheffield	£16,000
Homelessness Review	£20,000

Open Category

The Maternity Alliance	£38,000
Community Hygiene Concern	£30,000
National Alcohol and Drug Resource Centre	£10,000
City University	£22,000
Anna Freud Centre	£14,382
The Core Trust	£29,625

Developments in Primary and Community Care

Royal College of General Practitioners	£10,000
Age Concern Sutton	£40,000
Hammersmith Hospitals Trust	£17,953
United Medical & Dental Schools	£17,954

Improving the Quality of London's Acute Health Services

Personal Social Services Research Unit	£24,710
London Research Centre	£22,000
Centre for the Economics of Mental Health	£19,609
King's Fund – Fair Shares Scheme	£31,000
Mount Vernon Hospital	£15,000
The Partnership Trust	£11,400
Kent & Canterbury Hospitals NHS Trust	£14,000
King's College School of Medicine	£57,409

Small Grants Programme

London Interpreting Project	£2,000
Newham Deaf Asian Women's Group	£5,000
People First	£4,000
Tower Hamlets Health Strategy Group	£2,670
Art Money	£500
Progressive Youth Organisation	£7,000
Well Street Surgery	£1,000
Birth Control Trust	£4,000
South Bank University	£5,000
City University	£5,000
King's College London Centre of Medical Law and Ethics	£5,000

British Medical Association	£2,000
Centre for Accessible Environments	£2,000
The Partnership Trust	£2,725
Mukti Jain Campion	£2,500
Marilyn Monroe Children's Fund	£3,000
GLACHC	£1,500
South Glamorgan Health Authority/ Race Equality Council	£2,517
Black Carers' Forum	£1,540
Action for Sick Children	£1,500
INPUT	£3,000
Holloway Prison	£5,000
Higherland Surgery	£9,000
Queen Elizabeth's Foundation for Disabled People	£2,500
British Home and Hospital for Incurables	£6,750
National Extension College & SANDS	£20,000
National Association of Commissioning GPs	£5,000
Teddington Memorial Hospital NHS Trust	£1,200
Church Action on Disability	£952
The Royal Society of Medicine	£1,000
British Council of Organisations of Disabled People	£4,880
Roffey Park Management Institute	£10,000
The Royal Free Hospital School of Medicine	£5,371
British Deaf Association	£3,000
Royal College of Nursing	£1,000
King's Fund Major Grant 92 – Support Costs	£4,000
Theatre in Health Education Trust	£1,000
Celebratory Arts for Primary Health Care	£7,500
British Agencies for Adoption & Fostering	£5,000
Radcliffe Medical Press Ltd	£5,000
King's Fund Centre/Nuffield Institute for Health	£5,000

Other Grant Funds

Consultancy Fund	£6,300
Evaluation Fund	£4,057
Educational Bursaries	£50,000
Travelling Fellowships	£32,830
MTS Study Tour	£9,000
Total	***£1,654,622***

Centre Committee

Young People with Learning Disabilities Workshop	£500
Limbless Association	£250
Carers Conference	£1,000
User Participation – Better Futures Regional Conferences	£1,000
People First	£1,000
GLACHC	£600
Ugandan Refugee Community Group	£865
Patients Forum	£1,000
Redbridge Healthcare	£1,000
CHAR – Housing Campaign for Single People	£750
Carers in the Mainstream	£846
Help for Health Trust	£24,644
Family Services Unit	£590
First Step Trust	£500
Islington Mind	£980
Joint Community Care Commissioning	£50,000
Amounts set aside:	
Information to promote shared decision making	£200,000
Dissemination of clinical information by consumer health information services	£60,356
Total	***£345,881***

London

Improving health care for Londoners

From its inception in 1897 the role of the King's Fund has been to support the provision of health services by the Capital's hospitals. Over the years this role has been interpreted in various ways. Now, at a time when considerable controversy surrounds health service provision in London, the Fund has a most crucial part to play, not only in helping to promote public understanding and debate around the key issues, but in suggesting how changes can be most effectively and sensitively introduced.

Throughout the UK, health authorities and professionals are struggling with the development of services to reflect a modern concept of health care, characterised by a shift of provision away from large hospitals towards smaller community-based facilities, whenever that is consistent with quality and cost considerations. Fewer high-tech, specialised hospital centres will cater for more complex medical needs for a wider catchment population, while routine work will be dealt with in locations more accessible to local populations. Not least is the difficulty of agreeing what constitutes 'specialised' and 'routine' in this context. This vision of the future requires major structural change to become a reality. Nowhere is this more difficult than in London which has had, historically, a range of specialised hospitals, at times fulfilling the role of a general hospital, while primary and community services have often been rather poor.

The NHS health care market provides added complexity. It is inaccurate to talk in terms of a plan for London. Each agent, whether trust or purchaser, produces a business plan to meet its own objectives. At its best, the market provides signals and incentives to promote the changes required in London's health services. However, in an imperfect world there remains the potential for conflict between the need for orderly change and what the market can deliver. Assessing the overall impact of the plans of over 70 trusts and 16 purchasers is an increasingly daunting task.

The key issue facing those responsible for health service delivery in London is to ensure continuity of appropriate care while developing new ways of providing services. Also fundamental is the establishment of a fair level of financial and physical resources for London. Finally, the opportunity must be taken to listen and respond to the views of Londoners about the kind of health care they wish to receive and the level of access, both in terms of where and by whom.

Change in London is inevitable. If not, there is danger of atrophy. The King's Fund will continue to examine the viability of service delivery in the Capital within the context of a fair share of resources for the needs of London's residents, and try to ensure that the views of the public are heard and acted upon appropriately. The debate in London at times seems to focus on the great institutions to the detriment of the concerns of residents about their local services. On occasion, the interests of both may coincide.

The King's Fund has shown its commitment to London through the *London Monitor* which presents 'facts without sanitising them; by providing independent and informed commentary; and supplying a forum for discussion'. • *Seán Boyle*

Health partnerships in London, Mersey and the North East

The London Health Partnership is an alliance of charitable foundations, business interests and Government which was formed in June 1994. Its purpose is to generate a distinctive programme of work over 3–5 years to help develop urban primary health care. The Fund's primary care group is playing a leading role in this initiative, which is chaired by Liam Strong, Chief Executive of Sears plc. Parallel to the London Partnership are similar initiatives in Mersey and the North East.

The Partnership was given three clear messages from early consultations with community groups, GPs, charitable trusts and health care professionals:

- *not innovation* – what was wanted was not 'innovation' but help with the intractable problems of urban primary care, such as services for vulnerable elderly people. The Partnership has decided to focus on better ways of providing services for elderly people in or near their own homes.
- *not projects* – while the need for investment is great, it is extremely difficult to bring about lasting change with short-term project money which often has to be bid for

on a hurried, competitive basis. The Partnership has decided to experiment with new ways of thinking about using development funds.

- *not more of the same* – the Partnership should be about trying to do things differently at a time of unprecedented change.

With these in mind, the first phase of work in four London sites and two other cities, Newcastle and Liverpool, has concentrated on the complex system of health and social care which provides services for vulnerable people. Elderly people themselves have played an important part in this diagnostic phase. It is notoriously difficult for agencies working together to see 'the big picture', and solutions to problems often turn out to be 'sticking-plaster' solutions, with knock-on effects which merely shift the burden. Anything which helps the system understand itself as a whole seems likely to lead to better judgements about interventions which will in turn lead to lasting change and better-quality services. This is the hypothesis which is being tested over the next few months using 'whole systems events', in which service users play a vital part. A whole systems approach is more than an exercise in consultation. The aim is to encourage people to think differently about how they use the information they already have – in this case about older people's health needs – and to come up with creative solutions to the problems they know exist. The people with power and money to change things work alongside those who have views about what they want. Many different agencies are involved, and the work during this phase of the programme will take place at four levels in the health/social care system: neighbourhood; general practice population; borough; and city.

The Fund's partners in this development programme are the City Parochial Foundation, the Department of Health, London First, the Special Trustees of St Thomas's Hospital and, for urban primary care in Mersey and the North East, the Baring Foundation. • *Pat Gordon, Director of the primary care programme*

'At a time when considerable controversy surrounds health service provision in London, the Fund has a most crucial part to play, not only in helping to promote public understanding and debate, but in suggesting how changes can be most effectively and sensitively introduced.'

Seán Boyle
Fellow in Health Policy Analysis

Lucia Morris is a district nurse at Stepney Neighbourhood Nursing Development Unit, Tower Hamlets Healthcare Trust, and a participant in the Development Centre nursing development programme

Managing in a changing world

The phrase 'crafting ideas for the future' was adopted as the theme for a series of four workshops held at the Management College during the autumn of 1994.

All the workshops were built around the visits of internationally eminent management thinkers and were attended by about 25 participants divided roughly equally between College faculty and NHS practitioners. The four visiting guests were: Donald Schon, Ford Professor Emeritus at the Massachusetts Institute of Technology (September); Henry Mintzberg, Professor of Organisation at McGill University in Montreal, Canada and INSEAD in Paris (October); Margaret Wheatley, Managing Partner of Kellner-Rogers and Wheatley, Utah, USA (November); and Richard Normann, Senior Partner and Founder of SMG in Paris (December).

As implied by the theme, the purpose of the workshops was to explore and test the relevance of the ideas of these thinkers to the problems and challenges likely to face the NHS and NHS management, over the remainder of the century. One message that came through very clearly was that even though all four of the invited guests had very different ideas and different ways of expressing them, they all agreed that much managerial theory and what passes for 'best practice' are highly suspect. All four of them also stressed that there is a pressing need to look at things differently and, in so doing, to develop better ways of supporting the people and the organisations that are the NHS.

Six common themes

Although each of the workshops was rich in ideas in its own right, six key themes ran through all four.

First, Newtonian – or instrumental – views of the world are unhelpful and indeed, counterproductive, in trying to understand and act upon the social world. Linear, Newtonian ideas of causality – even quite sophisticated versions – provide unhelpful descriptions of social reality and are of little value in predicting the future. Models rooted in Newtonian thinking seek to predict the consequences of pursuing a given course of action. By contrast a systems, or developmental, approach is based on the premise that the future cannot be predicted in any useful degree of detail. The objective therefore must be to help organisations to learn continuously how to adapt more efficiently.

Second, if we view organisations as living systems, not machines, it becomes clear that they are transitory artifacts that reflect one – often ossified – stage in a continuous process of adaptation and renewal. Organisational structures, policies, jobs and roles are designed by group processes, cognitive capacities, environmental influences, and once conceived and implemented create an inertia resisting further change. The sources of this inertia include psychological attachment, power politics, 'sunk' investments and limitations to physical flexibility.

Third, it is important to recognise that every successful 'adaptation' incorporates the roots of its own failure. Natural systems adapt continuously to continuous changes in their environment. The most robust natural systems are those that adapt efficiently. Often, when organisations adapt to their environment successfully they fail to reflect on this success. When there is a recognition of declining success and of the need to change, attachments to the behaviours that created the initial success preclude a rethinking of the behaviour appropriate to the new situation. The assumption is that the behaviour is still appropriate but that performance needs to be enhanced. The response to changing demands is more of the same.

Fourth, control is different from order. Traditional models of management seek to diagnose what is wrong, prescribe what would be better and then devise a process for management to steer the organisation toward the desired state. In other words, these models try to help management to determine, and to control, the direction of change. When we view organisations as living systems however, it becomes clear that it is futile to try to control organisational change. The real challenge is to devise ways of freeing up organisations to adapt continuously in ways that will allow them to remain effective in changed external circumstances. In times of rapid change it is better to prompt and inspire self-organising order rather than to have to wait for a hierarchy to try to impose control on a dynamic, fast-changing world.

Fifth, information is the life blood of organisational change. It is what organisations use to learn and to transform

themselves. The generative properties of organisations are the creative and energising drivers of change. It is crucial to encourage all forms of feedback. Differences need to be expressed as clearly as possible and the resulting clarity used to generate new options and opportunities – not to close down and dampen options through negotiation, problem solving, bargaining and power politics.

Sixth, it is important to surface the unspoken, encourage 'legitimate' diversity and build constructively on conflict. From a systems perspective, the unspoken diversity and conflict constitute 'noise'. The chance event that can be utilised by the organisation to explore different system configurations may represent an evolutionary response by the system to its environment. Thus, connectedness and openness must be at the heart of our work.

Conclusion

In June 1995, the Faculty of the College were still engaged in trying to distil the implications of the workshops for their work. Pending their conclusions, the following quotation (from Goldstein, J. Beyond Planning and Prediction. *Organisation Development Journal,* 1992; 10(2)) offers a pointer to present thinking in the College:

> 'The planning and predictability bias of modern OD theory is not congruent with [modern systems] research ... Action research, with its emphasis on cycles of action, feedback, and response in organisational interventions, suggests that organisational change is not a part of a previously planned change strategy but that change is "discovered" as it happens. In this interpretation of action research, accidents, random events, serendipitous events, and crises are not envisaged as worst case scenarios. Instead, they need to be assimilated by the organisation just like surveys and interview results as a part of the process of development.' • *Gordon Best*

'There is a pressing need to look at things differently and, in so doing, to develop better ways of supporting the people and the organisations that are the NHS.'

Gordon Best
Fellow in NHS Management

Neslyn Watson Druee is associate non-executive director, West Lambeth Community Healthcare Trust and a trustee of St Thomas's Hospital. She is chair of the Race and Ethnicity Committee, Royal College of Nursing, and teaches on the Black managers' development programme and the senior Black women's development programme, Management College

London Mental Health Initiative

Over the last few years, the state of London's mental health services has come into public prominence as a result of several highly publicised incidents. The King's Fund has maintained a wide interest in mental health services. This concern, and continuing reports of pressures on acute psychiatric beds, problems with community services and controversies over supervision orders, have led to mental health being chosen as one of the main cross-Fund themes.

The result is the London Mental Health Initiative, a Fund-wide programme designed to improve the commissioning, management and delivery of services in the Capital. The work will involve a broad mix of people, from service users to policy-makers, who by working together will, it is hoped, succeed in making a distinctive impact on London's mental health services.

A range of developmental activity is already under way in the Fund, including a leadership and innovation programme for health service managers, support for health service commissioners, the development of service standards, and support for projects to establish sanctuaries for Black people with mental health problems.

The Sanctuary project

The Sanctuary project has been established as a response to the experience of Black people in the existing mental health system. It follows a general King's Fund theme of supporting the needs of ethnic minorities.

Research has indicated that Black people are more likely to be diagnosed as seriously mentally ill and are therefore also more likely to be subjected to compulsory admission under mental health legislation. This will result in them being liable to receive more severe treatment such as electro-convulsive therapy. Because of cultural reasons, Black people are also less likely to take up conventional community services. This means that there is a higher probability that they will present for treatment later, when the symptoms are more advanced and more difficult to treat. The Sanctuary project, based at two centres in Lambeth and Hackney, is an attempt to provide a facility which is both effective and culturally appropriate. Each centre will be accessible 24 hours a day and will offer a place where people can be assessed and receive treatment ranging much wider than medication. Other treatments on offer will include complementary therapies. The overall aim of the project is to provide Black people with a genuine alternative to hospital admission.

As the term implies, the Sanctuary centres will also offer a safe place to Black mental health users. It is hoped that they will see the centres as providing an environment where they can come to before a crisis has developed. The Lambeth centre will also offer respite for relatives of mental health users.

The King's Fund has provided resources to pay for development workers at each project, although in Lambeth this cost has now been subsumed in three years' major funding from health and social services. At present, plans for the Lambeth project are well advanced and the centre is due to open early in 1997. Some of the functions might be established earlier using accommodation from other similar projects. The Hackney project is at an earlier stage of development and as yet full funding and a site have not been identified. In both sites the development workers report to a steering committee composed of representatives from health, voluntary and social services. Both the Lambeth and Hackney projects are supported and advised by a development consultant at the King's Fund Development Centre.

Commissioning mental health services

New work focusing on the commissioning of mental health services is also being planned. Recognising the challenge presented by a primary care-led NHS, a programme is being developed involving GPs, their practice teams and other commissioning agencies. Help will also be made available to support health commissions and others who find themselves having to work in new ways and to take on new roles within the primary care-led agenda.

Although the London Mental Health Initiative is still evolving, it is clear that partnership must lie at the centre of activity. No one party has all the skills, knowledge and resources to make a difference. Collaboration will therefore be vital between service users and providers, between health and social care commissioners at both local and national levels, between generalist and specialist practitioners, and between statutory and voluntary organisations.

By working on several fronts intended to bring change in the shape and quality of mental health services, the Fund is in a unique position to exercise its diverse strengths and to harness the learning which is taking place. There are no illusions, however, about the enormity of the task. The challenges imply no less than finding ways of linking local experimentation with the development of strategic policy-making in the Capital. The key must be to explore the extent to which better mental health services may be created through the new primary care-led NHS. • *Janice Robinson & Sharon Jennings*

'By working on several fronts intended to bring change in the shape and quality of mental health services, the Fund is in a unique position to exercise its diverse strengths and to harness the learning which is taking place.'

Janice Robinson
Director of the community care development programme

David Crepaz-Keay is chair of Survivors Speak Out, which campaigns for the empowerment of people who have used or are users of mental health services. He is involved as an adviser on the King's Fund Mental Health Initiative, has worked with the Better Futures project and is currently participating in the Leadership and Innovation in Mental Health group at the Management College

Time to bridge the health divide

People who live in disadvantaged circumstances have more illnesses, greater disabilities and shorter lives than those who are more affluent. Statistics everywhere reveal that death rates at most ages are two or three times greater in disadvantaged than in affluent social classes.

Most of the main causes of death contribute to these differences and together they reduce the life expectancy of the least privileged by some eight years in Britain. Such inequalities have been documented for over a hundred years and exist across the developed world. What is particularly worrying in Britain, however, is that during the 1980s economic inequality grew more quickly than at any time since World War II and faster than in any other industrialised country. It is hardly surprising therefore that evidence is beginning to emerge that the health divide is widening.

The causes of inequalities in health are complex. Some of the factors that affect health, such as age, sex and genetic make-up, cannot be changed by individual choice or public policy. Others, however, are related to people's circumstances that could be improved. These include factors in the physical environment, such as the adequacy of housing, working conditions and air pollution; social and economic influences, such as income and wealth, levels of unemployment, the quality of the social environment and social support; behavioural factors and barriers to adopting a healthier personal lifestyle; and access to effective health and social services.

Tackling Inequalities in Health, published by the King's Fund in spring 1995, sets out an agenda for action for one example from each of these areas – housing, income maintenance, smoking prevention and access to health care.

Housing

Housing problems facing Britain today include homelessness, the poor physical condition of many homes and the social isolation and fear commonplace on many deprived estates. These problems have adverse effects on people's health. One well-documented example among many is that damp housing causes respiratory illnesses in children and stress among adults.

New policies are required to tackle these and related issues. Investment in new social housing and improving the existing housing stock should be promoted. Similarly, community regeneration schemes should be introduced to improve the environmental, economic and social structures of disadvantaged neighbourhoods. There are innovative ways in which such policies could be financed without putting a further strain on public expenditure. For example, removing the remaining mortgage tax relief would generate funds to invest in new homes, to reduce rents for social housing and to provide targeted help to owner-occupiers on low incomes.

Poverty

Decent incomes are essential to provide the prerequisites for health, such as shelter, food and warmth. Living in poverty magnifies the stresses and anxieties of daily living in health-damaging ways and reduces people's capacities for making healthy choices. It is not surprising therefore that people with the lowest incomes are much more likely to suffer poor health than those who are more affluent. Yet, a growing number of children are being brought up in poverty as a result of unemployment, lone parenthood, low wages and inadequate benefits.

The best way to help people escape from poverty would be to create real employment opportunities by improving education and training and expanding childcare facilities. The tax and social security system must also be reformed to promote a fairer distribution of income. A crucial first step would be to increase income support and family credit, especially the specific allowances for children. Possible ways of financing such improvements include the abolition of the upper limit on employee National Insurance contributions and higher marginal rates of income tax for wealthier people.

Smoking

Smoking-related diseases are the greatest single cause of premature deaths and excess illness in Britain. As smoking is now predominantly a habit of poor people it is a major cause of health inequalities. Particularly high smoking rates

are found among people who are unemployed and young adults with children, especially lone parents. Implicitly 'blaming the victims' by exhorting people to stop smoking, however, will do more harm than good. People's behaviours are significantly influenced by the adverse circumstances in which they live. A wide range of policies to reduce smoking must be strengthened. A total ban on advertising tobacco-related products, together with a real increase in their price would do most to reduce smoking, especially among the most disadvantaged groups. Substantially increasing the real price of cigarettes, however, would run the risk of reducing the incomes of some of the poorest people in Britain. It is an essential requirement, but it should not be contemplated in isolation from a broadly based strategy for eradicating poverty.

The National Health Service

The NHS is far from being the only or even the most important way of tackling health inequalities. However, the NHS does have a contribution to make. It must ensure that the historic commitment to equity of access to health care is fulfilled and lead a broader assault on the health divide.

At a minimum, the NHS must ensure greater equity of access to health care by distributing resources in relation to need and removing barriers that inhibit effective use of services. Ministerial decisions to dilute the redistributive impact of proposals to improve the allocation of resources to health authorities are disappointing in this respect. In addition, it is essential that the continuing development of GP fundholding does not diminish the capacity of local health authorities to assess the health needs of the population. In relation to service delivery the most effective way to remove barriers to access is to empower individuals and communities to define their own needs; to design services that are appropriate to users' lives; and to specify outcomes that reflect their priorities.

More generally, the DoH and the NHS have important leadership responsibilities to forge alliances with other government departments and local agencies to influence the social and economic determinants of people's health.

- *Michaela Benzeval*

'The health divide could be significantly reduced if the political will existed to promote fairer policies that would create healthy life expectancy opportunities for the whole population. A good time to start would be now.'

Michaela Benzeval
Senior Research Officer

Michaela Benzeval has worked at the Policy Institute since 1987. She is an editor of *Tackling Inequalities in Health – An agenda for action* published by the King's Fund in 1995

Living Options Partnership

After ten years the Living Options Partnership project, a joint venture with The Prince of Wales' Advisory Group on Disability, has come to a close. The formal end in March 1995 was marked by a successful conference in Birmingham which was attended by several hundred delegates involved in services for disabled people either as users, statutory agencies or, most important, as both. The notion of partnership between people who use services and those who have the statutory responsibility for providing them is the essence of the Living Options work, and the conference can be seen as a validation of the success of the project.

From lottery to partnership

Living Options is about partnership working to improve the planning, implementation and evaluation of services for disabled people. When the project began, services for disabled people were described as a 'lottery'. Statutory agencies did not appreciate the needs of disabled people and they had not grasped the concept that only disabled people could define the services that they needed. Much of the early work took place before the NHS and Community Care Act 1990, with its emphasis on user involvement, was put in place. Now disabled users are actually running services.

The Living Options grant programme has covered a wide range of activities, from funding packages of care for black disabled people to developing advocacy and peer counselling schemes. Perhaps the most innovative project was to fund the setting up of independent living schemes. This has meant the establishment of a legal trust for an individual disabled person so that health and social services could provide money directly for people to have the best package of care. This has been a major step forward towards providing services which are user-led and really based on disabled people's needs.

Another example of a successful needs-based scheme is the register of personal assistants for disabled people that is run in Southampton. This was created after disabled people revealed that one of the biggest problems was finding a replacement if their personal assistant left, particularly at short notice. The scheme keeps a register of personal assistants and also attempts to provide a temporary replacement.

The argument behind Living Options Partnership is that not only are services which are created and, where possible, run by disabled people better, they also offer greater value for money. Much of the most recent work to influence decision-makers has been based on this view.

The Living Options Principles

- Participation in the life of local and national communities is the right of all disabled people as equal members of society.
- Recognition that discrimination occurs as a result of the barriers disabled people face. Action needs to be taken to tackle discrimination on the grounds of disability, race, gender, sexuality or poverty.
- Autonomy is disabled people's freedom to make informed choices and control their own lives.
- Partnership between disabled people and service agencies to enable them to work together on an equal basis to plan, implement and evaluate services.
- Consultation to ensure services meet the needs of all disabled people.
- Information clearly presented in a way which is accessible to all disabled people.

One problem that remains is the lack of consistency in the standard of services throughout the country. Although the concepts are widely accepted, there is still great variation in putting them into practice. The key to uniform progress is a partnership between the statutory agencies and the users of services. The best outcomes in quality and effectiveness can only be achieved by working together. One mechanism that has been developed to help overcome local variations is the development of guidelines for purchasers.

Evaluation of services has also been at the centre of Living Options work. Until recently, service providers would

analyse the evaluations, make interpretations and draw conclusions. The key issue here is that the disabled people who use the services should evaluate their quality and then be involved in interpreting the information and in the decision-making process that follows.

Looking ahead

The next phase of good practice is for planners of services and facilities to take on the needs of disabled people right from the outset. This is about understanding much more than ensuring physical access. It is about integrating the needs of disabled people into all areas of health and social service provision.

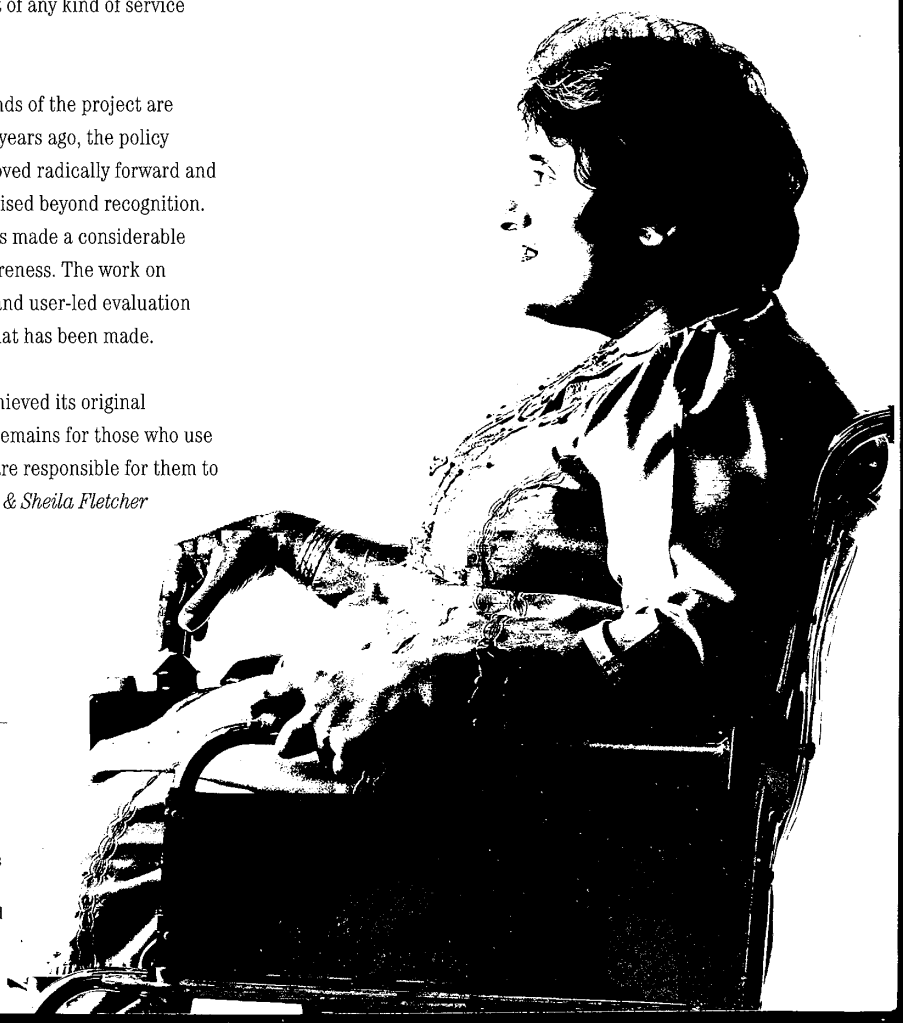
Disabled people do not just have disabilities. They also suffer from the same conditions as the rest of the population. Health planners need to understand that disabled people get flu and need cervical smears just like everyone else. The next big step is to realise that disabled people are not just consumers of disability services and this should be recognised at the outset of any kind of service planning.

At the time of writing, the loose ends of the project are being tied up. Compared with ten years ago, the policy agenda for disabled people has moved radically forward and the level of awareness has been raised beyond recognition. The Living Options programme has made a considerable contribution to this raising of awareness. The work on partnerships, independent living and user-led evaluation are all examples of the progress that has been made.

The Living Options project has achieved its original objective, and the challenge now remains for those who use statutory services and those who are responsible for them to take up the baton. • *Nasa Begum & Sheila Fletcher*

'The notion of partnership between people who use services and those who have the statutory responsibility for providing them is the essence of the work.'

Nasa Begum & Sheila Fletcher
Co-Directors, Living Options Partnership



Nasa Begum was co-director of Living Options Partnership which came to an end in March 1995 after ten years. Living Options was based on partnership between disabled people and statutory services; this partnership has now been cemented sufficiently for the project to have achieved its major purpose

Financial review

The following pages contain abridged financial statements extracted from the full accounts of the King's Fund, which are available on request.

At 31 December 1994, the valuation of the Fund's net assets was £119.7m, a decrease of £11.3m over the year.

The overall value of securities was £89.3m at the year end, a decrease of £9.9m over 1993. This decrease was attributable to the significant decline in stock markets worldwide, offset in part by profits arising from sales of securities. During the year, the value of the Fund's holdings in investment property decreased by £7.4m to £8.9m, as a result of the sale of two major investments, offset by a marginal increase in the value of the remaining property portfolio. The value of King's Fund premises increased by £5.5m to £19.1m, owing to the additional expenditure incurred in relation to the Fund's new offices in Cavendish Square. Other assets, including computer equipment and net current assets, increased by £0.5m to £2.4m, reflecting increased investment in information technology to reduce operational costs and increased cash holdings arising from property sales, earmarked for further investment in the Cavendish Square project.

Total income for the year amounted to £12.1m, of which £4.8m was investment and other income and £7.3m was received by way of grants from other bodies or was generated as fees for services provided by the Fund. This compares with a total income in 1993 of £12.8m, of which £5.7m represented investment and other income. The decline in investment and other income during the year reflected changes made in investment policy and had been anticipated in the Fund's operational budgets. Total expenditure of the Fund was £13.8m (compared with £13.0m in 1993), including grants allocated of £2.0m (£1.9m in 1993). The overall deficit for the year of £1.8m was in line with budget and was met from the General Fund.

During 1995, the Fund will move in its entirety to Cavendish Square, and the indications are that all other Fund premises will have been sold by the time of the move. This will enable the Fund to optimise its future investment strategy to ensure that adequate finance will be available to support the Fund's operations in its new unified and potentially more effective form.

The average number of staff employed by the Fund during the year was 253 (compared with 252 in 1993), of whom 68 (74 in 1993) were funded by grants from other bodies.

The Treasurer gratefully acknowledges all contributions, including legacies, 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 Ltd
Midland Bank plc

Auditors

Coopers & Lybrand

Solicitors

Nabarro Nathanson

Contributors in 1994

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

D & W Backhouse

CASPE
A H Chester
N H Clutton

V Dodson
K Drobig

S M Gray

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Morgan Grenfell Group plc

G Pampiglione

The Rank Foundation
Alber Reckitt Charitable Trust
River & Mercantile Investment Management

L V Stell
Sussman Charitable Trust

The Wernher Charitable Trust
D & K L Welbourne

Joanna Ibarra is programme co-ordinator, Community Hygiene Concern, which was set up to 'protect people and pets against parasites'. Community Hygiene Concern is partly funded by a grant from the King's Fund

Abridged statement of assets and liabilities

as at 31 December 1994

	Market Valuation	
	1994	1993
	£000	*£000*
Capital Fund	**38,814**	43,801
General Fund	**80,880**	87,201
Special Funds	**–**	24
	119,694	131,026
Represented by:		
Capital Fund		
Portfolio investments	**36,611**	43,121
Net current assets	**2,203**	680
	38,814	43,801
General Fund		
King's Fund premises	**19,127**	13,621
Computer equipment	**651**	472
Portfolio investments (incl. Investment Property)	**61,548**	72,349
Net current assets/(liabilities)	**(446)**	759
	80,880	87,201
Special Funds		
Portfolio investments	**–**	–
Net current assets	**–**	24
Net assets	**119,694**	131,026

In our opinion the abridged financial statements on pages 30 and 31 are consistent with the annual accounts of the King's Fund for the year ended 31 December 1994 and comply with the King Edward's Hospital Fund for London Act 1907.

Coopers & Lybrand
Chartered Accountants and Registered Auditors
April 1995

Abridged income and expenditure account

for the year ended 31 December 1994

		Income	Expenditure	1994 Net	1993 Net
		£000	*£000*	*£000*	*£000*
Investment and other income and receipts					
Securities and cash assets		**4,018**	**163**	**3,855**	4,705
Properties		**736**	**230**	**506**	542
Donations		**12**	**–**	**12**	8
Available to service the operations of the Fund		**4,766**	**393**	**4,373**	5,255
Operations of the Fund	*£000*				
King's Fund Centre		**2,480**	**3,373**	**(893)**	(881)
Contribution from DoH	*673*				
Conference fees etc.	*551*				
Grants from other bodies	*1,256*				
King's Fund College		**3,234**	**4,767**	**(1,533)**	(1,173)
Fees and service charges	*3,234*				
King's Fund Institute		**60**	**623**	**(563)**	(547)
Fees and publications	*60*				
King's Fund Organisational Audit		**1,221**	**1,476**	**(255)**	(128)
Fees for services	*1,033*				
Grants from other bodies	*188*				
King's Fund Other Projects		**192**	**361**	**(169)**	(41)
Grants from other bodies	–				
Grants allocated		**100**	**2,001**	**(1,901)**	(1,833)
Grants lapsed	*100*				
Net cost of operations		**7,287**	**12,601**	**(5,314)**	(4,603)
Administrative costs					
Head Office staff			**530**	**(530)**	(479)
Head Office other			**185**	**(185)**	(161)
Professional fees			**92**	**(92)**	(214)
Maintenance of premises			**11**	**(11)**	(41)
Total administrative costs			**818**	**(818)**	(895)
Total net expenditure				**(6,132)**	(5,498)
Totals of income and expenditure		**12,053**	**13,812**		
Excess of expenditure over income				**(1,759)**	(243)

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Annual Report 1994

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