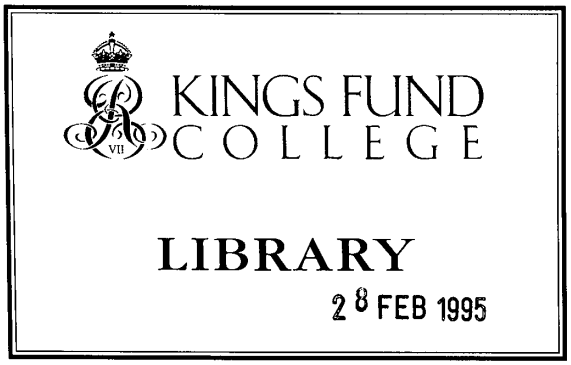
LONDON Monitor

Number 2

Focusing on London's health services



LONDON Monitor

Number 2

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CONTENTS

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Seán Boyle
Editor

FOREWORD

This is the second edition of *London Monitor*, edited by Seán Boyle, Fellow in Health Policy Analysis at the King's Fund, which we published for the first time in 1994. The purpose of *London Monitor* is to serve London by presenting facts without sanitising them; providing independent and informed commentary; and, supplying a forum for discussion. Our hope is that *London Monitor* can be used by everyone, whatever their differences of opinion, rather than wrangling endlessly over the statistics.

The 1995 edition is structured in four parts. The first part is a calendar of events in London's health care during 1994. This is followed by a commentary by the editor, Seán Boyle. In the third section, we present the relevant facts and figures based on the latest available evidence. *London Monitor* concludes with a set of articles by four individuals who each play a role in London's health care, ranging from the medical adviser to the London Implementation Group to the Director of the Greater London Association of Community Health Councils. The theme of this fourth section is 'Making Change Happen', and the contributors have been chosen with this in mind – moving on from discussion of the policy issues to the processes of implementation.

Where does the King's Fund itself now stand? Has the Fund changed its mind since the publication of *London Health Care 2010* in June 1992?

I addressed these questions in the King's Fund paper, *What next for London's Health Care?*, published in August 1994. Our recommendations for London remain the same: that over the 18-year period reviewed in our Commission's report, up to the year 2010, the balance of London's health services needs substantially to change. In this we would agree with the Secretary of State for Health, who has been courageous in sticking to an unpopular position. London needs better primary health care; better provision for frail elderly people and for people who are mentally ill; more general and less specialist hospital care; and, fewer and stronger specialist medical departments. Moreover, changes in patterns of care mean over the years a continuing reduction in acute hospital beds and in the number of principal general hospitals.

What worries me is not the long-term policy direction but the pace and handling of the changes. Ideally, three elements should provide security and confidence:

- new services should be put in place before old ones are closed;
- there should always be capacity in the system to deal with emergencies and crises so that no patient suffers indignity or neglect;
- everyone (public, professionals, institutions) should see potential gains as well as losses in what is happening around them and as many people as possible should be committed to the changes.

In general terms, what we have been experiencing in London feels as unlike this description of the ideal process as one could readily imagine. Of course, change on this scale was never going to be easy and to say that all is not well is not meant as a criticism of individuals. In part, it simply underlines the fact that determining the desired policy direction is much, much easier than bringing it about on the ground. My plea, however, is for much more attention to the pacing and sequence of the changes; to the incentives to bringing them about; and to gaining local understanding and ownership of what happens next, area by area. We badly need to move on from intellectual debate, power politics and institutional infighting to rebuilding London's health services in their new shape.

Robert J Maxwell
Secretary and Chief Executive
The King's Fund
February 1995

A Calendar of Events in London in 1994

In the last 12 months there have been a number of developments in the delivery of health care services in London. This section presents a calendar of important events during this period and a brief commentary on each one.

January 1994

5 **South West Thames Regional Health Authority** (RHA) approves merger of Wandsworth with Merton and Sutton health authority, and transfer of parts of Putney from Kingston and Richmond health authority to the new authority.

6 **Speculation** continues over the future of Guy's hospital as a firm decision is awaited. North East Thames RHA recommends decisions on trust status for University College London hospitals, Great Ormond Street hospital and the National Hospital for Neurology and Neurosurgery should be deferred.

6 **Criticism** from other acute hospital providers of Government intervention in the NHS market in London focuses on recent decision of Secretary of State for Health, Virginia Bottomley, to secure the future of University College London hospitals by giving transitional funding so as to allow prices to be reduced.

6 **Peter Griffiths,** former Chief Executive of Guy's and Lewisham Hospital Trust, becomes deputy Chief Executive of the independent health care charity, the King's Fund.

11 **Tom Sackville,** Parliamentary Secretary for Health, announces creation of new District Health Authority (DHA) in south London, Bexley and Greenwich, with effect from 1 April 1994, to replace existing Bexley and Greenwich health authorities.

11 **Royal College of Nursing survey,** *Waiting for Beds,* finds that patients being admitted from A&E are waiting overnight for a bed in almost half of the departments in London compared with a national figure of one in three.

12 **Lambeth, Southwark and Lewisham Family Health Services Authority** (FHSA) launches a mobile GP surgery to allow local GPs to perform minor surgical operations on their patients while the unit is stationed in the car parks of local stores. A theatre nurse from Guy's and St Thomas' Hospitals Trust will be responsible for daily running of the unit and it is estimated that 2,400 operations per annum will be carried out.

13 **Ian Donnachie,** Chief Executive of Riverside hospitals, leads a team developing a proposal for a Trust merging Charing Cross hospital and Hammersmith and Queen Charlotte's hospitals in west London, leaving the new Chelsea and Westminster hospital in a position to form an independent Trust.

18 **King's College hospital** attributes recent long delays in admitting patients as emergencies from A&E department to increase in patient numbers.

20 **David Hirst,** Chief Executive of North Middlesex Hospital Trust, reports hospital is facing extreme financial pressure and introduces number of cost-cutting measures as financial deficit of £1.5 million is forecast.

20 **Secretary of State for Health** says that long waits on trolleys in A&E departments – a particular problem in London hospitals – are unacceptable. Health authorities are instructed to ensure hospitals with which they contract are able to react promptly to short-term fluctuations in emergency workload.

20 **Figures** obtained by Labour MP, Nigel Spearing, show London Ambulance Service (LAS) emergency response times deteriorated between September and October 1993. The LAS will receive extra investment of £14.8 million in 1994-95 which will help to fund 120 new ambulances and extra staff and training.

27 **Baroness Cumberlege,** Parliamentary Secretary for Health, opens new £100,000 children's day care unit at Mayday Healthcare Trust in Croydon.

27 **Secretary of State for Health** announces decisions on fourth wave trusts but a number of London applications await decision including all of the Special Health Authority (SHA) hospitals, Newham Healthcare, Tavistock and Portman, and the proposed Royal Hospitals Trust (a merger of the Royal London, Bart's and London Chest hospitals). The applications of Riverside Acute Trust and Hammersmith and Queen Charlotte's are withdrawn, and a different reconfiguration involving two separate trusts, one, a merger of Hammersmith and Queen Charlotte's, Charing Cross and Acton hospitals and the other, Chelsea and Westminster Healthcare, will now be decided on in March. Decision on merger of Mount Vernon Trust and Watford General hospital is also expected in March. Proposed merger between University College London hospitals and Royal National Throat, Nose and Ear (RNTNE) hospital has been deferred, with RNTNE remaining a separate trust, and UCLH undertaking public consultation on an application in its own right.

31 **Secretary of State for Health** announces eight new regions to replace the existing 14 authorities. North West Thames and North East Thames combine as North Thames, and South West Thames and South East Thames as South Thames. The Chair of North Thames will be Sir William Staveley, currently chair of North East Thames RHA, and that of South Thames will be William Wells, currently Chair of the Royal Free NHS Trust.

February 1994

1 **The Charity Commission** appoints a receiver at the independent 200-bed Royal Masonic hospital in west London.

5 **Rumours** that Guy's hospital will be closed lead to charities discussing the possibility of claiming refunds of donations made for the construction of the £140 million Phillip Harris House, a state-of-the-art development on the Guy's site. Liberal Democrat MP, Simon Hughes, refers the matter to the House of Commons Public Accounts Committee.

7 **Labour Party** releases figures which it is claimed show that the number of GPs, district nurses and health visitors working in London has declined between 1990 and 1993.

7 **David Hirst,** Chief Executive of North Middlesex Hospital Trust, resigns after a vote of no confidence by the hospital's medical committee.

10 **Secretary of State for Health** announces further plans for the rationalisation of London's hospitals. These include the transfer of most services from Guy's to St Thomas' hospital. The following new trusts were approved from April 1: Moorfields Eye hospital; Royal Bethlem and Maudsley hospitals; Royal Brompton National Heart and Lung hospitals; Royal Marsden hospital; Royal (London) hospitals; Newham Acute hospital; Tavistock and Portman Clinics; and the Great Ormond Street Hospital for Sick Children. Trust applications from the National Hospital for Neurology and Neurosurgery, and the Eastman Dental hospital were refused.

10 **Parkside Community Health Council** (CHC) and Westminster Users Mental Health Forum express concern for continuity of services arising out of Westminster Local Authority's decision, announced in 1993, to put its existing community mental health services out to tender, which they claim would thereby effectively privatise services.

10 **Secretary of State for Health** announces that negotiations have started to buy the Queen Elizabeth Military hospital in Woolwich from the Ministry of Defence with a view to replacing facilities at the Greenwich and Brook hospitals.

15 **Signs of recovery** in the housing land market may enable health authorities to make substantial gains from the disposal of unwanted buildings and land in London. A £100 million development is announced on the current site of the Highland hospital, Enfield, whose services will be transferred, by 1997, to Chase Farm hospital.

16 **Dawn Primarolo,** Labour Party health spokesperson, reveals that London has lost 9,100 hospital beds in the last five years.

17 **Dr Brian Mawhinney,** Minister for Health, announces extra funding of £12 million to deal with waiting lists, of which £3 million will go to London.

23 **Prime Minister, John Major,** opens new £14 million Critical Care Complex at King's College hospital, housing ten operating theatres and 18-bed intensive care unit.

23 **GPs in Westminster and Newham** plan to set up multi-funds of 19 practices each, in the fifth wave of GP fundholding.

24 *Inquiry into the Care and Treatment of Christopher Clunis,* chaired by Jean Ritchie QC, reveals *'a catalogue of failure'* in the case of Christopher Clunis, a psychiatric patient who killed a man in a London tube station in December 1992. Lack of resources is identified as a part of the problem and the report calls for more funds, especially for medium-secure and general psychiatric beds in London, as well as accommodation for those who cannot cope in the community.

24 **Secretary of State for Health** announces an extra £10 million for community-based mental health services in London.

March 1994

1 **Brian Jarman,** Professor of Primary Care at St Mary's Hospital Medical School, in evidence to Labour MPs' inquiry into London's health services, claims the Tomlinson report is flawed because it was based on acute bed figures rather than all beds in London including those for elderly and psychiatric care as well as residential and nursing home beds. He claims that taking account of all categories of bed, London has fewer beds per capita than the rest of the country.

10 **LAS 1994-95 business plan** recognises that national standards for response to emergency calls – 95 per cent response within 14 minutes – will not be met in London until the end of 1996: targets are set at 80 per cent in 14 minutes by September 1994 and 85 per cent by April 1995.

11 **Internal inquiry** calls for improved staffing levels and organisation in the A&E department at Greenwich hospital following the death, described by a coroner as a *'catalogue of disasters'*, of an elderly woman there in September 1993 who was *'lost'* by staff in the hospital.

14 **Sir Bernard Tomlinson,** in a letter to the Times, rejects Professor Jarman's criticisms of his report on London's health services and maintains that there should be a shift in the balance of care from *'costly high-technology hospitals to more and better primary and community care'*.

15 **New NHS regional directors** are announced with Ron Kerr, currently Regional General Manager (RGM) at North West Thames RHA taking the North Thames post, and Chris Spry, current RGM at South West Thames taking the South Thames position.

17 **Professor Brian Jarman** analyses latest Department of Health figures on bed availability in London to show that, for 1992-93, London has 2.58 acute beds per 1,000 population compared with an England figure of 2.33.

17 **London Boroughs of Islington and Hackney** are granted leave to seek a judicial review of the decision to close Bart's A&E department.

17 **Association of London Authorities** claims LAS response times are getting worse. Proportion of responses within 14 minutes was 57 per cent in December 1993 compared with 59 per cent a year earlier and a Patient's Charter standard of 95 per cent. Parliamentary Secretary for Health, Tom Sackville, claims there has been an investment of £14 million for new vehicles and more staff.

17 **City and East London Community Health Services** (CELFACS) will become operational on 1 April after some delay while the final details of its responsibilities for services were determined. Employing 4,000 staff, CELFACS will have responsibility for provision of a range of services including mental health, long-stay care for elderly people and physiotherapy, but excluding midwifery and obstetric care about which there was local disagreement. CELFACS's goal is to facilitate development of seamless primary and community services in east London.

21 **Secretary of State for Health** announces the creation of four new hospital trusts in London with effect from 1 April: Chelsea and Westminster Healthcare; the Hammersmith Hospitals Trust, incorporating Hammersmith and Queen Charlotte's, Charing Cross and Acton hospitals; Mount Vernon and Watford Hospitals Trust; and University College London Hospitals Trust; and one new community trust, Harrow and Hillingdon Healthcare. Sir Christopher Bland is appointed Chairman of the new Hammersmith Hospitals Trust which the Secretary of State envisages will operate from its two main sites for the foreseeable future. The original application for the trust had indicated that services would be delivered on just one site with a reduction of bed numbers from 1400 to 800 but this will now be reviewed by the trust board. It was also announced that the RNTNE Trust would continue to operate as a stand-alone trust.

24 **Parkside Community Health Trust** announces development of £5.3 million community care centre on site of former Soho Hospital for Women.

26 **Charities and private donors** respond to the decision to transfer specialist services from Guy's to St Thomas' by stopping promised donations to the development of Philip Harris House and asking for the return of money already given.

31 **London waiting lists** rise by nine per cent to 165,000 between July 1993 and January 1994, according to analysis of official figures by the pressure group, London Health Emergency.

31 **Health Committee** of the House of Commons announces that it intends to carry out an inquiry into the London Ambulance Service.

April 1994

2 **Receiver** appointed by the Charity Commission recommends the Royal Masonic hospital should be sold and the proceeds applied to the benefit of sick freemasons. He reports that the hospital which has a deficit of £2 million may no longer be fulfilling its original objective to provide care for freemasons, as few masons now use the hospital.

7 **John Bowis,** Parliamentary Secretary for Health, announces £1.5 million Government investment in community psychiatric teams established to help homeless people in London with mental health problems.

7 **David Blunkett,** Labour Shadow Health Secretary, criticises a plan to convert a 28-bed ward in the new Chelsea and Westminster hospital into a 15-bed private ward, saying these beds should be used to reduce NHS waiting lists in London. North West Thames RHA estimates this new ward will raise £1.5 million per annum in private patient revenue, with a forecast profit of £350,000.

13 **Islington Mental Health Consortium and Riverside Mental Health** are among recipients of new wave of grants under Mental Health Task Force 'Supporting Specific Projects' initiative.

14 **Colin Reeves,** who was Finance Director of North West Thames RHA, is appointed NHS Executive Director of Finance and Corporate Information.

15 **Parliamentary Question** reveals less is spent per capita on health care in London than in many other cities in England. Labour MP for Dulwich, Tessa Jowell, claims this calls into question Government argument that too much is spent on health care in London.

20 **Judicial review** of the decision to close Bart's is told by Lord Lester QC, acting for the boroughs of Hackney and Islington and a local resident, who have brought the case before the High Court, that the consultation procedure was flawed as the Secretary of State for Health had effectively decided to close the site before statutory consultation began.

21 **Analysis** by the pressure group, London Health Emergency, shows London lost nearly 9,500 acute hospital beds between 1982 and 1993, and claims that 2,000 further beds will go as a result of rationalisation at Bart's, Guy's, Charing Cross and the Hammersmith hospitals.

25 **High Court** rejects the legal challenge by the boroughs of Hackney and Islington and a local resident to Secretary of State for Health's decision to close Bart's A&E department, and refuses leave to appeal.

27 **A study by the London Research Centre,** *Londoners' Views on the Future of Health Care,* published by the King's Fund, finds that Londoners want to retain well-resourced hospitals acting as centres of excellence together with an expanded range of good primary care services.

27 **Controversy** in the Commons as the Prime Minister, John Major, repudiates Department of Health instructions that reporters should not be allowed to accompany the Labour Party leader, John Smith, on a visit to Bart's A&E department.

28 **King's Fund report,** *London: the Key Facts,* argues that purchasing power for hospital and community health services in London should be increased by £200 million in order to meet the extra needs of London's deprived population. It re-iterates the view that primary and community services must be improved before acute hospital services are reduced.

28 **During a Commons Opposition debate** on health care in London, Secretary of State for Health defends plans to reshape London's health services. Labour Party leader, John Smith, calls for an immediate moratorium on hospital closures in London, and is accused of turning the NHS into a *'political football'* by the Prime Minister, John Major.

29 **Internal inquiry** is initiated at University College London hospitals following the death of a six-month old child who waited three hours for treatment.

29 **Fresh controversy** over claimed differential treatment of Conservative and Labour Party politicians as Michael Portillo, Chief Secretary to the Treasury, visits the Royal Free hospital as part of the Conservative local government election campaign in Hampstead but Dawn Primarolo, Labour Party health spokesperson, is prevented from visiting Kingston hospital before May 5, the date of the local election.

May 1994

5 **Anthony Close,** Group Director of Personnel with Trust House Forte, is appointed, on an interim basis, to the Chair of the Health Education Authority.

5 **South Thames Regional Office** announces intention to appoint 18 extra consultants at a cost of £1.6 million in effort to reduce junior doctors' working hours in line with Department of Health policy.

6 **Resignation of Professor Kay Davies,** world expert on gene therapy, from the post of Director of the Medical Research Council's Clinical Sciences Centre, Hammersmith hospital, is attributed to uncertainty around the future of Hammersmith and Charing Cross hospitals and the increase in hospital administrative duties which has followed.

12 **The former North East Thames RHA** makes out-of-court settlement with consultant paediatrician, Bridget O'Connell, who has been suspended since 1982 on full pay. The RHA apologises for the damage caused to her professional standing and agrees to discontinue disciplinary proceedings. Total cost of this affair, which is reckoned to be substantial, is the subject of National Audit Office inquiry which will report to the Public Accounts Committee of the House of Commons later in 1994.

20 **City of London businesses** help to raise funds to continue the campaign to keep Bart's A&E department open by lodging an appeal against the recent decision to disallow a judicial review of the Secretary of State for Health's decision to close the unit.

27 **Ian Donnachie** resigns as Chief Executive of Chelsea and Westminster Hospital Trust to become Chief Executive of Bradford purchasing agency. Operations Director Sonia Mills takes over as temporary Chief Executive.

31 **Report published** by the pressure group, London Health Emergency, claims that London has fewer hospital beds per capita than almost any capital city in Europe.

June 1994

6 **Westminster Local Authority** awards £1.2 million annual contract for the provision of local authority mental health services to Riverside Mental Health Trust, thereby facilitating closer co-ordination of health and social services for those with mental health problems. It was originally feared services might be contracted out to separate providers.

8 **Middlesex hospital** opens 14-bed private ward and a private operating theatre to NHS patients to help to reduce waiting lists. The health service union, Unison, claims this is due to bed shortages resulting from the closure of five wards in 1993.

9 **Professor Maurice Lessof,** Chair of Lewisham Hospital Trust, in a letter to staff, voices concern about the effect on quality of care and staff morale of the financial pressures which the trust is facing as it looks for further efficiency gains of £2 million in 1994-95.

15 **Patient sectioned** in London under the Mental Health Act is transported from Charing Cross hospital to a hospital in Leicester because bed on a locked ward cannot be found anywhere nearer. Chris Heginbotham, Chief Executive of Riverside Mental Health Trust, points to the difficulties of developing community services in a situation where there are insufficient acute psychiatric beds in the capital. Alan Langlands, NHS Chief Executive, indicates more money is likely to be made available for acute mental health services in London.

16 **NHS Clearing House** for staff who are affected by changes in configuration of hospitals in London, is extended to include managers as well as nurses and clinicians.

17 **Analysis** by the pressure group, London Health Emergency, shows that the number waiting for NHS treatment in London has increased by 14 per cent to 165,000 between March 1993 and March 1994.

19 **Nasima Begum,** an east London girl, dies in Royal London hospital after waiting 53 minutes for an ambulance to arrive.

20 **Secretary of State for Health** opens new £3 million Cardiac Catheterisation Facility at St George's Healthcare Trust in Tooting.

23 **Report** by management consultants for Wandsworth Local Authority calculates that Wandsworth health area, which is expected to lose £18.3 million of its £87.2 million budget under current regional formula for allocating financial resources, should reclaim £13.8 million under a fair and comprehensive assessment of local health needs which takes full account of the extra needs of inner cities.

23 **Brent & Harrow Health Agency** issues consultation document, *Acute Services Strategy: a basis for discussion*, which proposes the closure of Central Middlesex A&E department with future in-patient contracts favouring Northwick Park Hospital Trust and St Mary's Hospital Trust. Local health pressure groups see this as threat to Central Middlesex hospital.

24 **Launch of a £4 million project, London Health Partnership,** funded by the King's Fund, the Department of Health and a number of trusts, in conjunction with businesses, with the aim of improving health services for elderly people in London.

29 **Publication of the first hospital league tables** shows considerable variation in performance of London hospitals on criteria such as proportion of outpatients seen within 30 minutes and proportion of patients waiting longer than three months for an operation.

29 **LAS** is revealed as the worst ambulance service in the country with just 62.2 per cent of ambulances arriving within the ORCON standard 14 minutes compared to a Department of Health guideline of 95 per cent.

30 **Redbridge and Waltham Forest Health Authority** reveals likely £4 million budget deficit in 1994-95 and faces a possible reduction in its allocation of £7.8 million in 1995-96, but rejects demand from local GPs, consultants and patient groups for public inquiry into running of health services in the area.

July 1994

5 **Brian Jarman,** Professor of Primary Care at St Mary's Hospital Medical School, delivers a University of London lecture – *The Crisis in London Medicine; how many hospital beds does the Capital need?* – which questions the closure of hospital beds in London and asks if the current level of funding for London health authorities is sufficient.

6 **The inner London purchasing agencies,** with London Implementation Group support, set up an investigation to determine the appropriate level of bed resources for London, and agree to work with Brian Jarman to achieve a maximum consensus on the facts.

7 **City and East London Family and Community Health Services** (CELFACS) issues a consultation document proposing that it develops as a single trust running primary and community health services in east London. However, possibility of three separate trusts covering the erstwhile districts of Tower Hamlets, Newham, and City and Hackney is not ruled out.

14 **St Mary's Hospital Trust** obtains planning permission for office and retail development on the Paddington site which, it is claimed, will help to move the hospital into the 21st century. Interest is being sought from potential developers.

15 **John Cooper,** currently Chief Executive of the Royal Free Hospital Trust, becomes Chief Executive of the Hammersmith Hospitals Trust.

16 **Royal Free Hospital Trust** instructs GPs, as of 1 September, not to refer non-urgent Camden and Islington patients from outside local Hampstead area so as to reduce the number of patients treated. Camden and Islington Health Authority rejects this as unacceptable.

18 **Judge Bathurst Norman** criticises Ealing, Hammersmith and Hounslow Health Agency for failing to find a bed so that a mentally ill woman, in prison since October 1993, can be psychiatrically assessed for fitness to plead. She is remanded in custody until October.

19 **Harrow Crown Court** fines Parkside Health NHS Trust £50,000 after the trust accepts responsibility for the death, in January 1993, of an elderly patient because of what the judge describes as lack of care.

21 **City and Hackney CHC,** in a response to a consultation document issued by East London and City Health Authority in April 1994 – *A proposal for the future of hospital services for children in East London* – criticises plans to close Queen Elizabeth's Hospital for Children in Hackney and disperse children's services across east London.

22 **Exodus of leading medical scientists** such as Professor Bob Williamson of St Mary's hospital and Professor Lucio Lazzatto of the Hammersmith hospital from top posts in leading research departments in London hospitals is blamed on the NHS reforms: Lazzatto describes the reforms as a repudiation of the research base of medical care, and Williamson criticises them for introducing a competitive rather than co-operative and caring ethic to both medicine and research.

27 **Barnet and Brent & Harrow health agencies** issue joint consultation, *Changes in Service Provision in the Edgware Area*, recommending the closure of A&E department at Edgware hospital and the removal of in-patient services.

28 **Gerald Malone,** the new Minster for Health, is given specific responsibility for London.

28 **Local CHCs** combine with local authorities in their opposition to proposals from Barking and Havering purchasing authority to close A&E department at Oldchurch hospital, centralising services at Harold Wood hospital.

28 **Royal Free Hospital Trust** defers, until a Trust Board meeting in September 1994, decision on suggested prioritisation for elective surgery of certain areas of Camden & Islington health authority.

28 **Bart's losses of £7 million** of contract income in 1993-94 are partially covered by the use of £4 million of grant finance from special trustees of the hospital as well as £4.4 million of transitional funding from LIG.

29 **Court of Appeal** refuses campaign group leave to launch a judicial challenge to the decision of the Secretary of State for Health to close Bart's A&E department. Gerry Green, Chief Executive of the Royal Hospitals Trust, which includes Bart's, the Royal London and London Chest hospitals, announces plan to split services between the Royal London Whitechapel site and Bart's until the year 2000 when all services will be transferred to Whitechapel, at a cost of £144 million. Bart's A&E department is expected to close by the end of 1994.

August 1994

1 **Report from Robert Maxwell,** King's Fund Chief Executive, *What next for London's health care?*, calls for a cautious approach to the closure of hospitals in London. He urges a moratorium on further reductions in overall bed capacity and a review of the management and pace of change. While applauding achievements in primary care, Maxwell believes special transitional funding for London should be maintained over the next three years in return for a programme of change agreed with purchasers and providers, area by area.

3 **Dawn Primarolo,** Labour Party health spokesperson, contrasts increases of 48 per cent (668) in number of managers running GP practices in the Thames regions (covering London) with a fall in the number of GPs in London, between October 1990 and October 1993, from 3,223 to 3,200.

9 **Secretary of State for Health** announces that savings of £4.2 million on administrative costs are expected from the merger of North East and North West Thames RHAs.

9 **John Bowis,** Parliamentary Secretary for Health, announces award of £750,000 to projects aimed at helping young homeless people in London, as part of the Single Homeless Young Persons Initiative, which was launched in January 1991.

15 **Camden Councillor** organises public meeting to protest at proposals tabled by Royal Free Hospital Trust to restrict access for some non-urgent surgery to residents of certain areas of the Camden and Islington Health Authority.

18 **Evaluation** of the cost effectiveness of the London helicopter ambulance service by Medical Care Research Unit at Sheffield University, on behalf of the Department of Health, finds no reliable evidence of improved outcome or survival where the helicopter is involved.

22 **Havering Hospitals NHS Trust** concentrates its A&E services on one site at Oldchurch hospital and a Minor Injuries Unit is set up at Harold Wood hospital, in first phase of plan to centralise all A&E services at Harold Wood.

24 **Controversy** surrounds statements by Dr David Bihari, Director of the Intensive Care Unit at Guy's hospital, that computer-aided diagnosis might help to produce more cost-effective treatment of patients who are likely to die. Spokesperson for Guy's emphasises that such a computer was not being used currently for purpose of clinical decision-making.

25 **Joint report from the pressure group, London Health Emergency,** and the health union, Unison – *Rings of Crisis* – reveals proposed closures of A&E departments in up to 12 hospitals around London (seven of which are in outer London) based on analysis of plans of London health purchasers. However, no firm decisions have been made in most cases.

25 **Maudsley hospital** announces development of new psychiatric research centre, headed by Sir Michael Rutter, who is Director of the MRC child psychiatry unit. With initial funding of £2.6 million from Medical Research Council, the unit is reported to be recruiting leading US scientists, contrasting with recent losses of top medical researchers from London.

25 **Secretary of State for Health** writes to Association of London Authorities that she will not intervene to stop bed closures in London as these are determined at a local level.

September 1994

1 **Secretary of State for Health** announces that merger of South East and South West Thames RHAs is expected to save up to £6.5 million after April 1996.

2 *Five Essays on Emergency Pathways,* a report from a team of researchers led by David Morrell, former Professor of General Practice at the United Medical and Dental Schools at Guy's and St Thomas', and published by the King's Fund, points to some of the major problems occurring in the management of acutely ill patients in London and casts doubt on the theory that improvements in general practice in inner London will modify the demands made on London's A&E departments.

5 **Gleneagles Hospital (UK) Ltd** announces planned new £25 million 100-bed private hospital development on site of old National Heart hospital in Marylebone to specialise in treatment of cardio-vascular disease.

6 **Bob Nicholls,** Chief Executive of the London Implementation Group (LIG), confirms that LIG, which was set up to oversee the implementation of changes to London's health services, will be wound up over the next six to nine months, approximately a year earlier than was originally intended. The Thames regions will have primary responsibility for seeing through LIG's remaining strategic roles.

7 **Gerald Malone,** Minster for Health, launches £75,000 Croydon Community Trust 'healthmobile', a single-decker bus intended to bring services such as family planning, counselling, chiropody and health promotion to the community.

9 **The 'Save Bart's Campaign'** continues in the face of almost certain defeat: the Court of Common Council of the City of London votes unanimously to oppose the closure of Bart's.

14 **Task Force** led by Anthony Culyer, Professor of Economics at York University, which was asked to review how the NHS funds Research and Development (R&D) and supports that funded by others, publishes *Supporting Research and Development in the NHS.* One recommendation – a single funding source for R&D – will have major implications for London through its impact on the Special Increment for Teaching and Research (SIFTR) and the research element of London postgraduate hospitals.

15 **Differences emerge** over the best way to organise primary and community health services in east London as the option favoured by CELFACS of a single trust for Tower Hamlets, Newham, and City and Hackney is challenged by the alternative of separate trusts for Newham, and City and Hackney.

15 **Guy's and St Thomas' Trust** announces plans to retain some in-patient services on the Guy's site. These will include orthopaedic surgery and a head and neck unit. Some cancer and renal patients will be treated for at least the next three years. These revised plans – it was originally intended to move all in-patient services from Guy's – have yet to be approved by the Secretary of State for Health. The proposal to close the A&E department at Guy's stands.

15 **A report from the Royal College of Psychiatrists** – *Monitoring Inner London Mental Illness Services* – based on survey of 12 inner-London mental health units, identifies problems of overcrowding and lack of acute psychiatric beds. Alan Langlands, NHS Chief Executive, recognises the challenges facing those delivering services in London.

19 **LAS inquiry** into the death of Nasima Begum in June 1994, who waited 53 minutes for an ambulance, uncovers major errors and fundamental failures within the LAS. Andrew Brown, LAS Personnel Director, states primary reason for an inadequate response was insufficient availability of ambulances and a high volume of calls on that night, on top of which a number of operational mistakes were made.

20 **Sheila Adam,** who was Director of Public Health at North West Thames RHA, is confirmed as Regional Director of Public Health for North Thames; Sue Atkinson, currently acting Regional Director of Public Health at South and West RHA, is confirmed as Regional Director of Public Health at South Thames.

22 **St Mary's Hospital Trust** in west London announces the launch of a customer services department dealing with queries from patients and relatives, with free phoneline access, similar to those in the commercial business sector.

22 **North Middlesex Hospital Trust** is criticised for paying the equivalent of £150,000 annual salary to management consultants, Ernst and Young, for the services, as Chief Executive, of Shaw Edwards, a former Director of Finance at North East Thames RHA. The trust has yet to find a permanent replacement for David Hirst who resigned in February 1994.

27 **Report** by management consultants for 'Save Guy's Campaign' supports the option of retaining in-patient and A&E services at both Guy's and St Thomas' sites, claiming that this would cost less than relocating all services to St Thomas'.

27 *Mental Health in London: Priorities for Action,* report from the Mental Health Task Force London Project, set up by the Secretary of State for Health in February 1994 to look at the problems of service provision in London, finds that shortage of acute psychiatric beds in London is causing patients with severe mental illness to be discharged inappropriately with possible risk to themselves and the public. Alan Langlands, NHS Chief Executive, again publicly acknowledges the great pressure on mental health services in the capital.

29 **Neil Godwin,** currently Chief Executive of St Mary's Hospital Trust in Paddington, will take up the post of Chief Executive of Manchester health purchasing authority from November 1994.

29 **Report** from Thames Cancer Registry – *Cancer in South East England* – shows range of inequalities in incidence and success of treatment. Incidence of breast cancer, for example, in the south east is 14 per cent higher than the England and Wales average. Chances of patient surviving with breast cancer after five years ranges from 81 per cent in mid-Surrey to 63 per cent in East London and the City.

30 **East London and City Health Authority** votes against proposed single trust for primary and community services in east London, the option proposed by CELFACS.

October 1994

3 **Royal Brompton Hospital Trust,** in an innovative private finance initiative, considers bids from private consortia to finance and build the £20 million second phase of the hospital's redevelopment programme. Bid has been linked to the management of a range of support services and a 28-bed private unit, and in return the private sector will be able to redevelop redundant buildings.

4 **Gerald Malone,** Minister for Health, announces the creation of the Primary Care Support Force, headed by Judy Hargadon, currently Chief Executive of the Croydon Community NHS Trust, with a role, following on from the work of LIG, to encourage development of better primary and community care services in the London Initiative Zone: with a life expectancy of two years, annual running costs are estimated at £1 million.

4 **It is announced** that LIG will be wound up by April 1995 with strategic responsibility for London, and some funding, passing to a joint committee of the two Thames regions.

6 **Labour Party** calls for an independent inquiry into the death of Nasima Begum, which Parliamentary Secretary for Health, Tom Sackville, ascribed to astonishing incompetence on the part of the LAS. The LAS falls below Department of Health standards, in answering only 68 per cent of emergency calls within 14 minutes, though this is partly attributable to a rise in the daily volume of calls.

12 **Secretary of State for Health** orders urgent action to improve LAS following death of Nasima Begum. William Wells, Chair of South Thames region, is asked to lead inquiry into LAS delays which resulted in the death: among other things, the inquiry will consider deployment of staff, rostering and timing of annual leave and sick leave, and a report is due before Christmas 1994.

13 **Report by GMB union,** *Going Critical,* based on a survey of 171 staff, claims LAS is near collapse with poor staff morale, inefficient handling of calls by control centre, and lack of investment: report is criticised by LAS management and Unison, the union representing most ambulance staff. Unison identifies the problem as shortage of crews and vehicles due to lack of funding.

17 **Campaign** against closure of Bart's A&E department, which is planned for January 1995, continues with lobby of Parliament and launch of London Health Emergency report, *Caught in the Crossfire,* which criticises analysis behind the decision.

18 **John Bowis,** Parliamentary Secretary for Health, launches the Leadership and Innovation in Mental Health Project, jointly funded by NHS Executive and NHS Training Division, and managed by the King's Fund, with aim of promoting leadership and innovation in London's mental health services.

20 **GMB union** in evidence to Health Committee of the House of Commons on LAS, suggests that there should be system of prioritisation of calls introduced and that citizens should have right to sue for compensation if the service does not meet standards: the LAS is still only achieving a 68 per cent emergency response rate within 14 minutes.

21 **New guidance on distribution of financial resources** for hospital and community health services is published, (FDL(94)68), but its impact on London health authorities is not made explicit.

21 **In an opposition debate** in the House of Commons on London's health services, Peter Brooke, former National Heritage Secretary, expresses concern at closure of Bart's and calls for a halt to *'... the loss of beds in London until we are confident we have reached equilibrium.'*

26 **London-based European Medicines Evaluation Agency** establishes its offices at Canary Wharf: the agency provides technical and administrative support for the new Future Medicines Licensing Systems established by the European Union, which will eventually allow a single application for product marketing authorisation recognised by all member states.

27 **Gerald Malone, Minster for Health,** announces programme of education initiatives to improve quality of primary care in London: these include development of eight community resource centres which will support training of up to 80 new community-focused GP tutors, and support for academic departments and networks to enable 400 GPs per year to engage in programmes of professional development.

27 **Judge Bruce Laughland** threatens to seek court appearance of the Secretary of State for Health to explain why a hospital bed cannot be found for a mentally handicapped convicted prisoner from Stepney in east London, who appeared at the Old Bailey for sentencing.

31 **Bexley and Greenwich Health Authority** begins formal consultation on changes to the configuration of services: *Looking to the Future: a consultation document on proposals for changes to hospital services in Bexley and Greenwich.* It is proposed to make the Queen Elizabeth Military hospital the main hospital for Greenwich residents by transferring A&E services there and closing the Brook hospital, and most services at Greenwich hospital.

November 1994

1 **East London and City Health Authority** begins formal three-month consultation process by issuing consultation document, *Health Services for the Future.* This may eventually lead to closure of Bart's, which is the authority's recommended option.

2 **Lambeth, Southwark and Lewisham Health Commission** issues for formal consultation, *Looking to the Future: a consultation document on proposals for changes to hospital services in south east London,* recommending closure of the A&E department at Guy's hospital, transfer of most in-patient services from Guy's to St Thomas', and eventual development of elective in-patient unit at Guy's.

3 **Independent inquiry** chaired by Chris Heginbotham, Chief Executive of Riverside Mental Health Trust, reports on case of Michael Buchanan, a patient suffering from untreatable personality disorder, who was discharged from hospital by North West London Mental Health Trust, and subsequently was convicted of manslaughter. Report is critical of planning of the patient's care in the community and calls for revised guidance from the Department of Health to trusts, special hospitals and regional secure units regarding admission criteria. John Bowis, Parliamentary Secretary for Health, points to advances in delivery of care in the community since this incident occurred in September 1992.

14 **Report** from management consultants, Price Waterhouse, to New River Health Authority recommends replacement of Chase Farm hospital's A&E department in north London with a minor injuries unit.

24 **William Fitzhugh's** report on independent health care, shows that London trusts are among leading exponents of private health care provision with Guy's and St Thomas' Trust earning £7.5 million in 1992-93, increase of 68 per cent on previous year, and Royal Free Trust earning £6.9 million.

28 **Hillingdon Health Agency** issues consultation on the closure of A&E department at Mount Vernon hospital in north-west London – *Proposals to Change Services at Mount Vernon and Watford Hospitals NHS Trust: a public consultation document.*

December 1994

1 **Health Committee** of House of Commons hears evidence from health union, Unison, which claims that staff shortages have made it impossible for the LAS to meet Patient Charter standards.

3 **Outbreak of brochiolitis,** a viral infection of the lungs, puts paediatric intensive care beds under pressure in London, resulting in three-year old girl having to travel from her local Chase Farm hospital to Addenbrooke's hospital in Cambridge for treatment. British Paediatric Association has warned of national shortage of specialist beds and staff for children's intensive care.

5 **Freemasons** vote to wind up the charity running Royal Masonic hospital in west London, and allow the receivers to sell the hospital in order to clear debts.

6 **The Secretary of State for Health** announces increase of 0.85 per cent, in real terms, in all regional budgets for 1995-96 including Thames regions, which include London districts.

15 **Consultation** begins on plans to create three community health trusts, based on old districts of City & Hackney, Newham and Tower Hamlets, to replace City and East London Family and Community Health Services, after East London and the City health authority and North Thames region decide against continuing with a unified, pan-east London trust.

15 **LAS announces improvements** in response times to emergency calls in November with 72 per cent of calls answered within 14 minutes, though this is still well below the national Patient's Charter standard of 95 per cent.

28 **Row** erupts over allegations of 'dirty tricks' campaign at Bart's as Professor Michael Besser, former Chief Executive of the hospital, disputes claim by Alistair Wilson, Head of A&E department at the Royal Hospitals Trust (which includes the Bart's site), that various ploys have been used to make A&E department at Bart's seem busier than it was, and the hospital more efficient at treating patients from its waiting list.

This calendar is a collection of material from several sources. It includes items which were widely reported in the newspapers of the day, as well as in health service and medical journals. It has been checked against Department of Health press releases, for accuracy and authoritativeness, and also against material which has been made available to the editor by London purchasers and trusts. Finally, a number of original published reports have been used also as a source.

COMMENTARY

Introduction

The last twelve months in London have been marked by an apparently interminable process of decision-making which will eventually determine the configuration of hospital-based services in the capital for the rest of the decade. As the end of 1994 approached, formal consultation was underway throughout London on various proposals which would reduce the number of A&E departments and consolidate or rationalise the provision of in-patient services. 1995 should be the year of decision and between then and the end of the decade we can expect changes in London which will produce a very different system of hospital-based health care delivery.

In 1994, under the guidance of the Primary Health Care Forum (PHCF) of the London Implementation Group (LIG), there has been considerable extra investment – £85 million in 1994-95 – in the development of primary care in London. Over 900 separate projects have been funded since April 1993. Their impact is not yet obvious, which may simply be a matter of needing more time. Assessing what effect they have must, however, be important in determining what to do next.

Meanwhile, the problems of the London Ambulance Service (LAS) have refused to go away. At the end of 1994, the Wells Report – the latest in a series of reports on the LAS – still found much to criticise. Another major area of concern in London has been the inadequacy of acute mental health service provision. Various accounts of difficulties with discharge arrangements or large numbers of people waiting many hours, and sometimes overnight, for admission from casualty departments to a hospital bed, have also been endemic throughout the year.

Finally, if there is sparse evidence of real change in the actual delivery of health care services in London, there has been no shortage of views on what should happen, nor of concern that the process is being managed rather precariously. These range from the reports of pressure groups such as London Health Emergency (LHE) and the 'Save Guy's Campaign', through Professor Brian Jarman's persistent claim that London is under-resourced in health service terms, to various reports emanating from the King's Fund itself. Crucial to much of the debate are two questions:

- what is a fair level of financial and physical resources for London, and;
- what is the best way of providing health care services to Londoners to enable the development of a modern 21st century health care delivery system in the capital?

Whatever pattern of care does evolve, it is important that the process and pace of change is managed in such a way that the new system can develop while ensuring the continued provision of adequate health services during the transition period: both short- and long-term vision are required, and hopefully a degree of consistency between the two. Before tackling these issues, however, we set out a description of major developments in each of the following areas in turn:

- acute hospital services;
- primary and community health services;
- mental health services;
- the London Ambulance Service;

The articles in the *Analysis and Debate* section of this year's Monitor consider the process of change in London's health care system. At the micro level it would seem that there is much activity, but at the more macro level of developing the appropriate strategies for change, the picture is less clear. The emerging pattern of change is unconvincing, and for some more pessimistic commentators, if their views of the resource requirements of London are accurate, may be seriously flawed. This commentary concludes by considering what the future is likely to hold for London's health care. We turn now to the crucial decisions which are about to take place in London's acute hospital system.

Acute hospital services

The publication of *Making London Better* (Department of Health, 1993) to many seemed to herald a blueprint for the re-construction of London's hospital services. Yet 1994 is remarkable for the absence of any concrete outcomes: the first closure and sale of a major hospital as a result of what might be termed post-Tomlinson rationalisation remains some distance in the future. Nevertheless, the die would seem to be cast for some of the capital's best-loved and most renowned institutions. Formal consultations which, eventually, will have major implications for the delivery of hospital-based services in the capital, are underway in most parts of London.

Two interpretations of this hiatus are possible: that these delays are a good thing reflecting a need for thoughtful analysis and a constructive consultation process; or, that this is yet more evidence of the inadequacies of decision-makers, afraid to commit themselves to alternatives and live with the consequences. Whichever view is nearer the truth, the consequence for London has been another year of uncertainty for both staff and patients.

Last year's *London Monitor* (King's Fund, 1994) described the possible configuration of hospital-based care in five sectors of inner London – the East, North-west, North-central, South-east and South. Debate over a series of controversial plans has continued across London. Several outstanding issues are either out to formal consultation or being considered in the planning processes of trusts and purchasers.

At the same time significant changes are planned in outer London and the surrounding shires. Whether these developments in outer London are consistent with the recommendations of the Tomlinson Report (Department of Health, 1992) or the King's Fund's own report: *London Health Care 2010* (King's Fund Commission, 1992) is an issue worth consideration. Both reports reflected the widely-held view that the outer ring of the capital is under-resourced relative to inner London. If the pace of change in outer London outstrips that in the centre, the result may be an increase in the imbalance of resources within the capital.

These are issues of wide strategic significance which require managing across London as a whole. We now turn to consider the situation in each sector of London, and then attempt to appraise the implications of sectoral change for the capital as a whole.

East London: the Royal Hospitals Trust

In December 1993, to a barrage of outrage from the press and some sections of the medical establishment, the decision was taken to close the A&E department at Bart's, to take effect in early 1995. At the same time the Secretary of State announced preparations for the creation of a trust bringing together the services of three hospitals – Bart's, the Royal London and the London Chest. This Royal Hospitals Trust was formally established in April 1994. What remained was to iron out detailed options for the future provision of services and go out to formal consultation on these. It was almost 12 months after the announced closure of the A&E department, in November 1994, that East London and the City Health Authority issued *Health Services for the Future: a consultation document on proposals for changes to health services in East London and the City.*

The health authority's recommended option is the closure of two of the three trust sites with the transfer of services to the existing Royal London site at Whitechapel. Included in the consultation is an expansion of services at the Homerton Hospital in Hackney, mostly to respond to patients no longer treated at Bart's. A separate consultation will follow on the development of services at Newham Healthcare Trust which is currently responsible for service delivery at Newham General and St Andrew's hospitals.

It had already been decided, following a period of public consultation, that the A&E department at Bart's should close in January 1995 (to be replaced by a Minor Injuries Unit). The current consultation appears to vindicate the view that the closure of Bart's hospital would follow close on the heels of the A&E department.

There have been a series of legal challenges to the decision to close Bart's A&E department, each with seemingly less chance of success than the predecessor. In March 1994 the London Boroughs of Hackney and Islington were granted leave to seek a judicial review of the decision to close Bart's A&E department on the grounds that the consultation procedure was flawed since the Secretary of State had effectively decided to remove A&E services from the site before the consultation process began. The High Court rejected this challenge and refused leave to appeal.

Although Islington Council then set up its own public inquiry into the future of Bart's, this was a gesture with no legal significance. City of London businesses raised funds for the continuation of the Save Bart's Campaign and once again the legal process was invoked – but once again, the result was a foregone conclusion. In late July, the Court of Appeal refused the campaign group leave to launch a judicial challenge to the decision to close Bart's A&E department. Nevertheless the campaign has continued: the Court of Common Council of the City of London voted unanimously

to oppose the closure of Bart's. In a debate in the House of Commons on London's health services, the former National Heritage Secretary, Peter Brooke, expressed his apprehension at the planned closure of Bart's:

> *Those apprehensions are that a great hospital is being surrendered into a structure that will not even be the sum of the constituent parts, let alone something greater* (Hansard, 21 October 1994, p539).

Nevertheless, as we go to press, the expected closure of Bart's A&E is going ahead, and the rancour continues, with some medical staff at the Royal London and Bart's firing off accusations at each other regarding the way in which the case for Bart's has been argued.

Consultation on the future of the whole site is due to end in February 1995. The preferred option of the health authority entails the complete closure of the London Chest Hospital and the retention of just a Minor Injuries Unit and GUM out-patients department on the Bart's Smithfield site – effectively closing Bart's and the London Chest Hospital by the turn of the century. Thus one of the original proposals of the Tomlinson committee, to close Bart's, may be formally decided upon some 30 months after its report was published.

South-east London: Guy's and St Thomas' Trust

A similar process is underway in south-east London. Throughout 1994 there has been controversy surrounding the future of Guy's hospital. In February 1994, the Secretary of State announced further plans for the rationalisation of services in London which, not unexpectedly, included the transfer of most services from Guy's hospital to St Thomas'. The furore with which this was greeted was equally predictable.

The decision was made more controversial by the fact that a new development was nearing completion on the Guy's site. This was Philip Harris House which was intended to provide state-of-the-art facilities for oncology, cardiology, neurology, endoscopy and renal medicine, and a specialist asthma and allergy unit. A substantial part – £44 million – of the £140 million cost had been met from charitable donations, including a £6 million donation from Philip Harris himself, the ex-Chairman of the Guy's and Lewisham Trust.

Leading charities have withheld donations or asked that their donations be refunded on the grounds that the original charitable intentions were in danger of not being fulfilled. Professor Nicholas Wright, Director of Clinical Research at the Imperial Cancer Research Fund (ICRF) expressed his concern for the £1.7 million which the ICRF had 'invested' in Philip Harris House, and made it clear that the donation would be cancelled if expected research and treatment facilities were not made available to match the original agreed specification for Philip Harris House.

An all-party Save Guy's Campaign was launched, including Conservative MP, Roger Sims, Labour MP, Tessa Jowell and Liberal Democrat MP, Simon Hughes. Throughout the summer the debate over the future of the Guy's and St Thomas' sites continued. The trust put forward proposals in September for the delivery of services on the two sites, retaining some in-patient care on the Guy's site, but maintaining a commitment to close the A&E department, which many see as the factor determining the long-term viability of the site.

The Save Guy's Campaign responded by issuing an independent report commissioned from KPMG Peat Marwick, which supported, on financial grounds, the option of retaining in-patient and A&E services at the Guy's site. The argument for retaining A&E services at Guy's hinged on the recognition that there would be unacceptable risks involved in removing A&E from Guy's without first developing the primary care infrastructure and alternative emergency cover for local and commuter populations. It was an argument for increased flexibility and reduced risk while the impact of other developments such as the closure of Bart's unfolded. However, the report also recognised that subsequent developments might result in the eventual removal of emergency services from the Guy's site.

Perhaps, as one commentator had stated in February, *'the choice of site was too close to call on any objective grounds'* (Robert Maxwell, Health Service Journal, 17 February 1994). Or, in the words of the Secretary of State when giving evidence to the Health Committee of the House of Commons in July 1994, *'... it was a finely balanced judgement'*. She said that an issue which particularly carried weight was that St Thomas' had the largest A&E department in London and served both Victoria and Waterloo stations.

What is clear in such circumstances is the need for careful consideration of the evidence. This will hopefully be afforded by the consultation which Lambeth, Southwark and Lewisham Health Commission began in November 1994, with the publication of *Looking to the Future: a consultation document on proposals for changes to hospital services in south east London.* In this document the Commission recommends closure of the A&E department at Guy's which would be replaced by expanded services at St Thomas', King's and Lewisham hospitals. There would be a transfer of in-patient services from Guy's to St Thomas'. Guy's would concentrate on treatments that do not require an overnight stay – out-patients, day surgery and minor injuries, and an elective in-patient unit would be developed there. Consultation ends in February 1995 and shortly after, a decision may be announced.

This consultation also includes detailed proposals for developments at the King's Healthcare Trust sites and the Lewisham Hospital Trust sites. King's will expand its facilities in order to meet the extra demand which the closure of Guy's A&E department is predicted to bring. It will also eventually become the site of a Neuroscience Centre bringing together consultants and facilities currently dispersed at the Maudsley and Brook hospitals as well as at King's. In the longer term the viability of the two King's sites – at Denmark Hill and Dulwich – will be considered. Lewisham hospital will have to expand, also, to meet the extra demands which the closure of the A&E department at Guy's, and possibly at the Greenwich and Brook hospitals, will bring (see section on outer London changes).

A complex picture emerges in south-east London as the impact of one change after another on the demand for services in neighbouring hospitals is difficult to assess. Moreover, as the Lambeth, Southwark and Lewisham consultation document recognises, both King's and Lewisham are currently operating close to capacity. Some of the problems which King's hospital has faced in 1994 in dealing with the admission of emergency patients are related to these pressures and it is proposed, quite independently of what happens elsewhere, that King's should develop extra facilities for emergency patients (it is proposed that 60 extra beds be available by April 1995). In such circumstances perhaps the note of caution introduced by the Peat Marwick report on the proposals for Guy's and St Thomas' would be well heeded.

North-west London

There have been significant changes in the managerial organisation of hospitals in north-west London though no firm decisions on closures or re-configuration of services, as yet. Early in 1994 a change of direction was signalled when the applications for trust status of Riverside Acute Trust (Chelsea & Westminster and Charing Cross hospitals) and Hammersmith and Queen Charlotte's hospitals were withdrawn. In March, the Secretary of State announced the successful application for trust status of the Hammersmith Hospitals Trust (incorporating Hammersmith, Queen Charlotte's, Acton and Charing Cross) and Chelsea & Westminster Healthcare.

The debate in this part of London has centred around the future of the Charing Cross and Hammersmith hospitals. Although the original intention had been that services would be delivered on just one of the two existing sites, the Hammersmith or Charing Cross, the Secretary of State announced that the Hammersmith Hospitals Trust would operate from both its main sites for the foreseeable future. The trust board has, therefore, planned on this basis. St Mary's Hospital Trust and the Chelsea & Westminster Healthcare Trust are the other major acute providers in the area. The Royal Marsden and Royal Brompton hospitals, which had been Special Health Authorities (SHAs), as was the Hammersmith and Queen Charlotte's, entered the health service market as trusts in April 1994, under the steady state rules which implied no change in contracts in 1994-95. The need for rationalisation in north-west London seems clear, but what form it will take remains uncertain.

North-central London

This has been a fairly stable period for hospitals in central London, perhaps reflecting the success with which the major trusts (University College London Hospitals, the Royal Free and the Whittington) responded to changes over the previous 18 months. However, this may be the lull before the storm. Of particular interest in this sector is how the former SHA hospitals – the Great Ormond Street Hospital for Sick Children, the National Hospital for Neurology and Neurosurgery, and the Eastman Dental Hospital – react to their first full year in the market, albeit in a semi-protected state.

As early as January 1994 there was controversy over suggestions that Great Ormond Street hospital might merge with University College hospital, and the National Hospital transfer its services to the Royal Free hospital site in Hampstead. In the event, Great Ormond Street became a separate trust in April 1994, but applications for trust status from the National and Eastman Dental hospitals were refused because of concerns about their financial viability. University College London Hospitals Trust has continued to look at the options for potential relocation of services involving its own hospital sites and those of the National and Great Ormond Street, though as yet there has been no public consultation.

South London

This has always been the least controversial area in terms of decisions about the major provider, St George's Healthcare Trust, whose continued existence has not been in doubt. Nevertheless, decisions regarding the configuration of other hospitals in south London which we discuss briefly below will have significant implications for the residents of this area.

Other parts of London

Meanwhile there has been a lot of planning activity in the outer suburbs of London where some changes to hospital-based services have already occurred and a number of consultations are underway. These are likely to have significant consequences, not just for local residents, but for those of adjacent areas.

Thus, Brent & Harrow Health Agency produced a draft consultation document, *Acute Services Strategy: a basis for discussion,* in June 1994, proposing that future contracts should favour Northwick Park and St Mary's hospitals, and that the Central Middlesex hospital should lose its A&E department. This would have cast doubt on the viability of that hospital. However, the Authority subsequently decided to continue to support the Central Middlesex as a provider of a range of emergency and elective services, retaining its A&E department.

Barnet and Brent & Harrow health agencies issued a joint consultation document in July 1994, *Changes in Service Provision in the Edgware Area,* recommending the transfer of A&E services and in-patient services from the Edgware General site to other hospitals – mainly Northwick Park and Barnet General, which is currently in the process of substantial redevelopment. A Minor Accident Treatment Service would be established on the Edgware site together with a day surgery unit and a range of community health services. These proposals met with much local opposition particularly from the Community Health Councils, who viewed them as effectively leading to the closure of Edgware General hospital.

Hillingdon Health Agency issued a consultation document, *Proposals to Change Services at Mount Vernon and Watford Hospitals NHS Trust,* in November 1994. In this, the Agency recommends the replacement of the A&E department at Mount Vernon hospital with an Accident Treatment Centre for less serious injuries, with other emergency cases going to Watford, Hillingdon or Northwick Park hospitals. Also recommended is the removal of non-specialist children's services from Mount Vernon. Finally it is recommended that Mount Vernon becomes primarily an elective surgical centre with Watford General as the centre for emergency surgery.

In August 1994, Havering Hospitals Trust concentrated its A&E services on one site at Oldchurch hospital and a Minor Injuries Unit was set up at Harold Wood hospital. This is the first stage in a planned re-development of A&E services at Harold Wood and the eventual closure of Oldchurch hospital. This will have an impact on other acute providers in the outer reaches of east London including the Forest Healthcare and Redbridge Healthcare trusts, whose main sites are Whipp's Cross hospital and King George's hospital respectively.

The purchaser in west London, Ealing, Hammersmith and Hounslow Health Agency, has been examining the options for fewer A&E departments to serve its residents, though no official consultation has taken place. This may yet have significant consequences for the configuration of services at a number of west London sites including Ealing hospital, the West Middlesex hospital and the Hammersmith hospitals.

Bexley and Greenwich Health Authority is also in the process of consulting its local population with the publication, in October 1994, of *Looking to the Future: a consultation document on proposals for changes to hospital services in Bexley and Greenwich.* The main proposal, already referred to in the context of its impact on residents of south-east London, is to make the Queen Elizabeth Military hospital the main hospital for Greenwich residents by transferring A&E and in-patient services there. This entails closing the Brook hospital and, effectively, Greenwich hospital except for out-patient services. The closure of the Brook would result in the transfer of specialist cardiac services from there, mainly to Guy's and St Thomas' Trust, and neurosciences to King's Healthcare Trust. Queen Mary's hospital, Sidcup, would continue to be the main provider of services to Bexley residents.

The situation in the south of the capital remains unclear. A review of services in south-west London was undertaken by the South West Thames region, but no decisions on changes to the configuration of hospitals have been announced. The Secretary of State for Health, in evidence to the Health Committee of the House of Commons in March 1994, was asked about the state of deliberations on the future of A&E services at Queen Mary's hospital, Roehampton. She replied that *"there should be no further significant changes until other matters in London have had longer to settle down."* The specialty review of Plastics and Burns (1993) had recommended the transfer of plastics and burns services from Queen Mary's to St George's in Tooting, and possibly the Royal Surrey County hospital in Guildford, but no action has so far been taken on this proposal.

1994 has seen a series of consultations in outer London, all with one thing in common: the closure of an A&E department at one hospital site and the transfer of most in-patient services to another local site, often accompanied by the development of local or community services on the stripped site. In each case a convincing argument may have been made for the proposed changes. Less convincing is what the overall picture of services in London will be as the knock-on effect of these changes makes itself felt. Clearly there is a need for the plans for north and south London to be assessed as a whole so as to ensure some mutual consistency, and to phase the changes in such a way as to minimise the risk of services being unable to cope. This problem of a lack of overall strategic responsibility is the subject of the next section.

Who makes the decisions?

Changes to the configuration of health services in London are inevitable. In more doubt is the mutual consistency of these changes as a series of decisions unfolds. The Secretary of State for Health has indicated that she is not in the business of issuing a prescription for London's health services. She has nevertheless expressed her determination that the

changes which occur will lead to an improvement in health services for Londoners. If this is to happen, then she must ensure that those decisions that are made, are consistent with the delivery of better health care for the people of London.

Currently, responsibility for decision-making is widely dispersed with no one body taking an overall view. The London trusts in co-operation, and sometimes conflict, with London purchasing agencies, with support from the Thames regional organisations, will determine the detail of future configurations of health service provision in the capital.

Whether the recent announcement of the demise of LIG, earlier than originally planned, is a sign of failure or success, or simply a change in direction, it removes from the scene the one body with a London-wide remit for health services in general. From its inception, the role of LIG was clearly non-executive: it was to act in an advisory capacity to facilitate development and change within both purchasers and providers in London. However, now would seem to be the time when such a facilitating role might be most useful.

It is important that the responsibility for ensuring there is an overall improvement in the health care provided to Londoners is firmly located, both in an operational sense as well as in terms of the appropriate development of policy. This involves a clearer definition of the terms by which improvements will be measured than has been evident so far, and a clear locus of responsibility for the management and co-ordination of change. Neither of these are self-evident.

The theme of this issue of the Monitor is *Making Change Happen in London*. However, in 1994 there has been little change in the overall structure within which care is provided in London's hospitals. Unless there is significant backtracking – and this cannot be ruled out – then 1995 should be the decisive year. By the end of the century, as the pattern of hospital-based provision becomes clear across the capital, we should be able to assess, on the basis of appropriate measures of quality, access and cost, whether the resulting system is an improvement. We now turn to developments in primary and community care in London.

Primary and community health services

While the focus of much media attention has been on the controversial decisions unfolding in the hospital sector, 1994 has seen a steady stream of developments in primary and community care in London. These have resulted mainly from the application of funds specifically for this purpose – £85 million was announced by the Secretary of State for 1994-95. LIG has been responsible for the administration of these funds within the London Initiative Zone (LIZ), an area comprising those parts of London estimated to have the greatest need for primary care development (part or all of 12 district purchasers are included). In October, plans for a new Primary Care Support Force were announced, to take on LIG's role in supporting further developments in primary and community care in London.

Making London Better gave a clear statement of intent that in applying substantial new investment, the aim would be to build on local initiative to *'... accomplish the much-needed shift in London from a health service over-dependent on hospitals to one where effective care at a community level is a consistent reality.'* However, it is difficult to give an overview of the impact of initiatives arising from the application of LIZ funds since 1993, as there has been no systematic attempt so far to gather and evaluate the evidence. In fact, a detailed, comprehensive description of the kind of projects which have been supported is not available. Any commentary on these developments would wish to consider how successful the distribution of development money has been, first, in terms of original intentions, second, in terms of geographic and service range of projects and, third, in terms of firm evidence of beneficial effects.

In the last two years, over £125 million has been made available for primary care development in the LIZ area resulting in over 900 projects. A range of projects have been funded which can be summarised under five headings:

- care-group-specific;
- extending services within the community;
- other forms of community development;
- improving basic GP services;
- training, research and development.

Care-group-specific projects include those aimed at people with mental health problems, elders, minority ethnic groups, and projects devoted to improving advocacy and access. Extending community services includes projects targeting community nursing, expanding the number of community beds, hospital-at-home schemes, outreach projects, and the development of nurse practitioners. Other forms of community development have included encouraging health promotion activities, and projects relating to dentistry and pharmacy.

Improvements to GP services have involved expanding the range of services offered, including placing GPs in A&E departments, projects related to GP fundholding, improving GP premises, and dealing with problems of list inflation. Finally, a

range of development activities has been funded to assist training and research generally as well as specific functions such as health needs assessment, project management, developing information technology and computing expertise, and commissioning support. There has been some funding specifically for the evaluation of LIZ projects as well.

Of projects funded in the first year, 1993-94, care-group-specific (26 per cent), improving GP services (28 per cent) and training, research and development (29 per cent) accounted for the greatest proportion. In 1994-95 the proportion of schemes which might be termed training, research and development increased to 37 per cent with the proportion in the other two categories decreasing slightly. In the first year many of the schemes were aimed at improving GP premises (13 per cent) though this had fallen to less than ten per cent in 1994-95.

A diverse range of projects has been funded, ranging from an audit of cervical services costing a few thousand pounds, for example, up to £1 million for major projects such as the development of a health centre. The list of projects reveals a fairly disparate assortment with no indication, on the face of it, that these represent part of a co-ordinated approach to the development of primary and community services aimed at the ultimate transfer of work from hospitals to the community.

Of course this may not be the chief focus of most of the projects. *Making London Better* indicated three focii for the development of primary care in London: getting the basics right in terms of high-quality premises and staff; developing new types of primary care services and settings; and encouraging the transfer of care from hospital to the community. Certainly the aim of bringing services in London up to the standard of those available elsewhere in the country features highly in the list of projects funded so far. But if this is the case, then there is a need for some clarity about the expected overall impact of changes both on the mode and location of delivery of care as well as the interface between primary and acute care. Clearly different criteria of judgement pertain depending on what view is held of the substitutability of community and hospital-based provision of services.

If no substitution is expected then this gives a different perspective to the rundown of hospital-based services, the success of which must then depend primarily on cost savings from a smaller number of sites to continue to deliver an equal or greater level of care. This is not a problem peculiar to London but results from a lack of clarity about the aims of much of community care development throughout the country. Is it intended to complement or substitute for hospital-based care? If the answer is a bit of both then it must be clear what the purpose of each individual project is so that each can be judged accordingly.

Mere managerial competence to see a development through is clearly not a sufficient judgement criterion to apply to these projects. Measures of outcome are required which will allow a better assessment of the worth of the myriad of projects which so far have been funded. This requires more than just a comparison between the intended and actual impact of a scheme but also some examination of the relationship between these micro-level changes and a set of strategic targets such as improving the way in which GPs deliver services in their surgeries, or shifting the location of care closer to the community using it, or improving the interface between services. For example, is it being suggested that improvements to GP premises (which represent over ten per cent of the projects funded) will make a substantial difference to where current in-patient hospital services will be delivered, or are better premises a goal in themselves?

This assortment of primary and community care projects, though less newsworthy individually, perhaps, than issues arising out of the rationalisation of hospital stock, lies at the heart of the Government's programme to re-shape health services in London for the 21st century. It remains unclear how successful they have been, whichever criteria are chosen for the purpose of evaluation.

There is an urgent need to develop better primary and community care in London for one group of patients in particular, those with mental health problems. An issue which has seldom been out of the public view in 1994, we turn to this now.

Mental health services

Care for those with severe mental health problems has been a fundamental issue in London, in terms both of individual examples where the system has failed to make adequate provision, and also the weight of learned response to these failures, eg the Ritchie Report (1994) and the report of the Mental Health Task Force on London (1994). A series of reports have had one conclusion in common – that the current level of provision of services in London for those with severe mental health problems is dangerously inadequate. The problem arises from a failure to develop alternative community care services that will actually substitute for hospital care before closing down these hospital-based psychiatric facilities, set against a background of an inadequate supply of secure accommodation for those who need to be detained.

Thus, although the year did not start, as did 1993, with a lion in London Zoo savaging an ex-mental health patient, before the end of 1994 a

similar tragic incident had occurred. Moreover, the murder on a London tube station of Jonathan Zito by Christopher Clunis remained uppermost in the mind of the public, and in February 1994 the Ritchie inquiry published the results of its investigation into this incident – *Inquiry into the Care and Treatment of Christopher Clunis.*

Describing the events which led to this tragedy as *'... a catalogue of failure'*, this was one of several damning indictments of mental health services in London. The report called for more funds, especially for medium-secure and general psychiatric care, and also pointed to the failure of the policy of 'care in the community'. The Secretary of State's immediate response was to announce expenditure of an extra £10 million on community-based services in London. Funding has also been made available, as part of a five-year national programme, to provide an extra 170 medium-secure beds in the Thames regions by 1995.

The Secretary of State also asked the Mental Health Task Force (MHTF) to look at service provision in London for those with severe mental health problems and to assist local agencies (providers, purchasers and others) to develop and implement short- and long-term strategies to address problems identified. The MHTF is a national body established in 1993 to work with statutory authorities in planning the closure of old-style psychiatric hospitals and the development of smaller, more appropriate places of sanctuary so as to produce high-quality community-based services for those with mental health problems.

In its work on London the MHTF was restricted to consideration of just those areas within the LIZ. In September 1994 the Task Force published its findings in *Mental Health in London: Priorities for Action.* A key finding supported by other reports, eg *Monitoring Inner London Mental Illness Services,* Research Unit of the Royal College of Psychiatrists (1994), and confirming the everyday experience of those attempting to provide for the needs of people with severe mental health problems in London, was that there is:

> *'... a serious problem of emergency access to appropriate care for mentally ill people in several but not all inner London boroughs (resulting in the fact that) some patients with severe and chronic mental disabilities are being discharged without adequate supervision or the provision necessary to meet their housing, social and health needs... (which) could increase risk not only to public safety but also to the safety of the individuals concerned, and to the safety of staff in non-specialist accommodation or other services.'*

The report also identified key priorities for action including collaboration between health and local authorities, better communication and co-operation between key provider and purchaser agencies, clear identification of the population of severely mentally ill people and protocols for ensuring continuity of responsibility, development of community-based support and effective development of the care programme approach and supervision registers.

However, it was the recognition, once again, of the pressures on acute psychiatric services and secure accommodation, which requires immediate action. Levels of acute need appear to have been underestimated. Given that community mental health services currently are unable to cope, the closure of long-stay hospitals, and transfer of care, must depend on the development of adequate alternatives. In a sense this is just 'the transfer of care from hospital to community' issue writ large: whatever form of care, it is necessary to ensure that new means of provision are in place before the old are removed.

It will take more than a firm commitment to the development of primary-care-led mental health services among professionals to solve the problems raised by the inadequacy of basic facilities. This is not mere short-termism. It ranks currently as the most urgent issue for those with mental health problems. In the long-term there may be a need to ring-fence funds for the care of those with most severe mental health problems, particularly if the extension and expansion of GP-fundholding leads to more fragmentation of services. When other hospital services are removed before adequate community services are in place the results may be less apparent for the care-group involved than is the case for those with mental health problems. It is still an issue even then.

The problems of those with severe mental health problems in London demand an urgent response. John Bowis, the Junior Health Minister responsible, has taken pains to ensure that the positive actions of the NHS are not forgotten, nor indeed the increased funds being made available. Among achievements he highlighted in September 1994 – in response to a report from the Mental Health Foundation on community care for people with severe mental health problems – were: a ten-point plan for the care of those with severe mental health problems; a new Code of Practice under the 1983 Mental Health Act; revised hospital discharge guidance; and the establishment of supervision registers for those considered to be particularly at risk.

Mental health care professionals are generally agreed that there is a need for further development of systems of co-ordinated team management with 24 hours a day, 7 days a week, responsibility. There is a clear need also, to ensure there are sufficient secure beds for psychiatric emergencies and for those patients who are a danger to themselves or to others. It is of crucial importance in 1995 that the ubiquitous recognition of the dilemma facing those responsible for the delivery of mental health services in London is translated into actual improvements in care for those with mental health problems.

The London Ambulance Service

In last year's Monitor we reported on the breakdown of the London Ambulance Service's (LAS) computer-aided dispatch system for ambulances, and the subsequent Page Inquiry. Matters do not appear to have improved greatly since. Thus, throughout 1994 the LAS has failed to come close to national standards of response to emergency calls. The LAS business plan for 1994-95 acknowledged that national standards of 95 per cent response within 14 minutes would not be met until the end of 1996. The target set was 80 per cent by September 1994, but throughout the year the proportion has ranged between 60 and 70 per cent.

The death, in June 1994, of a young girl in east London who had waited nearly an hour for an ambulance highlighted the problems and resulted in the Secretary of State announcing an inquiry into the delays which had resulted in the death. The recently published report of this inquiry – the Wells report – found that weak management, poor working practices, high absenteeism and a lack of sufficient funding were largely behind the consistent failure of the LAS to meet national response standards. The report recommended restructuring of management, major changes to working practices, capital investment of £11 million over two years and an extra £2.7 million for running costs.

The Health Committee of the House of Commons has undertaken its own inquiry into the parlous state of the LAS, and is expected to report some time in the first half of 1995. Although there has been additional funding made available to the LAS already, this does not seem to have solved the problem. There has been a substantial increase in the volume of activity, estimated to be 12 per cent up on last year. Moreover it is estimated that the closure of A&E departments in London – and, as we have seen, a lot more are in the pipeline – has resulted in an increase in the time taken on individual emergency calls.

Various alternatives have been suggested for dealing with the problems of the LAS from considerably more investment in financial and human terms to the introduction of a system of prioritisation of calls. There must be some question over just how important the target response rates are. If they are to be taken seriously then by implication the consistent failure to meet them in London must be having detrimental consequences for the residents of the capital. Whatever solution is devised it should ensure Londoners have access to a service which is as good and safe as that available elsewhere in the country. The lack of progress in the last three years places a substantial question-mark over the ability of the Government to deliver this at the present time.

The future of London's health care

It is generally accepted that there has been an inappropriate balance of services in London with too many hospitals and too few resources devoted to primary and community care. The ability of any proposed new system of health care delivery to provide an adequate level of services, not just at some distant date in the future, but during the period of transition, is of fundamental importance. A separate argument though one that is in danger of being confused with the issue of the balance of services, is that London has received more than its fair share of financial resources when compared to the rest of the country.

The allocation of resources to London

The question of determining a fair distribution of resources to London, though complex, is proving crucial to the process of change which is driving the realignment of health care services in the capital. Although there is a coherent argument for changing the system of delivery in London so that it becomes less acute hospital-based, a more powerful argument for those responsible for the financial viability of hospital trusts in the capital, or for the budgets of London's sixteen purchasing authorities, is the need to continue to provide similar levels of care within a reducing overall budget constraint.

As discussed in the *Facts and Figures* section of this Monitor, assessing the distribution of resources to London is no simple question. First it is necessary to distinguish between different types of health care expenditure. The statement that London has more than its fair share of resources usually refers to resources devoted to Hospital and Community Health Services (HCHS). Clearly any analysis which does not take account of all forms of health-related expenditure including that on Family Health Services (FHS) and that by the Social Services Departments of local authorities is likely to be flawed. It seems especially strange to accept that the balance of services in London is inappropriate and yet not to consider the totality of funding for HCHS and FHS, the two elements of NHS expenditure. Less in fact is spent on FHS in London per capita resident population than is the case in England as a whole (£128 compared to £134 in 1992-93).

London district purchasing authorities spend more on HCHS, in terms of per capita resident population, than the average in England as a whole

(£457 compared to £378 in 1992-93). However not all of this is necessarily spent on their residents. Total resources available to purchasers include their main allocation (based on some estimate of the needs of their population) and funds made available from regional or national top-sliced funding. In the case of London the latter can be a particularly important element.

The main 'weighted capitation' allocation (approximately 90 per cent of HCHS funding in 1994-95) is distributed to district purchasing authorities by regions, from allocations they receive based on a national formula which attempts to assess relative regional needs. This is the crux of the argument concerning fair allocation of financial resources at the moment, and it is on the basis of these 'weighted capitation' allocations that it is claimed London is over-funded. The most recent Department of Health estimates suggested that London received just over £65 million, or 2.6 per cent, more than its fair share, on this basis, in 1994-95. Hence most London purchasers are planning on the expectation of a reduction in their budgets, in some cases substantial, over the next five years.

However, a review of the system of allocating resources to purchasers for HCHS had been announced by the Government in February 1993 and a team from the University of York was commissioned to carry out an analysis which would inform this review. The intention was to re-assess the allocation of resources on the basis of new information available from the 1991 Census, and the application of the most advanced analytic and statistical techniques.

This work is now complete and some substantial changes in the formula for allocating HCHS resources were announced by the NHS Executive in a recent document – *HCHS Revenue Resource Allocation: weighted capitation formula* (1994). However, guidance issued from the Department of Health, FDL(94)68, on 21 October 1994, suggested that, in the interests of continuity and stability, there was no intention to implement fully these changes in allocation formulae in setting 1995-96 budgets.

In line with this advice, the latest Department of Health allocation to regions, that for 1995-96, increased budgets equally across the country, in contrast to previous years when the Thames regions had been allocated proportionately smaller increases than other parts of England. The guidance also advised RHAs to limit redistribution to those districts substantially under target and ensure that no over-target district loses resources in real terms. It is not clear what the overall impact of the new 'weighted capitation' formula will be on London, but our preliminary estimates suggest that inner London districts would benefit compared with an allocation based on the previous formula.

While there is still uncertainty about what level of financial resources London is entitled to, it would seem rather precipitate that so many purchasers in London are having to plan on the basis of significant reductions in budgets. There is no quarrel with the need to provide better primary and community care but there may be a case for continuing to use hospital-based provision, at least in the medium-term, if the level of resources will allow this. Robert Maxwell, in *What next for London's health care?* (1994), argued the case for halting bed closures and re-considering the situation with respect to A&E departments while pressures on London's hospitals remained so great. He also suggested that London should be sustained with transitional funding for the next three years while a changed balance of services is being negotiated. These arguments are given that much more weight by the possibility that London's entitlement to health care resources, *in toto*, has been underestimated.

The reconfiguration of health services in London

There are two important considerations in assessing the likely success of changes to the system of health care in London. The first is the ability of proposals, looked at individually, in different sectors of London, to deliver an improvement in health care provision in terms of the trinity of quality, cost and access to care. The second is that the combination of these individual changes to services throughout London will result in some systematic improvement in overall provision without a more definite effort to co-ordinate the changing pattern of delivery.

We have pointed to themes which are common to most of the proposed changes to hospital-based provision. The starting-point seems to be a need to reduce the number of A&E departments in London. The reason sometimes given is that existing services are unlikely to retain clinical viability, especially if the issue of reducing the hours of junior doctors is taken seriously. Often these clinical considerations are linked to the issue of more cost-effective provision, and at times this itself seems to be the main driving force.

Where an argument is made for the removal of A&E services this is commonly developed in one of two ways: either it is proposed that the site losing its A&E department becomes essentially a centre for ambulatory care with some out-patient facilities and community services offered, and sometimes a facility for dealing with minor injuries; or the site retains some elective in-patient care facilities as well as those just mentioned. The retention of a facility for the delivery of day-case services is a variant on the second option.

Arguments for these changes to in-patient services are usually based on cost and quality considerations. Often they are linked also to the issue of extending locally-based access by

improving the ability of primary and community services to cope with what would previously have been seen as hospital-based services.

Developments in primary and community care lie at the heart of any such hope. However, large-scale change should not be based on this prospect alone until we are sure the development of new modes and locations for the delivery of care has become a practical reality. A detailed assessment of the impact of LIG's investment in primary care in terms of this transfer of the location of care into the community is a prerequisite for the kind of extensive changes in hospital-based delivery currently under consideration.

Moreover, in planning for future provision we must not lose sight of current problems. There have been signs in London of pressures on hospital services caused both by difficulties with discharging patients and an unpredicted increase in the number of emergency admissions. Evidence continues to suggest that London hospitals have difficulties in discharging patients once their needs for medical care are complete. Although not solely a problem for more elderly patients, there is a link with the shortage of private residential and nursing care provision in the capital (the degree of which is highlighted in the Facts and Figures section of this Monitor).

The increase in the level of emergency admissions, which is not just a London phenomenon, must bring into question the ability of hospitals to deliver planned levels of elective care, where these are based on assumptions incorporating previous trends in the number of emergency cases. Current plans to change the pattern of provision will have to be able to produce service configurations which are robust in the face of both these problems.

In the case of any individual changes which are proposed the evidence must be examined carefully on its merits. For a true consensus to develop around the changes to London's health services it is essential that the consultation processes are as open to public perusal, and as well-evidenced, as is feasible. However, there is a second issue, that of the consistency of these individual choices. On the basis of recommendations contained in the consultations we have discussed, the map of London's A&E services would be re-drawn substantially. The same is true of in-patient and ambulatory services. It is essential that any new pattern of provision which emerges is examined in terms of its ability to produce a viable pattern of services for London as a whole.

We have already pointed to concerns about where the ultimate responsibility lies for ensuring that these changes are managed and co-ordinated sensibly. Although the LIG A&E Reference Group took a pan-London view of A&E services, recent reports on the LAS continue to highlight these problems of co-ordination. The decrease in the number of A&E departments has already been indicated as a factor leading to increased pressure on London's ambulance services. Further reduction will lead to more pressure. A London-wide review of emergency services would have to take into account the ability of the LAS to deliver emergency ambulance services within whatever pattern of A&E provision ultimately emerges.

Conclusion

Two questions have been posed by this commentary but no definitive answer is available to either. The question of what is the fair level of financial resources for London's health care requirements is one which must be answered in 1995. This is paramount if London's purchasers, and trusts, are not to make a series of irreversible decisions on the basis of an imperfect assessment of the health needs and special conditions in London.

The second question of how to effect a change in the system of delivery of health care from a largely hospital-based system to one based more in the community, and perhaps more fundamentally, how far and how quickly to take these changes, has clearly not been answered in 1994. Certainly a vision must be created of a better and more modern system of health care delivery for London, but this must also be matched by a determination to ensure that high-quality services continue to be available in the capital, and elsewhere in the country, even while the disruptive process of transition takes place.

FACTS AND FIGURES

Introduction

In this part of the Monitor we present the latest available information describing the population of London, its health, the health care services available in the capital, and the use which is made of these services. As ever, the availability of compatible data is a limit on the comprehensiveness of such an enterprise.

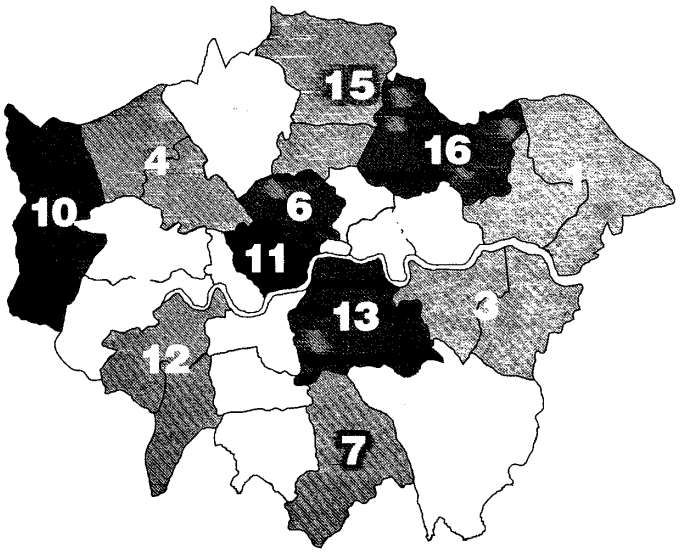
Nevertheless we provide a snapshot of some of the main features of the health and health care of Londoners. In some cases an update is provided of the tables in last year's London Monitor, in others we present different information. This provides a basis for comparison with previous reports on London – particularly those published by the King's Fund Commission (Benzeval *et al.*, 1992; Boyle and Smaje, 1992; Boyle and Smaje, 1993) as well as last year's London Monitor (1994).

The position in London is compared with that of England as a whole using a variety of perspectives which are primarily dictated by the data available. Information is presented on a London-wide basis, and in most cases using a categorisation of London into three types of area: inner-deprived, mixed-status and high-status, based on a classification system devised for the original King's Fund Commission work referred to above, which groups areas according to socio-economic and demographic characteristics.

Usually information is organised by district purchaser or Family Health Services Authority (FHSA) according to which services are being discussed. In cases where a different organisation of the data is used this is made clear. In subsequent years, as DHAs and FHSAs are formally merged, it will be possible to present all data in terms of a single entity – the health agency. Five districts are identified as inner-deprived London purchasers: Kensington, Chelsea & Westminster; East London & the City; Camden & Islington; South East London (now known as Lambeth, Southwark & Lewisham); and Wandsworth. Of the remainder, four are classified as mixed-status: Ealing, Hammmersmith & Hounslow; New River; Redbridge & Waltham Forest; and Brent & Harrow: and the remaining eight are high-status areas. When data are presented in terms of FHSAs,

Map 1: The London purchasing authorities, 1994-95

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



Wandsworth is merged with Merton and Sutton, and this area is then transferred to the mixed-status category for the purposes of this analysis. In April 1994 Wandsworth and Merton and Sutton health authorities merged to form one purchasing authority. This will be reflected in subsequent analyses when the new authority will be part of the mixed-status category.

A map of London is provided which shows the current boundaries of the London purchasers. There are approximately 40 acute hospital trusts in London and 20 community or mental health trusts. Both acute and community or mental health trusts may be responsible for the management of hospital sites, and in some cases, trusts have responsibility for several sites. Of the acute trusts, over two-thirds are in north London; 15 are in inner-deprived London.

The first section, using Office of Population Censuses and Surveys (OPCS) estimates for 1993 and projections for 1995, provides information on the structure of the population of London purchasers. This is followed by a section presenting some broad indicators of mortality based on the data underlying the Health Services Indicators (HSIs) for 1992-93, (Department of Health, 1994).

The third section considers the availability of resources in London, both in terms of funds available to London purchasers and in terms of the availability of beds in London. The total revenue expenditure of London district purchasers is presented and a breakdown of expenditure on Family Health Services is also given. Figures on the availability of hospital beds, based on the latest Department of Health data (Department of Health, 1994), are also presented and contrasted with the availability of places in residential care homes (Department of Health, 1994).

Section 4 provides information on the use of Hospital and Community Health Services (HCHS) by residents of London. The analysis refers to 1992-93 and is based on the data underlying the HSIs. Section 5 presents some important indicators of Family Health Services (FHS) activity and staffing levels using a mixture of information from the 1992-93 HSIs and General Medical Services (GMS) Basic Statistics for April 1994.

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

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

London's Population

This section presents the most recent estimates of the current population of London, based on OPCS 1993 mid-year estimates, broken down by age-group. Health care purchasing agencies are used as the basic geographic unit. Changes to health care purchaser boundaries have brought the definition of London, for health care purposes, closer to the local-government-based definition of Greater London. These changes mean that London purchasers no longer have responsibility for non-London areas (Brentwood, Spelthorne and Esher). However it makes comparisons during this period of transition more complicated, particularly as the data we use often refer to periods when only partial boundary changes had been enacted. We have ensured that the population bases used throughout correspond as closely as possible to the areas for which London purchasers had responsibility, at the time to which the data refer.

Because of these changes, the population of London, for health care purposes, is now less than it would otherwise have been. To some extent this has been disguised by the growth in the population of London during recent years. In 1993 the population of London was 6.94 million (OPCS mid-year 1993 estimates using current health authority boundaries). On the old definition of London health areas, this would be 7.11 million. There is still a slight difference between the estimate of London's population based on local authority areas, and that based on health areas, due to minor local authority boundary changes on the perimeter of the capital which are reflected in the local authority definition but not in that of the health authority (this affects Barnet, Harrow and Hillingdon). Care must also be taken in interpretation of data from Kingston & Richmond, and from Wandsworth health authorities. In April 1994 Kingston & Richmond Health Authority became co-terminous with its constituent local authorities, thereby losing responsibility for the population of Esher and for parts of Putney which transferred to Wandsworth's control.

Figure 1 compares the breakdown, by age-group, of the population of London with that of England as a whole. London has a relatively younger population and, in particular, has considerably more 25-44 year-olds. Exceptionally, there is a higher than average proportion of people aged 85+ in high-status London areas. There are also clear differences within London: high-status London areas generally have an older age profile than the inner city.

1995 population projections, based on current trends in fertility, mortality and migration, are used

Figure 1: The age distribution of London's population, 1993

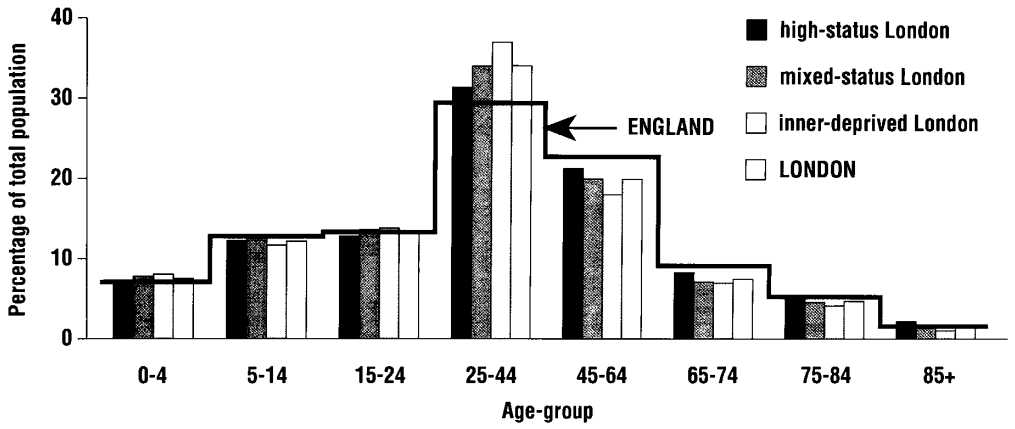
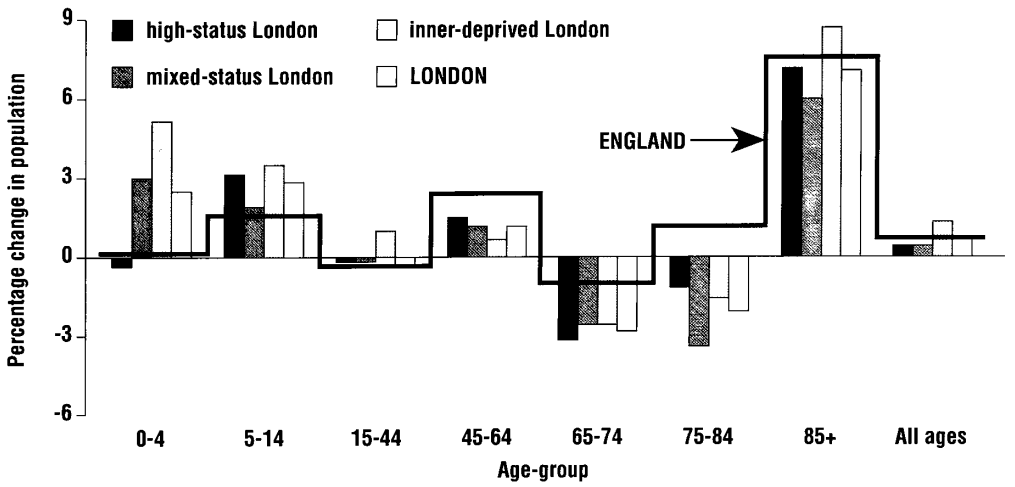


Figure 2: Projected percentage changes in London's population between 1993 and 1995

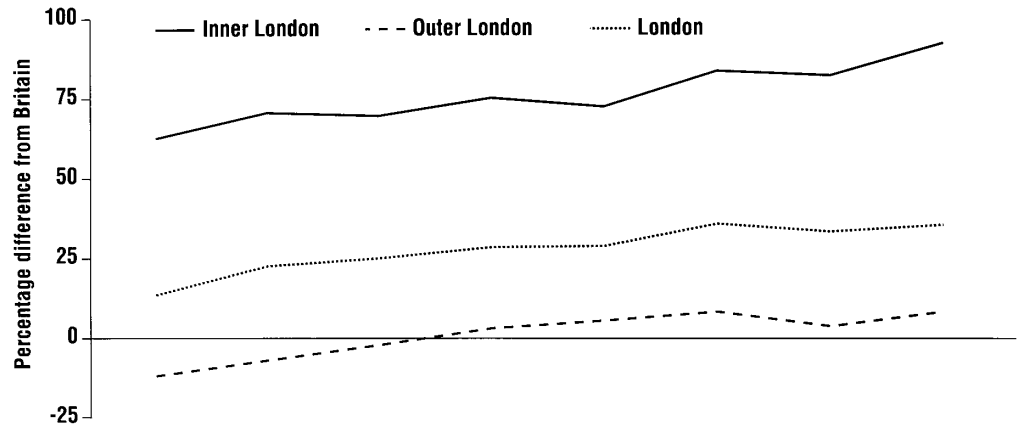


in Figure 2 to show the proportionate change in London, by age-group. The overall population of London is projected to grow by over 50,000 by June 1995, a rate of change equivalent to that of England as a whole – less than one per cent. The population of inner-deprived London is expected to grow at almost twice the national rate, though this still represents a small absolute increase. However, there will be significantly greater increases throughout the country in the 85+ age-group, with an increase of 7.6 per cent in England and 8.7 per cent in inner-deprived London. This is potentially a high-cost age-group in health service terms. The most recent estimates by the Department of Health indicate approximately £2,260 per capita was spent on this age-group in 1992-93, five times as much as the overall per capita expenditure on HCHS which was £420.

Last year we presented a profile of the current population of London based on the 1991 Census in which it was shown that inner London had over 60 per cent more unemployment than England as a whole, twice as many one-parent families, and three times as much overcrowding and poor amenities (though this variable affects only a small proportion of the population). Over a quarter of the inner-deprived London population belongs to minority ethnic groups compared to just six per cent in England as a whole.

This year we present some more detailed information on the social and economic conditions

Figure 3: The rate of unemployment in London, 1991 -1994

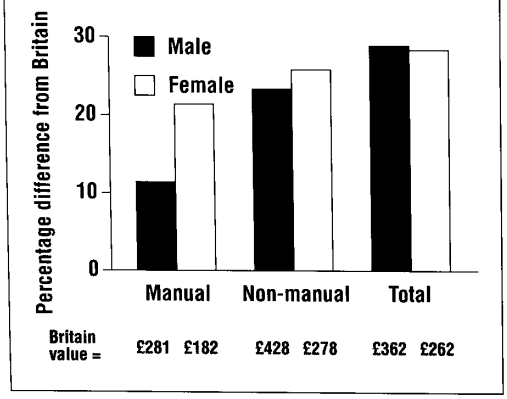


facing Londoners, based on analysis by the London Research Centre (LRC), (1994). These data reflect factors such as unemployment, housing conditions and labour costs all of which may impact on the use and cost of health services in London.

The unemployment rate in London increased steadily from April 1991, reaching a peak of 14.1 per cent in August 1993. Although the rate had fallen to 12.2 per cent by October 1994, it was still 3.4 percentage points above that of Britain (8.8 per cent). Figure 3 compares the increase in unemployment in London with that of Britain as a whole. Inner and outer London in this instance are defined in terms of inner and outer London local authorities.

The proportion of people unemployed in London relative to that in the rest of Britain has been increasing steadily since 1991. By October 1994 the unemployment rate in London was nearly 40 per cent more than the national average. The unemployment rate in inner London is now almost twice the rate of Britain. Thus the Census figures underestimate current differentials between unemployment in London and the rest of the country.

Figure 4: A comparison of average earnings between London and Britain, 1993



An LRC analysis of the 1994 New Earnings Survey revealed the extent of the difference between labour costs in London and the rest of Britain. Figure 4 shows the percentage difference between average gross weekly full-time earnings in London and Britain, for manual and non-manual workers, male and female. Non-manual labour costs are approximately 25 per cent higher in London in the case of both males and females; manual labour costs are over ten per cent higher for males in London compared to the national average, and over twenty per cent higher for females. Although these findings reflect wage differentials generally, this evidence supports the common assertion that the cost of health care production is higher in London than elsewhere.

Finally, according to the LRC, the number of households officially accepted as homeless has fallen by three per cent in London between 1992 and 1993 to 36,587. The proportion of these housed in temporary accommodation by the London boroughs fell by approximately 5,000 between September 1992 and September 1993. Less bed and breakfast

accommodation has been used with an increasing reliance by local authorities on private sector leasing or other uses of private sector properties.

The health of Londoners

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

Once again Standardised Mortality Ratios (SMRs) are used to reflect the health of the population (Department of Health, 1994). The SMRs reflect the rate of death in an area relative to an age-standardised norm, which in this case is derived from English death rates. Figure 5 shows differences between high-status, mixed-status and inner-deprived London, and London as a whole, for SMRs of three age-groups, 0-14, 15-64 and 65+, together with the SMR for all ages.

A positive difference indicates that there are more deaths than would be expected on the basis of national rates for that age-group, a negative difference, less. It is immediately apparent that the direction and extent of differences between areas of London and England as a whole is very much dependent on which age-group is considered. The SMR in inner-deprived London is considerably higher than the national value in all but the 65+ age-group: in the case of 15-64 year olds, who make up 65 per cent of the population, by almost 25 per cent. However, for the 65+ age-group, all areas of London exhibit a lower SMR than is the case nationally. Over 80 per cent of deaths occur in this age-group, and so when the SMR for all ages is calculated it is just two per cent higher in inner-deprived London than is the case elsewhere. On this basis alone London appears to be healthier than average with an SMR some four per cent below that of England as a whole, and in high-status areas of the capital all age-groups would appear to be healthier than average.

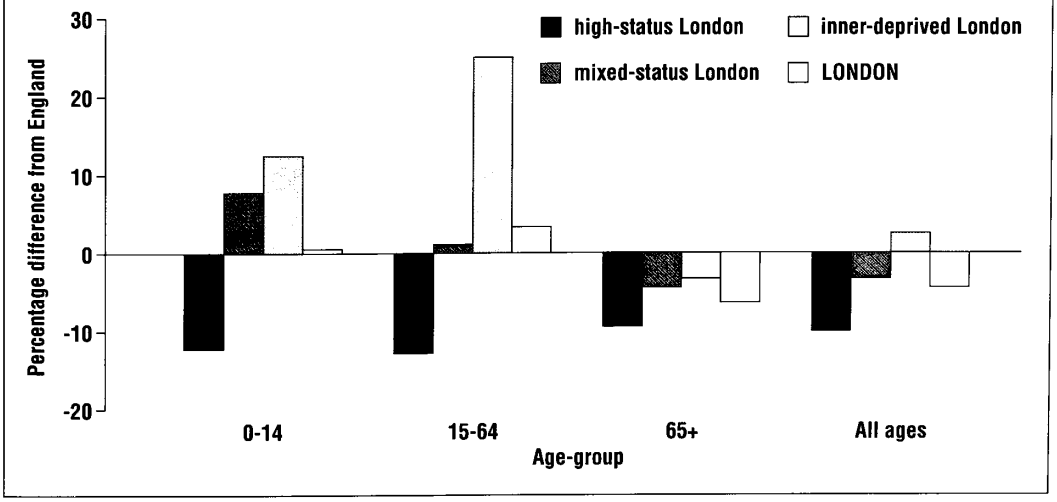
Although the SMR is not a perfect proxy for ill health it provides a starting point for looking at the health of any population group. 25 per cent more residents of inner London areas in the 15-64 age group die annually than would be predicted on the basis of national figures, and 12 per cent more children under the age of 15. If these are good predictors of ill health among these age-groups then the evidence suggests that the majority of inner London residents suffered more ill health than is the case nationally.

Resources in London

Expenditure on health services

We turn now to how much is spent on health services in London. In 1994 the twin issues of how much is spent on the health care of Londoners and what is a fair amount to spend relative to expenditure in the rest of the country have assumed great significance. The first question is more difficult than it seems as part of what is spent in London is not correctly attributable to expenditure on the residents of London. For example a considerable amount is spent on medical education and research. The use of simple district expenditure figures can therefore be misleading. Nevertheless, it is useful as a starting point for any

Figure 5: Percentage differences in all-cause SMR between London and England, 1993



discussion to know exactly how much is spent by London purchasers.

The second issue of what is a fair amount to spend on the health care of Londoners is considerably more complex. In 1993 the Department of Health commissioned work from the University of York which has formed the basis of the most recent allocations of HCHS funds to regions. The level of funds available to London purchasers has generally been higher than that nationally. This reflects three factors: the higher costs of inputs in London which, historically, has been taken into account through various special factors: London Weighting, the Market Forces Factor and the Thames Special Allowance; the higher level of need in some London districts; and possibly, the historic overfunding of London districts which is gradually being reduced. This overfunding element has recently been estimated by the Department of Health at £65 million for 1994-95 (Health Committee of the House of Commons, 1994).

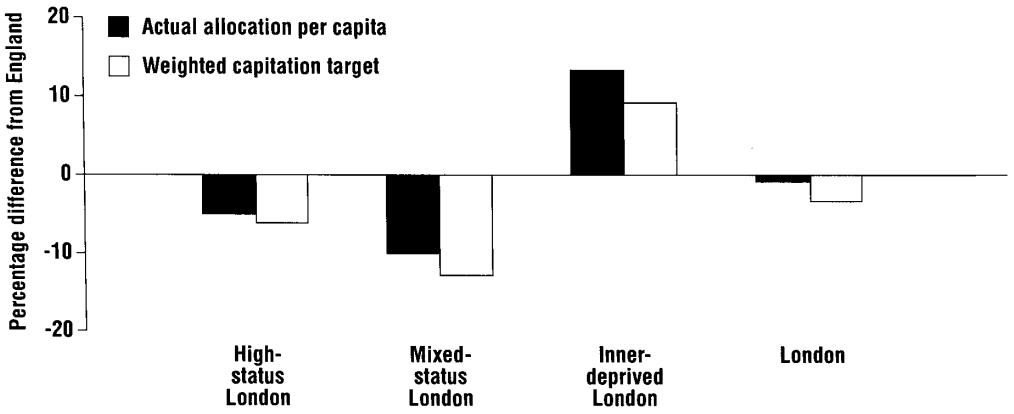
In this section we present information both on total expenditure by purchasers on Hospital and Community Health Services, and on the estimated differences between the funds received by London districts and their 'fair shares'. We also consider the main constituents of Family Health Services expenditure.

Figure 6 is based on information provided by the Department of Health (Health Committee of the House of Commons, 1994), and refers to 1994-95 allocations by the Thames regions of that part of their budgets which they considered should be allocated on a 'weighted capitation' basis (actual allocation per capita). What should be allocated thus, and how it is done, varies between regions.

When compared with the total 1994-95 HCHS allocation which the Department of Health indicated should be allocated on a weighted population basis (the weighted capitation target), the data show that per capita expenditure in inner-deprived London districts is in fact intended to be just nine per cent greater than the England average. High-status and mixed-status London districts, on the other hand, have a target allocation which is below the England average, by six per cent and thirteen per cent respectively. The target allocation for London overall is some three per cent below the national average.

However, if these are regarded as 'fair' differences based on some notion of the needs and special conditions in different parts of the country, then, in Figure 6, the differences between the columns showing actual and target allocations in 1994-95 indicate an 'unfair' level of expenditure in some parts of London, even though this actual allocation is still less than the national average in all but inner-deprived London. London as a whole is estimated to be 2.6 per cent over its 'fair' target allocation. This is composed of 1.5 per cent in high-

Figure 6: London purchaser allocations and weighted capitation targets, 1994-95



Notes

1 1994-95 allocation data are derived by individual RHAs using methods which may differ.
2 Allocations include money which is allocated to GP fundholders.
3 Allocations do not take acount of SHAs.

	Difference from target absolute	percentage
	£000s	%
High-status London	13,920	1.5
Mixed-status London	23,604	3.5
Inner-deprived London	27,705	2.9
London	65,229	2.6

Figure 7: Total DHA revenue expenditure per capita, 1992-93

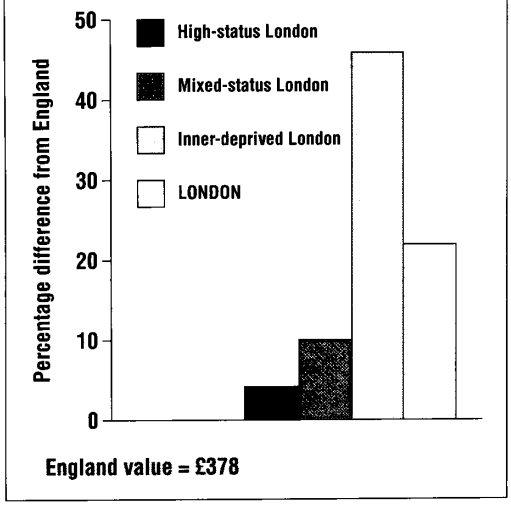
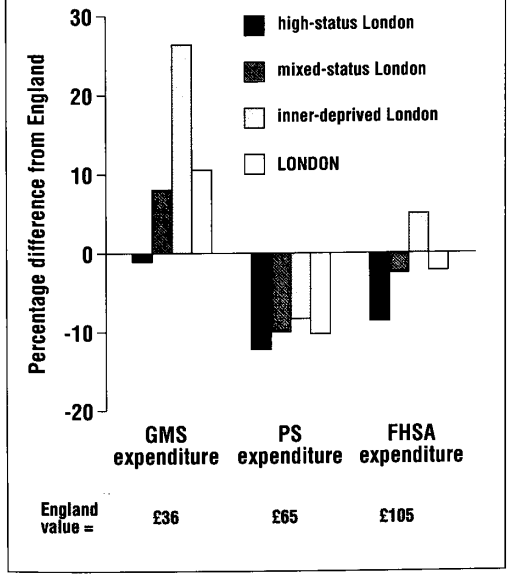


Figure 8: FHS expenditure per capita, 1992-93



status areas, 3.5 per cent in mixed-status, and 2.9 per cent in inner-deprived London. However, differences vary considerably across London. It is on the basis of these allocations and the attempt to correct what is seen as a mis-allocation, that so many districts in London are struggling to bring their budgets in line with national targets.

However, this is not the total expenditure for which district purchasers have responsibility, a matter which serves to confuse the issue further. Using the same source, Figure 7 shows per capita expenditure in London in 1992-93 compared with per capita national expenditure. We see that in London as a whole, expenditure per capita was 22 per cent greater than the England average. In inner-deprived London, per capita expenditure is 46 per cent greater than the England average.

Turning to expenditure on Family Health Services, a somewhat different picture emerges. Using the HSI data for 1992-93, Figure 8 shows the breakdown of FHS expenditure in London compared to the national picture in terms of the two major expenditure items, General Medical Services (GMS) and expenditure on pharmaceutical services (PS).

Inner-deprived London FHSAs spend over 25 per cent more per capita resident population on GMS than their counterparts in the rest of England. London overall is spending over ten per cent more. This is a similar finding to that for HCHS expenditure, although the disparity in London is considerably less for GMS. A different picture emerges when expenditure on PS is considered. All London districts are spending less than the national average – 10 per cent in most cases. This is due to a lower level of prescribing in London, where there are nearly 10 per cent less prescriptions dispensed per capita than is the case nationally. The effect though is to make the overall level of expenditure on these two services less in London than in England as a whole: overall expenditure in inner-deprived London remains four per cent more than the England figure; however, in London as a whole three per cent less is spent.

Availability of beds

It is often claimed that beds are not a useful measure of the availability of care in an area. This is based primarily on the assumption that in future there will be less hospital-based care, with more services delivered in community settings. Moreover, what is delivered in hospitals will be produced more quickly as the proportion of daycases increases ever more rapidly. Nevertheless the need for hospital beds (and staff) remains, and so there is some validity in comparing the situation in London with that in England as a whole – if only because a central tenet of recent policy is that there are too many beds, and hospitals, in London. It is only by examining how many beds there are now that we can begin to answer if there are the correct number.

The decline in the number of acute beds in London relative to the rest of England is well-documented. Between 1982 and 1993-94 the number of acute hospital beds in England reduced by 23 per cent, from 143,500 to 110,000. In the same period the number of beds in London fell by almost 40 per cent, from 29,250 to 17,600 (these figures include Special Health Authority (SHA) beds).

Figure 9: Availability of hospital beds for acute and elderly care in London, 1993-94

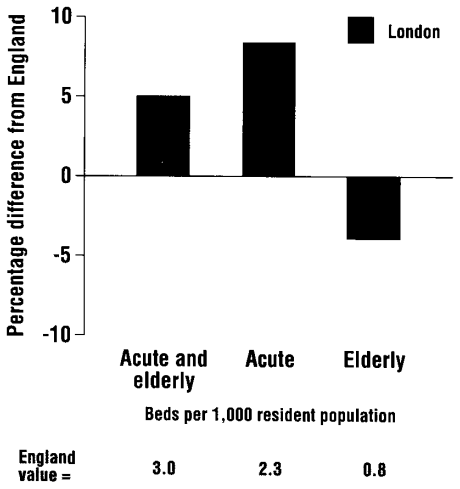


Figure 10: Availability of residential care places in London, March 1994

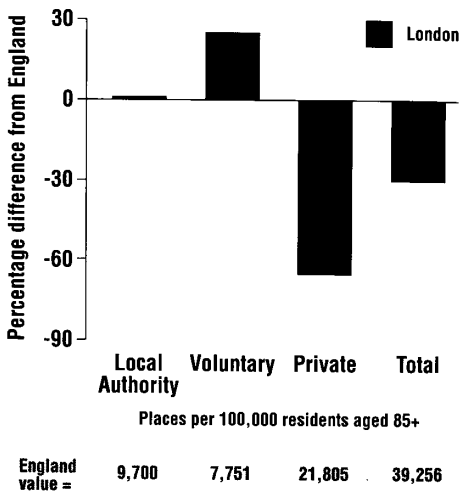


Figure 9, which is based on the latest bed availability figures from the Department of Health (Department of Health, 1994), compares the number of beds available in London, per capita resident population, with that in England as a whole, in 1993-94. Comparisons over time are complicated by the fact that some London authorities have lost responsibility for parts of their population, as referred to earlier, and similarly, at least one acute trust is no longer strictly within the boundary of London health authorities.

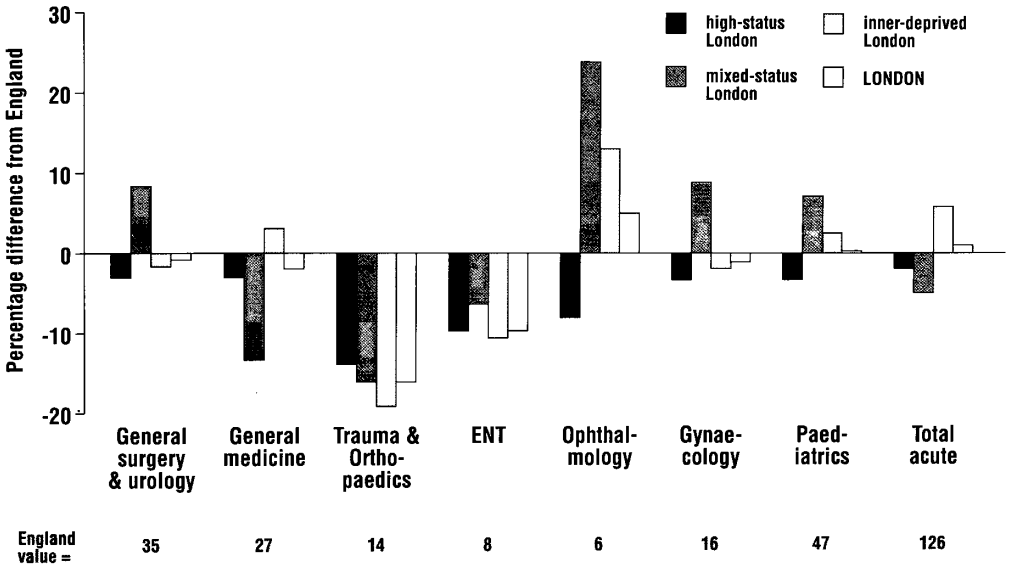
Bearing this in mind, the number of acute beds in London as a whole has fallen by nearly 1,300 since 1992-93, compared to a decrease of 1,700 acute beds in the rest of England (boundary changes account for a little over 200 of these beds in London). Figure 9 shows that there are eight per cent more available acute beds per capita in London than in England as a whole. We have not included figures for the other London categories on this occasion as recent changes are making interpretation of such figures uncertain. Inner-deprived London purchasers have over 40 per cent of the total acute beds in the capital within their boundaries, but the geography of London is such that very often these hospitals serve as local hospitals for the residents of mixed-status areas.

Figure 9 also shows that London as a whole has four per cent less beds per capita for elderly services than the England average. When beds for acute and elderly services are aggregated, then London has five per cent more beds in total. SHA beds have been included. If these were excluded from the analysis, then London would have approximately the same number of beds as the England average.

It is important when considering care of elders to look at the availability of residential care, as lack of such places may result in greater and inappropriate pressure on hospital beds. Figure 10 shows there are considerably less residential care home places for London's elderly population than is the case nationally. The majority of people using such homes are in the 85+ age-group, and so availability has been expressed in terms of places per capita resident population aged 85+. The results are unaltered if the 75+ age-group is used.

London as a whole has only 70 per cent of the national average number of residential care places per capita. As Figure 10 shows, this is primarily due to a lack of places in private care homes, which make up the greatest proportion of such care nationally (56 per cent): the availability of private care places in London is just 36 per cent of the England average. The voluntary sector in fact accounts for a large proportion of residential care in London. This lack of residential care in London (and a similar situation exists when nursing care places are considered) is reflected in hospital admission figures for the 75+ age-group in London which, as we show in the next section, are higher than average.

Figure 11: Standardised hospitalisation rates per 1,000 resident population, 1992-93



The use of health services by Londoners

In this section we look at three aspects of the use of Hospital and Community Health Services by Londoners: the number of in-patient and daycases in the major specialties; the use of mental health and care of the elderly services; and the use of district nurse and health visitor services in terms of contacts. In each case 1992-93 HSI data are used.

Hospitalisation

Figure 11 presents standardised hospitalisation rates for high-status, mixed-status and inner-deprived London, for seven major specialties plus a total acute figure which includes all of these specialties except paediatrics, plus some of the minor medical specialties, which figure more prominently in London than elsewhere. Hospitalisation rates are a measure of utilisation of hospital services, expressing the number of in-patient and daycases per capita resident population.

According to these data London residents make approximately the same use of acute hospital services as is the case nationally with a standardised hospitalisation rate just one per cent more. Inner-deprived London uses six per cent more services than the national average. There has been a reduction in utilisation since the previous year when London overall, and inner-deprived London residents in particular, had higher than expected utilisation rates, on the basis of age structure and England average rates. This is primarily due to the significant reduction in the use of the General Medicine specialty by London residents.

As Figure 11 shows, in the General Medicine specialty, where approximately 20 per cent of total activity takes place, inner-deprived London areas use just three per cent more than would be expected. There is considerably less use of the Trauma & Orthopaedics specialty in most areas of London – almost 20 per cent less in inner-deprived London – but greater use of Ophthalmology services. In London as a whole, hospitalisation rates in paediatrics are about average although high-status London uses less than average and other areas of London correspondingly more.

Taken at face value, this evidence would seem to confirm that efforts to reduce levels of hospital-based activity in London relative to the national picture have had a definite impact.

Care for Elders and those with Mental Health Problems

Figures 12 and 13 show the use of mental health services and services for elders, in 1992-93, measured in terms of resident population. Figure 12 reveals a varied pattern of utilisation of mental health services in London. Considerably greater use is made of acute mental health services by the 16-64 age-group – London as a whole uses 28 per cent more services than the national average – but in the 65+ age-group there is nearly ten per cent less utilisation in the capital. In the 16-64 age-group most of the excess is due to the rate of utilisation in inner-deprived London which is over 70 per cent above the national average. Older inner-deprived London residents also use more services but this is compensated by the considerably less use found in other areas of the capital. High-status London residents aged 65+ actually use nearly 25 per cent less mental health services than the average in England as a whole.

Figure 13 compares the utilisation of services for elders in London with that in England as a whole. Again a varied pattern emerges. In the 65-74 age-group there is a remarkably low rate of utilisation in London, almost 60 per cent of the England average. This may be an artefact of the data reflecting the fact that this age-group is more often cared for in another specialty, in which case we would expect this to emerge in the data discussed previously. It does not.

In the 75+ age-group there is greater utilisation in London – approximately seven per cent in London as a whole and over 15 per cent in inner-deprived London areas. This may be a reflection of the lack of residential care available in the capital. In any case it needs to be considered in the light of the evidence which was presented in Figure 10.

Community nursing

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

Figure 14 compares the number of district nurse contacts in London with the national average for two client age-groups, 16-64 years and 75+ years. Most contacts actually take place with the latter client group, in some areas ten times as many as in the 16-64 age-group. In both cases, as the figure shows, London residents have less contacts per capita than the England average. In the more important 75+ age-group there are almost 20 per cent less contacts per capita in London overall; in the 16-64 age-group, 30 per cent less. On the basis of these data the situation in London appears to have deteriorated between 1991-92 and 1992-93, for both age-groups (see last year's Monitor).

Figure 15 shows similar information for contacts by health visitors with three client groups, the one-year-old age-group, the 2-4 year-old age-group and those aged 75+. In this case it is the two younger age-groups where most activity takes place. In the

Figure 12: The use of mental health services in London, 1992-93

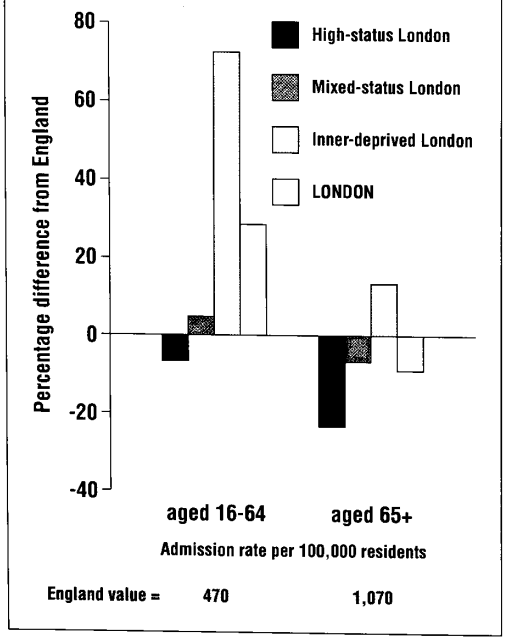


Figure 13: Health care for elders in London, 1992-93

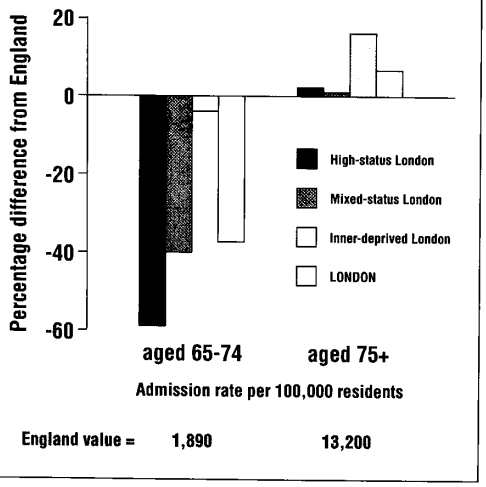


Figure 14: District nurse contacts per capita in London, 1992-93

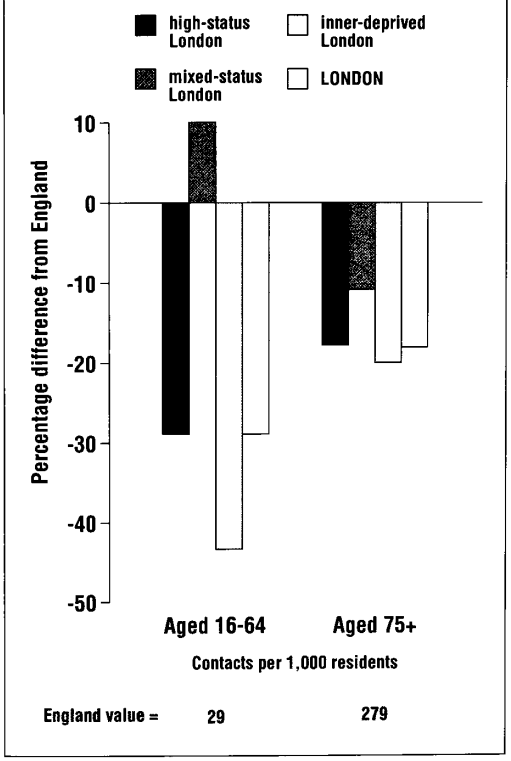
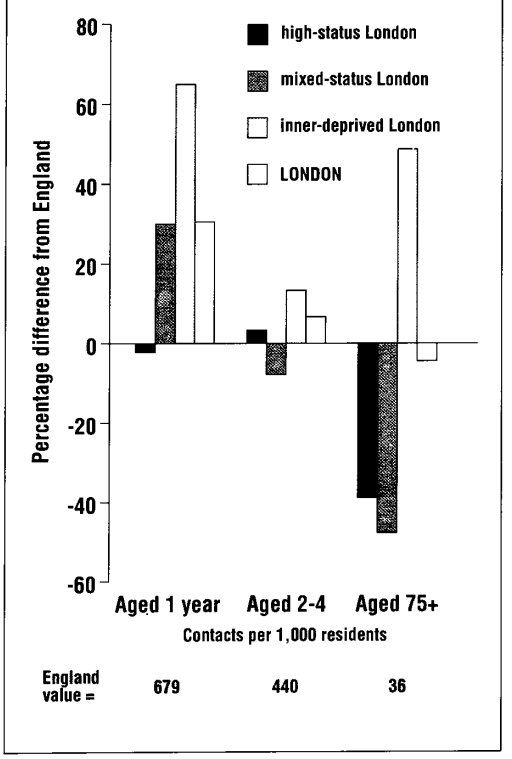


Figure 15: Health visitor contacts per capita in London, 1992-93



youngest age-group London has 30 per cent more contacts per capita than the England average, with, as the figure shows, a considerable differential across London. High-status London is close to the national average but inner-deprived London areas have nearly 65 per cent more contacts per capita.

In the 2-4 year-old age-group London residents again make more use of health visitor services, though only five per cent more; for the 75+ age-group, contacts per London resident are four per cent below the national average. There is a wide diversity between types of London area with high- and mixed-status London almost fifty per cent below the England figure and inner-deprived London nearly 50 per cent above.

Primary Health Care Provision

This section compares the level of staffing of family doctor services in London with that nationally and presents a profile of those services. Figure 16, based on data for April 1994 from the GMS Basic Statistics (Department of Health, 1994), shows that, on average, there are nearly nine per cent more GPs per capita in inner-deprived areas of London

Figure 16: Primary care staffing in London, April 1994

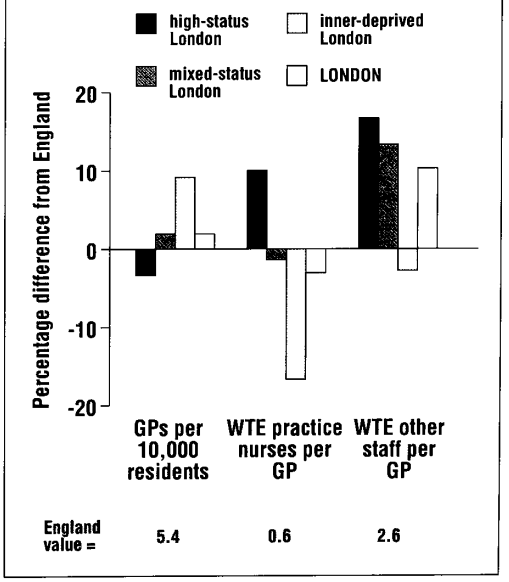
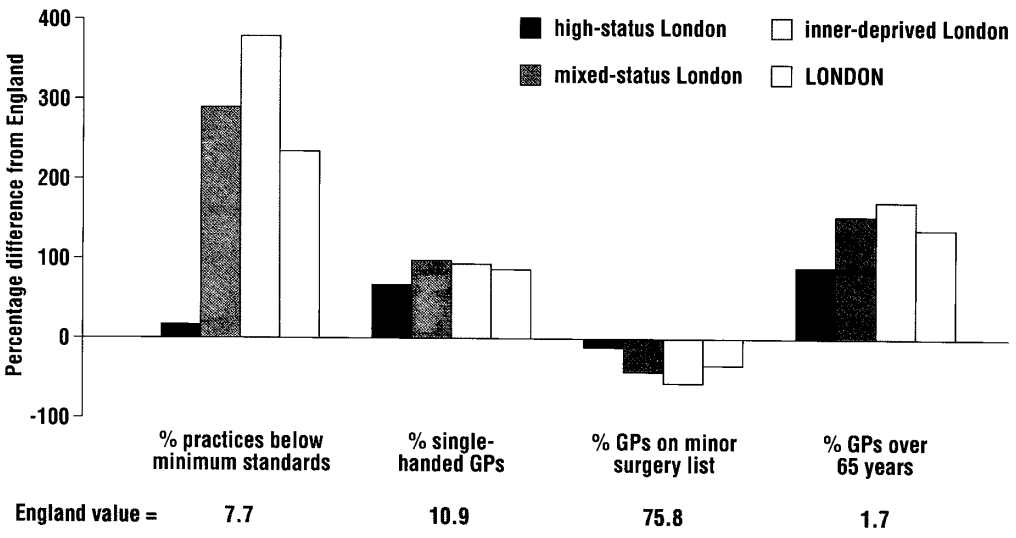


Figure 17: Primary care profile, 1992-93



than in England as a whole; in mixed-status areas there are just two per cent more and in high-status areas there are in fact nearly four per cent less GPs per capita. As a result London as a whole has now just two per cent more GPs than the England average. Though this is a fairly similar picture to that for 1992 (see last year's Monitor), surprisingly, London has experienced a slight fall in the number of GPs per capita resident population.

However, there is a marked improvement with respect to the number of support staff for each GP. Thus, although there are still less practice nurses per GP in London when compared with the England average (three per cent less), there are now over ten per cent more 'other support staff' such as receptionists and practice managers. Inner-deprived London remains less well-served than the rest of the country, and is particularly short of practice nurses with 17 per cent less than the England average per GP. In fact 32 per cent of practices in inner-deprived London are without a practice nurse compared to 10 per cent in England as a whole.

Figure 17 presents a profile of family doctor services comparing London with England as a whole on a number of indicators, derived from the HSIs for 1992-93. The situation in London, particularly inner-deprived London, is very different from England as a whole, and continues to confirm the picture of an underdeveloped service which has been highlighted elsewhere (Boyle and Smaje, 1993).

Thus over 37 per cent of inner-deprived London practices and nearly 30 per cent in mixed-status London are below minimum standards. The figure for London overall is over 25 per cent compared to England where less than 8 per cent fall below these basic standards required under the rent and rates scheme. If anything the position in London has deteriorated compared to that shown in last year's Monitor, for 1991-92, and certainly compared to England as a whole. The proportion of GPs in London offering minor surgery to their patients has increased slightly in London since 1991-92, but remains low compared to the England figure.

Over 75 per cent of GPs nationally are offering minor surgery to their patients, an increase of nearly seven per cent in one year. In inner-deprived London the figure has increased to 35 per cent and in high-status London, 65 per cent are now providing this service.

London has long been characterised as having more single-handed, elderly GPs than the country as a whole, which though not necessarily problematic in itself, may be indicative of the special difficulties which London faces in providing a fuller range of family doctor services. In 1992-93 London as a whole had almost twice as many single-handed GPs and twice as many over the age of 65. In the inner-city areas of London the position is marginally worse.

There is some evidence of improvements in the infrastructure of family doctor service provision on the basis of the nationally available comparators which we have presented. In particular there has been a substantial increase in the number of support staff. However, in the case of basic minimum standards, for example, London is standing still in relation to other parts of the country.

Conclusion

The information provided here gives a further insight into the way in which the overall pattern of health and health care in London has developed in the wake of the NHS reforms and the spate of planning and development activity following the reports of the King's Fund and the Tomlinson Committee. As yet, what evidence there is suggests that any significant change to the imbalance between primary and acute services in London is occurring through a reduction in the provision and use of hospital-based services rather than substantial improvements in primary and community care services. The familiar pattern of underdeveloped primary services and relatively high expenditure in the Hospital and Community Health Services sector remains.

It is still important to monitor developments in the pattern of care in London, and more difficult as the sources of information become dispersed and disparate. We strongly recommend that there is a firm commitment from health services agencies at all levels to make their reports and underlying data available for independent assessment of fact and argument. The first test of this commitment may come with the publication of the report on work commissioned by the Inner London Health Authorities on the current state of health care in the capital.

As we concluded last year, crucial to any attempts to assess the development of health services in London is the continued provision of detailed information about all aspects of health and health services in the capital.

Analysis and debate

MAKING CHANGE HAPPEN IN LONDON
A medical perspective

Peter Simpson

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Introduction

Many of the household names of British medicine are to be found in London. Famous hospitals such as Great Ormond Street and Bart's have earned the public's gratitude, over centuries in some cases, and done so not by pointing to past achievement but by offering patients the most recent knowledge and techniques and caring for the local community. Progress has not been evenly paced, but rather has spread in ripples, sometimes generated by clinical advances leading to the formation of a specialty, and in the past perhaps a specialist hospital, sometimes for organisational reasons (the 1946 NHS Act and 1974 reorganisation) or to introduce research (the Hammersmith Hospital), to improve education (Flowers) or to replace facilities (the Hospital Building Plan).

Over the last three years a number of publications have taken stock of the situation including the Tomlinson report (Department of Health, 1992), the King's Fund Commission Report (King's Fund Commission, 1992), Making London Better (Department of Health, 1993), the Specialty Reviews (LIG, 1993) and the Research Reviews (Review Advisory Committee, 1993). These reports have shared the perspective that the delivery of health care in London should change in response to the growing fundamentalism in bio-sciences, complexity in medicine and opportunities in therapeutics which have led to increased specialisation in both the academic and clinical worlds. As the number of specialists has grown so has the need for collaboration to provide a comprehensive programme. London has fallen behind in the size of its groupings – as the cancer review commented, no centre in central London any longer provides a comprehensive service.

Similarly there are opportunities to bring basic science and clinical research more closely together, and the Higher Education Funding Council is seeking a smaller number of larger medical schools in which the new integrated General Medical Council syllabus will be taught. This is the first time that the ripples in service, research and teaching have run together and in a tight financial situation are, by their synergy, generating suggestions for a major realignment of medical practice.

This article describes the way in which discussion has developed on a broad geographically sectoral basis, and refers to a number of big issues which may temper the way in which change takes place. Some questions are then raised about the readiness of London's health services for change before finally describing the task ahead.

The development of sectors

A natural reaction to criticism of small departments was to propose extra appointments and to take up the Government's challenge to compete in the market place, and to succeed as money followed the patients. This approach has tended to lose ground as it became apparent that extra money was not forthcoming because revenue allocations were following the demographic shift away from inner London. Moreover, general practitioners and patients demonstrated a preference for their common conditions to be treated at their local hospital rather than travel into the capital. If the 43 acute hospitals with over 250 beds each took on more staff, even more consultants would be vying for smaller shares of each hospital's resources resulting in a demand for more space which site availability and planning regulations would not permit, and purchasers could not afford. With inner London already having twice the number of consultants per head of population found elsewhere in England, and a third more than other university cities, this would be a path fraught with personal and institutional danger and frustration.

In its place a broad measure of agreement is developing that the answer could lie in a group of hospitals working in collaboration with each other and with a university college to establish an interdependent network of clinical specialties and academic departments. The purpose would be to generate comprehensive departments which meet the full range of responsibilities in service, teaching and research. Such departments would hope to attract patients with the most complex and severe illnesses over a wide area, for treatment at a cost that is defrayed by centralising facilities in each specialty, particularly in-patient beds, increasing the use of minimally invasive techniques and day care regimens, and rationalising common support

facilities. Some might describe this as an interpretation of the 'regional specialty' concept applied across medicine as a whole.

In seeking to form appropriate groupings of hospitals in London, discussion has led to the identification of five sectors, North West, North Central, North East, South East and South West, four of which are associated with a college of London University, which are respectively Imperial, University, Queen Mary and Westfield, and King's Colleges. The exception is St. George's Hospital in South West London which is developing a comprehensive medical campus largely on site. Each of the sectors has features in common such as teaching hospitals, associated university hospitals, single specialty hospitals and postgraduate Institutes, currently within the British Postgraduate Medical Federation. The hospitals vary in size and specialist interest and in the current standing of their service, research and teaching programmes. Each unit can identify internal changes in practice that would improve their financial position and competitiveness, but they also realise that in some cases collaboration with a neighbour could result in a quantum leap forward in performance and prominence. The sectoral approach would be no less competitive, but instead of fighting the battles of Shepherds Bush or Camden Town, it would be national and international recognition that was at stake.

In this context, the single specialty hospitals are thinking again about multi-specialty collaboration, and the postgraduate Institutes are considering how best to exploit the potential of associating with the university colleges. Every teaching hospital does not have to be self-sufficient in its range of departments but each core specialty in the syllabus must be taught somewhere, which might involve undergraduate teaching by staff at postgraduate hospitals. This however does not mean hospitals would be left without a service in important specialties, but rather there would be acceptance of the suggestion made in several of the specialty reviews, of working on a hub and spoke principle. This means concentration of expensive techniques, surgical intervention and beds on one site, the hub, with out-patients, routine investigations and day care regimens throughout the group of hospitals that are the spokes. Progressively concern for these functional relationships is receiving more attention with somewhat less emphasis placed on loyalty to a particular site.

What is yet to be devised are the ways in which service and academic interests will work together in each sector. Who is to embody the sectoral interests and what will be their source of authority? With trusts only recently established, there may be considerable resistance to the ceding of powers and to heeding suggestions made from a sectoral perspective. Some joint trusts have been formed, of which Hammersmith and Charing Cross is one of the best known examples, but the problems of a 'united nations' of hospitals will be very real if caveats and exceptions are allowed to extend discussion, and the chance of action is missed. Careful and effective communication between purchasers and between providers of care will be essential and would be helped by geographical coherence between the main purchasing authority, university hospital and medical school. What is becoming increasingly true is that the sector is no longer just a descriptive convenience, it has real meaning for the delivery of a comprehensive service and an academic programme.

This discussion has now moved on to the point at which practical solutions for achieving sectoral development are being sought. A range of options have been advocated in a variety of ways that are not surprisingly oriented by their authors' personal involvement in departments that may have taken a career-lifetime to build.

Within the trusts, action has had to be taken already as purchasers have reacted to major differences in price even though these are somewhat uncertainly derived. Opportunities to improve efficiency have been sought through better programming, adjustment of job plans, introducing new minimally invasive procedures and imaging techniques, and merging departments. Efforts have been made in the hospitals to become more user-friendly towards general practitioners and their patients, but as the press has reported, problems remain in several accident and emergency departments and in the admission of medical emergencies (Morrell *et al.*, 1994). Progress to reduce overheads by rationalising the estate and occasionally closing sites remains contentious but is proposed in the business case for the development of the Royal London site at Whitechapel.

Between the trusts, collaboration within specialties has varied greatly, some preferring war to the death to the prospect of working together. But generally, and often under academic leadership, there has been more willingness to accept working to a common purpose than was anticipated, even if united hubs are hard to agree. Centralisation and rationalisation of the specialty services bring cash flow problems for the trusts concerned and have raised questions concerning the need for changes in organisational relationships. Some see a mega-trust as necessary to achieve the site rationalisations and closures that will be required in delivering a coherent vision, but for others it is an awesome prospect. They would prefer to develop franchising and buying in of services with perhaps loose federations around university colleges. Such arrangements would be an extension of contracting out and would not require formal operating relationships between the parties. These ideas are currently in their infancy and may first be tested in relation to pathology departments, where supra-regional assay services have been known for some time.

In discussions between trusts, there has been a marked increase in the level of contact between executives, directors, deans and others whose plans and decisions affect each other. What is more there is growing contact amongst colleagues around London whose issues are essentially similar. Given the potentially immense programme of changes, this communication is essential for solutions to be found and action taken on the innumerable problems. This sharing includes colleagues representing the professions in colleges, funds, institutes, committees, councils and the BMA, RCN and IHSM who have a formal interest in London's evolution. As plans develop it will also be essential to keep the press and public informed about the reasons for change and what it could mean for people in terms of comprehensive care, with discoveries and initiatives of world class.

Tempering considerations

With the publication of each report on London, the comment has been made that it is the latest addition to a list of over 20 pronouncements , none of which has seemed to generate action. So what is to be different this time that will cause the synergy of ripples in service, teaching and research to become a tide. Machiavelli is famous for his warnings to the Prince who would contemplate a new order. Certainly his general propositions, regarding resistance generated from a sense of self-preservation, remain true in London today. As well there are currently four specific causes for concern that may and, some say, should, temper change.

Research

Firstly, the research community has been worried throughout that a service-oriented market approach will prove inimical to a thriving research programme. This is in line with a similar concern for the vulnerability of blue skies research when undue emphasis is placed on the application and practical value of scientific discoveries, and it goes well beyond the recent Culyer recommendations for funding research itself (Research and Development Task Force, 1994). What in practice is required is for service, teaching and research to be so handled that the service provides the practical foundation for research to use in the clinical stages of enquiry and to gain a sense of orientation, with teaching as the vital ingredient by which both are invigorated by the next generation. Damage to any one of the three components puts the future in jeopardy, no matter what the short-term advantage may be. That does not mean that every department at each hospital must be in the same image. In service and research, what suits bio-medicine is not the same as the requirements for successful surgery. Educationally doctors have a multiplicity of career paths which serve patients in different ways, and their training must be tailored to their different objectives. Within the community and within the sector, variations should be welcomed and respected for their distinctive contributions.

The single specialty environment

Secondly, and on a somewhat similar line, comes the concern of the single specialty hospital or large specialist department that its nature will be damaged by incorporation in a major hospital. The Special Health Authority hospitals come to mind first but specialist departments such as neurosciences have also encountered genuine problems with regard to their financial position and independence. However, medical sciences are converging towards their molecular basis, crossing traditional organ boundaries, so that these specialist hospitals will have to look again at their academic plans for the next century and consider whether their care programmes would also benefit from closer association. There will undoubtedly need to be stages in the development of any association beginning with the sharing of common services, the provision of a united service, the merger to form a hub and finally integration of management with the retention of a separate budget heading. During this process, the personal position of the doctor and the manager will be different. The specialist doctor may continue to lead the merged team, but the trust manager is likely to become part of a hierarchy and no longer be the ultimate voice. This may affect their relative enthusiasm for the change.

The programme for clinicians

Thirdly, to pursue this more personal note, the programme of changes currently faced by doctors is formidable. Clinical practice has been changing fast, with endoscopic approaches, minimally invasive techniques, new forms of imaging and therapeutic advances. Junior doctors are less available and will require a shorter, more extensive and intensive education. Multi-professional audit and charter standards are now expected. Clinical directorates, trust management, contracting with commissioners and fundholding general practitioners all take time. Clinical complaints are increasing and the long-standing responsibilities in research, writing, lecturing and examining all remain. Add to that performance-related pay and local pay bargaining and it could mean that doctors will lack the will or energy to lead the development of new departments. Motivating hospitals, where clinical teams feel they have lost out, will be a considerable problem.

Adequacy of resources

Fourthly, Brian Jarman has raised the question, *"Is London over-bedded?"* and has decided that the

answer is *"no"*. He analysed the situation for inner and outer London , drawing attention to the recent accelerated decline in the number of beds to an overall level approaching the national average. From his own experience of difficulty in arranging the admission of medical emergencies, the increased use of the Emergency Bed Service to arrange patients' admission and the reports of patients held for hours in A&E departments waiting for beds in the hospital, he concludes that no more bed closures should take place.

The traditional knee-jerk reactions in the health service to shortage of money have been to cut the training budget and then close a ward. With inner London tight for cash and the considerable effort currently being put into studies of site rationalisation, Jarman's warning is timely. However, it encourages the thought that beds are the primary consideration rather than the secondary consequence of decisions on the way services will be provided. It obscures the important distinctions that must be drawn between surgical and medical care, between secondary and tertiary care, between social and medical need, and not forgetting the particular problems in psychiatry.

To begin with the distinction between surgical and medical care, the development of day surgery and the adoption of minimally invasive endoscopic techniques have reduced the surgical requirement for beds at a time when the number of medical referrals to A&E departments and subsequent admissions have risen. Whatever the reasons for these changes in medical referrals, a critical review of bed usage is now needed. It may well be appropriate in certain hospitals for beds no longer required for surgery to transfer to medicine – some people have even suggested the possibility of an all-medical hospital.

In some teaching hospitals, this pressure for secondary medical admissions can create tension with specialist departments that are reserving beds for the referral of patients with cancer, endocrine or other problems. Bringing together the specialist (previously regional) services onto fewer sites should release beds that would ease the situation.

It is generally accepted that acute hospital beds are inappropriate for elderly people who have difficulty with the activities of every day life and whose failing strength will not respond to further medication. Recent changes in the community care arrangements have tended to exacerbate the situation when delays in assessment or in making arrangements prolong a hospital stay in a high-dependency bed. Now the problem is more often in finding a suitable place for the patient to go, or recognising too late that a person cannot cope without supporting services so that re-admission is required. The missing ingredient is the supply of nursing home beds which could be tackled if national nursing home organisations such as Takare or Westminster Healthcare were to operate in central London. Site costs and London weighting have deterred such organisations from coming to the capital.

Finally, recent studies by the Mental Health Task Force and the Royal College of Psychiatrists have emphasised the present shortage of beds for the acute admission of psychiatric patients and recommended that a halt be called to the closure programme, until the situation is stabilised.

To these clinical perspectives has to be added the reduction in numbers of patients travelling into town, which has fallen by five per cent annually in some hospitals. This is largely a reaction by purchasers to the higher costs of care in inner London, due in many instances to grade differences, temporary employment of nursing staff, and greater staffing levels, particularly amongst doctors. The market is forcing staff reductions and this needs to be tempered urgently by information on case severity and the quality of care in order to distinguish inefficiencies from differences in practice.

The general message remains that change is appropriate and inevitable, not only in London but in cities across the country. Future changes in the bed complement are likely to be similar in the capital and other cities. Those who are seeking to reduce the 46 per cent extra expenditure by the DHAs in inner London and the higher cost per case for London teaching hospitals will not find the answer in bed reductions alone. Indeed, where overheads are not released, bed closures may make only a very marginal difference. This is a complex subject on which the Inner London Commissioning Authorities are carrying out further research in collaboration with Brian Jarman.

Amongst the subsidiary arguments on bed numbers, the comparative data for some other cities in England and countries across Europe attracted attention, showing London to have by comparison fewer beds. Was this the explanation for emergencies not finding a bed and increases in numbers on waiting lists? Whatever the money available at a particular time, the purpose should be to maximise the amount of care, so the relevant consideration is to spend money on therapy and keep the hotel cost of in-patient beds to a minimum. This is all part of the relentless search for efficiency that Roy Griffiths and Derek Rayner saw as so essential, maximising the value achieved from the capital investment and revenue available. So rather than seeing the recent accelerated bed closures as impending disaster, the positive view can be taken that 20 reports on London have helped to generate changes in practice which have occurred more rapidly in London than in other cities such as Manchester, Newcastle and Liverpool and resulted in quicker bed reductions. Internationally, our European colleagues are sometimes remarkably far behind in the value they are achieving. Of course this rests on the premise that adequate provision is made for medical and psychiatric admissions.

Choosing the moment for change

So is this the moment? Is the time right for realignment in London to occur? There are at least three parts to the answer which come in response to more specific questions that have been posed politically, organisationally and operationally.

Funding the changes

The question doctors ask the politicians is, *"can they afford it?"* Relocation costs money, not only for the clinical services but also the investigation departments, their laboratories and equipment, and other supporting services. Associated research programmes, many funded by charities, have to move as well, and this cost may well have to be met by the health service as instigator of the changes. On occasion, the intended expansion of the service goes beyond the scope of what the current buildings can accommodate so that refurbishment of other stock or new building will have to be commissioned. For these reasons doctors ask whether the Department of Health will be able to persuade the Treasury to provide the capital.

Financial justification for this investment comes from the revenue consequences of the proposed changes that could result in significant annual savings that would quickly defray the up-front costs. In the last three years up to £100m has been spent annually on 'transitional funding' for London, largely to subsidise the current pattern of service, and the sum is growing. Hospital building is expensive but given these sorts of figures and the scale of the realignment into sectors described above, it could be justified, provided that the moves did not raise expectations to the point where additional requirements made the revenue consequences of the scheme unaffordable.

Organisational development

But is the health service organisationally prepared for such changes? Until recently there is no way the health service could have handled logically an issue of this sort and some say it is not ready yet. Essentially judgements are required on the volume, quality and cost of clinical programmes for which the database is scarcely assembled and some items are poorly understood, such as financial distribution of overheads and depreciation of capital assets. Until the clinical directorate system had been developed and the specialty titles recognised in the framework of accounts, it was virtually impossible to link patient care to costs involved – even now it remains approximate and will continue to be so while patients do not have a unique identifier.

The development of a system of medical audit with concentration on outcomes as well as the processes of care will, over time, make it increasingly possible for value to be assessed. But the teaching hospitals in particular will remain concerned that until severity and complexity can be accurately described, their contribution is at risk of being undervalued. The Culyer proposals for the funding of research have only recently been published and considerable work remains to be done developing the rationale for the service increment for teaching. Although these programmes are as yet incomplete, they are sufficient to inform the iterative series of decisions on action required in each sector, and hopefully will provide the means of sustaining confidence in what is done.

Making the change

Just as important is the question, *"will the system deliver it?"* For those who accept in principle the need for change, the concern remains that the handling of events may let them down, and the proposition that the process will be led through the purchasing programme is not entirely reassuring to medical staff. The contracting process is in its early stages of development. It has yet to involve many of the consultants who actually provide the care, and other consultants who have taken part are worried by its simplicity and inability to take into account differences in complexity of care. These consultants and their managers will require considerable reassurance that they will not be left in the lurch as and when the effect of relocation on the pattern of clinical practice takes an unexpected turn.

Academics and consultants are also worried by relocation, because a carefully nurtured ethos could be damaged, vital time could be lost in a research programme, or scheduling changes could impede a clinical programme. These concerns have in part a common root, lack of confidence amongst the staff regarding promptness and efficiency in the health service. Operational problems do not always get a timely decisive answer, and requests can be gobbled up into committee room discussion. Undoubtedly any teams set up to make changes would be closely inspected for their attitude, their ability to take decisions, the resources they command to settle problems, and their past track record and experience in this field.

The third requirement of the system will be to look after staff interests during the changes. Depending on the distance involved, not all the present staff will be able to make proposed moves, and where savings in numbers have to be made, relocation or redundancy costs will be incurred. Such problems have been anticipated and arrangements through a London Clearing House are in hand to ensure that clinical practices move in their entirety as far as possible, and, where not, that staff interests are fairly handled in offering

alternative employment and help with removal costs. There are already a few examples of whole departments moving successfully, but until clinicians have personally tested the system, they may well remain apprehensive.

The way ahead

Progressively, in the hospitals and in the community, a sense of direction is developing as the opportunities for simultaneously meeting service, research and teaching needs have clarified. What the Evening Standard finds it expedient to portray as a series of unconnected cuts and projects is part of an emerging new vision for London's health services for which the ways and means have yet to be fully described. Plans are being made, some with a long lead time, that will require action throughout the system from Ministers in both the Health and Education Departments through to the professions at the bedside and lecturers in their departments. Increasingly they share a common purpose and all parties will need to be clear on the contribution they should make. There will need to be flexibility in selecting the means of achievement and willingness to accept variation in detail as some schemes close off unexpectedly, and serendipity leads to the recognition of new possibilities.

Success will depend on willingness to collaborate, having pride in the achievement of the group as well as the individual hospitals, and acceptance of shared organisational systems. It will be vital to maintain confidence in the decisions on the distribution of clinical and research teams and their contracts, in the apportionment of monies amongst multi-site hospital practices, and in the equitable and proper handling of redundancies with regard to the number and distribution of staff and departments.

The ability for lateral thinking has to be nurtured in order to generate the new ideas on medical care. In making their contributions, managers and professionals will have to use all the various levers for change on the patients' behalf. There will be full consultation with the public as conclusions are reached and then firm decisions will be vital to remove uncertainty that would otherwise be most damaging to the attraction and retention of clinical and academic staff. Decisions will have to be taken on site developments and retractions, so that as much money as possible is spent directly on patient care and academic programmes.

Success will be measured directly by detailed knowledge of the outcomes of care and the level of scientific achievements. It will be recognised in contracts won in open competition; the number of departments of national and international repute that are sustained; the pride and pleasure this gives to the people working in each sector; and most importantly the satisfaction of patients and their families with the care they receive.

For a capital city it is appropriate that the standard of comparison should be on a national and international scale which would justify the considerable demands that will be placed on staff, who will sometimes be accepting great personal inconvenience out of respect for the interests of their patients in the short- and long-term, and to ensure thriving institutions.

To steer London's medical services successfully through such great change will be one of the most challenging tasks that health care has faced in any country. The stakes are high. Success will demonstrate an enduring value of our National Health Service, still capable of cost-effectively improving people's health and re-directing energies after nearly 50 years. Failure will be a measure of our incapacity to seize the initiative, look ahead, think afresh and achieve accordingly. This is the task facing the North and South Thames regions and their field authorities as they take on the work of the London Implementation Group.

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THE SINGLE SPECIALTY HOSPITAL
The experience of the Royal National Throat, Nose and Ear Hospital

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Introduction

The theme of this second issue of the London Monitor is *'Making Change Happen'*. This article addresses how changes have come about at the Royal National Throat, Nose and Ear Hospital (RNTNE) NHS Trust since the introduction of the internal market in April 1991. It has not been a matter of *making* change happen, so much as responding to the new opportunities created by the internal market to provide services to the mutual benefit of the Trust, purchasers, GPs and patients.

This article outlines these opportunities, describes the response at the RNTNE, identifies the problems and issues confronted and makes recommendations for further developments that will continue to stimulate positive change.

Market opportunities

Many managers and clinicians brought up in a cash-limited and inflexible NHS were excited by prospects of an internal market for medical services. It was felt that:

- *resources would be loosened from the strait-jacket of local cash limits.* It was expected that extra resources would be injected. The Secretary of State's success in negotiating real growth of around 4 per cent per annum for the last three years has more than justified that view. Although in the short-term, contracts for services were block-funded there was the prospect over time of more opportunities becoming available to secure resources through competing for contracts and persuading GP fundholders (GPFHs) to refer patients. Over 30 per cent of the work at the RNTNE is now GPFH or extra-contractual referral (ECR). Income generation moved from being a fringe activity to being the activity that could potentially make the biggest impact within a hospital.
- *there would be new opportunities to use capital resources creatively to develop services.* In practice there have been substantial additional delegated powers available to trusts to proceed with modest capital developments – a limit of up to £1m for larger trusts. Recently further opportunities have been presented by encouragement of the use of private sector capital and expertise.
- *there would be clearer organisational and personal incentives.* Criteria for success and failure of the organisation and of individuals is now much clearer; real incentives are available to reward additional effort and achievement. This is likely to be reinforced by greater movement toward local determination of pay.
- *clinical accountability would increase.* Purchaser focus on quality and outcomes as well as efficiency would ensure that poor performance would lead to loss of support and that good service would be reinforced. This would lead to individual pressure to improve services.
- *the patient would receive a more consumer-oriented service rather than the poor treatment all too common in the old-style NHS.* For the first time resources are seen to follow the patient rather than the patient being seen as a drain on resources. Enormous improvements have been made to the cosmetic and human side of providing services to patients as is best evidenced in the reception of patients in most hospitals.
- *there would be greater division of responsibility and clarity of role between Government/NHS Executive/RHA/purchaser/provider.* Although there is some way to go, enormous strides have been taken to avoid the confusion of roles and politicisation of issues.

The RNTNE response

The RNTNE responded to these opportunities in five ways:

- critical self-examination
- marketing to GPFHs
- marketing to local purchasers
- developing and motivating staff
- private sector collaboration

Developing an image: critical self-examination

It soon became clear that it was ineffective to over-sell the professional services involved in medicine. If patients or GPs or purchasers were to keep coming back then services had to be accessible, of high quality, at reasonable cost and provided in a conducive environment. Market research surveys of patient attitudes and discussions with purchasers and staff identified the need to improve the environment of the hospital, reduce waiting times, improve patient literature/communication, improve GP contact/communications and to engage in a fuller dialogue with purchasers and GPs of the services actually delivered.

These surveys and discussions also reinforced what were the strong points of the hospital. These were:

- high recognition factor
- high levels of perceived quality
- good accessibility both in terms of location and waiting times.

Out of this came:

- *improvements to image* – new logo, new improved letter-head, patient handbooks, new badges/uniforms for staff, better lighting, signposting, paint on walls, carpet on floors, refurbished entrance/reception area, the appointment of friendly reception staff and training for staff in dealing with patients.
- *improvements of communications with GPs and purchasers* – regular newsletters have been produced, GP liaison staff appointed, a GP help line installed, improvements to develop better procedures, GP seminars, appointment of contract and marketing staff and public relations advisors.
- *a commitment to improve services* – a developed quality programme, headed by an Executive Director has helped develop the many small things that improve the stay, e.g. consultation with children led to changes in anaesthetic practice and meals.

Marketing to GP fundholders

The RNTNE perceived that the GPFHs represented a significant opportunity for the Trust to attract increased levels of referrals and extra resources. This would reinforce the survival of the organisation and at the same time address a major unmet need. The GPFHs were all too often frustrated by long waiting times at the local provider, poor communications, poor support, and large numbers of chronic attenders in the GP surgery – 25 per cent of all GPs' patients are ENT/Audiology patients.

The response of the RNTNE was to establish contact with GPFHs, identify the local problem, offer to help with accumulated waiting lists, offer to provide an outreach clinic where a consultant or audiological technician can see up to 20 regular patients, share knowledge with the GP on individuals and treatment and establish a positive, healthy, supportive relationship. Services were costed in as much detail as possible so that the GPFH was clear the charges were specific to treatment.

Where issues have been raised, e.g. some GPFHs expressed a preference for audiological testing services as opposed to a full consultant-led referral service, RNTNE policies have been explained and changes made when appropriate. Over 200 outreach clinics are supplied currently and referrals come from a wide catchment area. The hospital is greatly helped by rapid transport links to King's Cross. Unfortunately British Rail would not negotiate a discount for patients travelling to the RNTNE.

GPFH work is now about 25 per cent of the total income of the RNTNE and rising rapidly. For every case lost through contract adjustments by district purchasers to take account each year of transfers of purchasing power to GPFHs, there are three gained from fundholders directly. This markedly different attitude to the purchase of ENT services gives the RNTNE great confidence for the future as fundholding expands.

Marketing to local purchasers

The single specialty hospital has traditionally relied on a broad catchment area to maintain the critical mass of patients required to justify teams of highly specialised staff and the most advanced facilities and equipment. The challenge presented by the new market environment is that many purchasers have a preference for a more local provision of services.

In response to this the RNTNE has developed collaborative arrangements with other providers in agreement with their local purchasers whereby dedicated RNTNE consultant support is provided to lead in the provision of local day care and out-patient clinics. In-patient referrals are made to the RNTNE. A very successful arrangement along these lines exists at Newham Healthcare Trust and collaborative arrangements are in place at Havering.

There is still much potential for the development of this model. It is particularly appropriate for elective, short-stay patients who prefer a local service but who welcome the opportunity to have more advanced diagnosis and in-patient treatment at a recognised centre. Discussion with colleagues at other specialist hospitals in London and around the country suggests similar responses. Viability is secured by projecting the hospital's services over a wider catchment area. The organisation ceases to be just the physical hospital building and becomes

the team of clinicians and skilled staff.

The criticism of London hospitals that they are protecting institutions and vested interests is misplaced in the case of many single specialty hospitals. These hospitals are composed of rare teams of skilled staff concerned that their ability to help patients with special needs and maintain their economic viability is prejudiced by a misguided notion that the only way to deliver local services is to attempt to recreate new departments and teams from scratch.

Clinical services are highly professional, personal services requiring the commitment and presence of teams of suitable staff in a labour market where supply is limited. In these circumstances efforts to create new departments in remote, difficult to travel to, institutions with underdeveloped infrastructure or traditions are unproductive. The specialist hospitals on the other hand have shown themselves to be able to project their services over a wide catchment area.

The intriguing aspect of this phenomenon remains the significant level of resistance to this model from some quarters. Accusations of wanting to be a monopolistic provider, of competing unfairly and of being comparatively costly have all been made. The inconsistency in supporting a local monopoly, effectively excluding competitive forces, and not including in cost comparisons the costs of teaching, research or the costs of effective treatment of the patient with more complex needs is not acknowledged.

Retention and motivation of staff

In a changing environment there is a need for the sensitive development and motivation of staff. Staff loyalty has proved to be a key input at the RNTNE. The dominant theme which staff have recognised is that the organisation must compete to survive, and to compete, it must deliver what people want. Such reactions enabled a computer system to be purchased and installed within six weeks; enabled in-patient activity to be increased by over 50 per cent; produced new radical ways of service delivery (outreach and satellite services); and persuaded staff to give up tenancy rights to expedite the sale of residential property.

In all cases the incentive which motivated staff was that change was in the interests of developing the organisation. The fact that the hospital achieved a large financial surplus in its first year as a trust and has been seen to invest in new facilities and improving services has reinforced the commitment of staff.

Private sector collaboration

The changes introduced in 1991 and, more recently, the Private Finance Initiatives have encouraged the use of private sector expertise and capital. The RNTNE is prepared to work with anyone that can improve its provision of services. For example the hospital is one of the few NHS hospitals to receive the bulk of its pathology services from the private sector.

In addition the hospital is in the process of negotiating an arrangement with a private hospital group which will both refurbish the out-patient area and provide additional purpose-built private patient capacity. These arrangements further strengthen the Trust.

Market uncertainties

The RNTNE has made significant strides in reacting to the opportunities of the internal market. However there remain a number of uncertainties.

Purchasing is underdeveloped

Although there are notable exceptions, it is commonly felt that purchasing health authorities have not yet realised their opportunities to improve healthcare for their residents. GP Fundholders on the other hand who are closer to the needs of patients and less concerned to protect local hospital services have been much more effective purchasers of health care. The problem seems to be that the purchaser is not being guided by market signals but by abstract plans and *political* forces.

It should be for the Regional Offices to intervene to support the restructuring of hospitals when contracts are lost. Purchasers must not put the viability of hospitals before the interest of patients. Although it can be argued that long term viability is a valid concern, the uncertainty and scale of long-term trends are such that the purchaser will be taking enormous risks by not minimising commitment to essential local services and retaining competition in all other areas. Otherwise there is a risk that by supporting an unviable overhead purchasers will limit their options for patients.

Purchasing power is uncertain

There is uncertainty at three levels:

- the impact of GP Fundholders;
- the impact of Weighted Capitation;
- the impact of more accurate costing and pricing.

All three factors are difficult for a provider to assess in the long-term. The approach of the RNTNE is described below.

The impact of GP fundholders

There is much debate regarding issues of methodologies for allocating funds, the control of funds, the extent of the services to be purchased, the pricing of GPFH work by providers and the pace of development of GPFHs. Given the often

markedly different purchasing patterns of GPFHs and local purchasers, the resolution of these issues and their long-term impact have major implications.

For example GPFHs have a much lower tolerance for long waiting lists than district purchasers who persist in regarding ENT as low priority medicine and hence do not invest in reducing waiting lists.

The impact of weighted capitation funding

There is on-going debate on the weighting which should be given in the funding formulae for factors such as age and inner city morbidity. Perceived long term trends have produced increased expectations in some areas and a crisis mentality in others. The current level of uncertainty and scope for future political involvement is such that proceeding with costly development on the expectation of increased funding may be very risky. Equally, over-hasty bed reductions may inhibit the delivery of care.

The impact of more accurate costing and pricing

Although the impact of weighted capitation has received much attention the issue of the impact of more accurate costing and pricing of services has been largely ignored. Contracts currently tend to be set on an average cost per in-patient episode basis. However the reality, particularly for the inner London providers, is that actual costs are distributed widely around the average. For example the average cost of ENT services at the RNTNE can vary by as much as 300 per cent across purchasers (see Figure 1). Not surprisingly, there is a relationship between distance travelled and average costs of the case-mix as the tendency to travel is affected by the severity and complexity of the illness (see Figure 2).

Little study has yet been possible on this subject as the data have not been readily available. In the past when authors have discussed case-mix as a factor in their analysis of the excess cost of London hospitals often this has been related to the mix of specialties not to differences within each specialty. Once case-mix differences are fully taken into account the excess cost of London teaching hospitals may well reduce significantly. Excess costs will be seen as a function of what is done rather than where it is done.

A problem arises when district purchasers expect to pay local prices for what is a complex workload in an inner London hospital. Examples already exist of attempts to re-direct patients to a more local provider in the teeth of resistance from local GPs and patients. The real costs may then be borne by the patient in terms of reduced quality of care or having essential treatment delayed.

ECR and tertiary referral

ECR and tertiary referral mechanisms are not working smoothly. The patient is kept in the dark about the bureaucratic delays in obtaining approval for treatment. These delays can reach Kafkaesque proportions and can result in approval for an appointment being so delayed that there is not enough time to inform the patient of the appointment leading to the whole process having to be repeated. New procedures intended to

Figure 1: Average cost of case-mix by purchaser, 1994-95

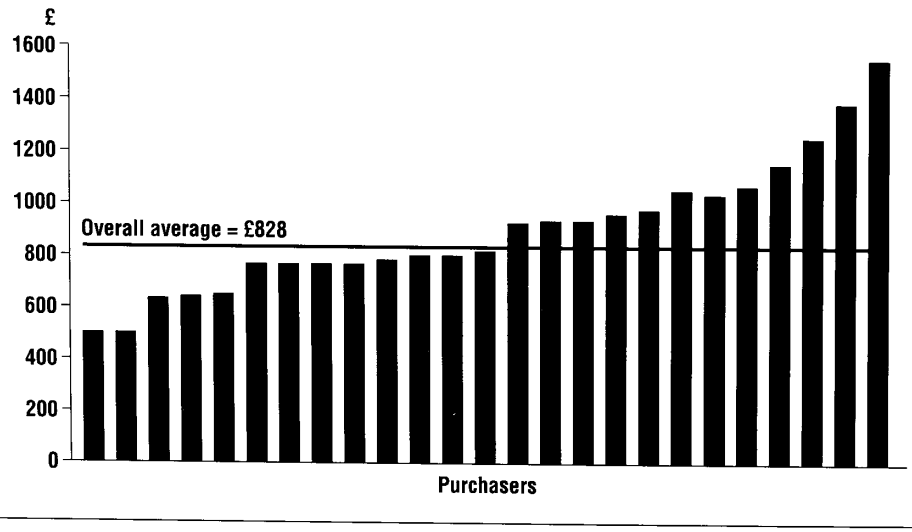
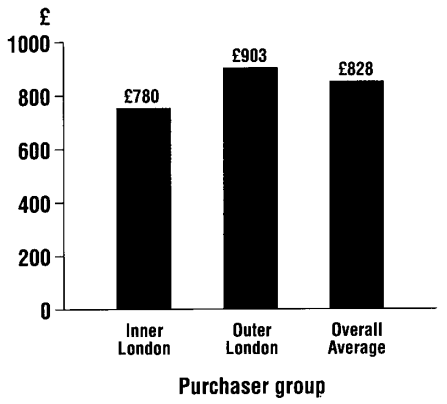


Figure 2: Average cost of case-mix by location of purchaser, 1994-95



simplify the system will be issued shortly. This is to be welcomed and will have an effect on workload if it makes it easier to obtain approval for ECRs or tertiary referral.

Uncertainties in the funding of teaching and research

It is essential that market forces do not force out good education and research, but there is still little understanding as to how this is to be achieved. At the moment the RNTNE falls between stools; it neither receives significant SIFTR (Special Increment for Teaching and Research), as it has a postgraduate rather than undergraduate bias, nor does it receive the support which was given to the hospitals of Special Health Authorities (SHAs), as it ceased to be a SHA in 1982 when it became part of Bloomsbury Health Authority.

Other successful institutions who have historically provided a disproportionate amount of training, education and research face similar problems. Unless a formula is found soon, education and research activities are likely to be threatened. Although the messages in the Culyer Report were encouraging there is still a disturbing lack of clarity or urgency to protect threatened organisations.

Lack of direction

Developments in London's health services at the moment might be characterised as a battle between those who would wish to extend the opportunities discussed above to introduce pseudo-market forces within the internal workings of the NHS and those that wish to retain central control. It is not possible to reconcile the two easily, and currently there is a lack of direction as the battle ensues. Successful organisations are being levied to support the weak, subsidies are provided to some and not others in an arbitrary way, merger is being strongly suggested to some hospitals but the rules are vague and time-consuming. It has been acknowledged that the rules are being written as the process evolves. This maximises flexibility but undermines the clarity of vision.

Conclusion

As others have stated, the genie is out of the bottle and there is little enthusiasm or confidence that it can be returned. Problems seem to be caused by the lack of resolve in going forward. More confidence should be placed in managers and staff to respond to the new incentives and if, as a result, market signals identify winners and losers, then so be it.

However, it is difficult to accept that peremptory decisions are made while there remains great uncertainty of purpose, no clear rules to the game, many unresolved major issues and countervailing actions being taken to restrain the process of identifying winners and losers.

The RNTNE has proven itself capable of responding to new incentives, but remains vulnerable in a situation where the mechanisms to recognise the true costs of complex work and training, education and research are as yet undeveloped, and purchasing remains slow to impose new models of service delivery.

We suggest that the following recommendations be acted upon by policy makers:

- establish a certain funding mechanism that funds the costs of providers' contributions to education and research, including the excess service costs;
- establish mechanisms which make it easier and quicker for patients who are ECRs to receive timely and appropriate treatment;
- clarify the long term future of GPFHs and their relationship with district purchasing agencies;
- decide on weighted capitation policy but only implement changes after progress on costing and pricing. A study should be initiated on the likely impact of case-mix pricing to inform expectations;
- establish rules on financing capital developments and administer them independently;
- clarify the rules on merger so that change only occurs after a clear business case has been identified;
- reinforce incentives for good performance and remove the restraints on the development of such incentives.

A COMMUNITY-ORIENTED APPROACH TO MANAGING ACUTE STROKE PATIENTS IN WEST LONDON

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Introduction

Caring for acute stroke patients in a primary care setting is an example of the type of change which was recommended by the King's Fund Commission (King's Fund Commission, 1992) and the Tomlinson Report (Department of Health, 1992). The priorities for change identified by the King's Fund Commission included:

- *addressing the deficit in primary and community services that currently exists across London, especially for health care designed to support people with chronic disease;*
- *encouraging primary health care practitioners to undertake aspects of treatment that currently take place within acute hospitals and their associated out-patient clinics.*

Between 54 and 78 per cent of people who have acute strokes are admitted to hospital, depending upon where in the country they live (Dennis *et al.*, 1989; Wolfe *et al.*, 1993). No specific therapeutic interventions of proven effectiveness are presently available to treat stroke patients (Wade, 1992). Therefore, the priorities when managing patients after acute strokes include:

- making an accurate diagnosis;
- providing adequate supportive care;
- offering a coherent rehabilitation programme.

The particular local configuration of services in acute and primary care is the main determinant of what proportion of acute stroke patients can be managed in primary care and what proportion managed in secondary care. A recent review of the research literature on the effectiveness of stroke units suggests they improve survival rates after acute stroke (Langhorne *et al.*, 1993). Since no specific treatment is of proven effectiveness in treating stroke the current presumption is that the improved survival associated with stroke units results from a systematic approach to organising care. These observations, relating to how care can be provided for stroke patients, underlie the hypothesis that a proportion of services for acute stroke patients can be transferred into primary care, resulting in a mixed pattern of service that includes an increased primary health care component.

This paper looks at the logistical issues involved in developing a primary care approach to managing acute stroke patients in five localities of London that made up the former Riverside District Health Authority, covering a population of approximately 300,000 people. For convenience, these localities are referred to as 'Riverside' in this paper. Issues such as the perceptions and wishes of patients and their carers in relation to stroke care, though important, are not considered in this paper.

Current services for acute stroke patients from Riverside

Before considering how to change services for acute stroke patients in Riverside, it is essential to understand how services are currently configured. Information on actual, and estimated numbers of acute stroke patients, and the services available to them in Riverside, were obtained using the following data sources:

- hospital activity returns to North West Thames Regional Health Authority (RHA);
- a point prevalence survey of local hospital care for acute stroke patients;
- a point prevalence survey of care for stroke in the community within Riverside;
- literature on the epidemiology and effectiveness of care for acute stroke.

Hospital-based services for acute stroke patients in Riverside

After suffering acute strokes, patients from Riverside are treated in any one of six main acute hospital provider units in London. Admission data for acute stroke patients to these hospitals were obtained using routine data from North West Thames RHA. Table 1 provides these data for the year 1992-93, based on the diagnostic codes – ICD9 codes 431-434 and 436-438 (excluding subarachnoid haemorrhage and transient ischaemic attack). In 1992-93, 593 patients from Riverside were admitted to acute hospitals with a primary diagnosis of stroke.

Table 2 applies the incidence rates for acute

Table 1: Stroke admissions of Riverside residents to acute hospitals

HOSPITAL	MALE	FEMALE	TOTAL	BED DAYS	ALOS[1]
1	124	171	295	8,584	29
2	111	113	224	7,672	34
3	5	5	10	711	71
4	17	17	34	455	13
5	7	8	15	190	12
6	7	8	15	282	17
TOTAL	**271**	**322**	**593**	**17,894**	**30**

1 ALOS = length of stay Source: NWTRHA, 1992-1993

Table 2: Expected incidence of stroke in Riverside

AGE	45-54	55-64	65-74	75-84	>85	TOTAL
MALES	10	52	79	81	21	243
FEMALES	7	31	83	130	66	317
TOTAL	17	83	162	211	87	560

Based on: Dennis *et al.*, 1989

stroke from a community study in Oxford (Dennis *et al.*, 1989)to the resident population of Riverside to give an indication of the anticipated annual number of new strokes occurring there. Applying the expected rates of hospital admission for acute stroke from community studies in Oxford and Frimley (Dennis *et al.*, 1989; Weddell and Beresford, 1979) to the Riverside population produces the projected profile of hospital admissions shown in Table 3.

Actual admissions are greater than the anticipated total number of strokes for Riverside which is 560, and far exceed the 198-387 anticipated stroke admissions to acute hospitals. It seems unlikely that the incidence of stroke is unusually high in Riverside. Local age-standardised mortality ratios for stroke, in the under 65s and in the 65-74 age-group, do not suggest this.

A more probable explanation is that the figures for stroke admission to hospital are unreliable in relation to acute stroke. Data for acute stroke admission to hospitals may have been confounded by the admission data including stroke patients other than those suffering acute stroke. The ad hoc report for stroke requested a primary diagnosis of stroke in patients. This diagnosis could not exclude patients whose stroke occurred months or years previously, and whose admission was for investigations or treatments prompted by the late

Table 3: Expected hospital admission rates for acute stroke

		LOW RATES	HIGH RATES
Male	45-54	5	11
	55-64	20	43
	65-74	39	73
	75-84	41	71
Female	45-54	3	5
	55-64	13	22
	65-74	27	57
	75-84	50	105
TOTAL ALL AGES		**198**	**387**

Based on: Dennis *et al.*, 1989; Weddell and Beresford, 1979

sequelae of stroke. Another possible source of error is that diagnostic coding errors occurred. Nonetheless, the data leave an unproven presumption that the rate of hospital admission following acute stroke in Riverside may be high. More light may be shed on this issue by the acute and community hospital point prevalence studies which are reported in the next section.

Acute hospital and community point prevalence surveys

In October 1993 a point prevalence study of the hospital care for acute stroke patients in Riverside was undertaken. Tables 4 and 5 present data from this survey.

Table 4 shows that there were 36 patients from Riverside in local hospital wards following a diagnosis of acute stroke, on one day in October 1993. The average age of patients was 77 years, with a range of 56-97 years.

Table 4: Point prevalence of acute stroke patients in a major local acute hospital provider unit in October 1993

	NO. OF STROKES	AVERAGE AGE	AGE RANGE
Male	14	74	56-84
Female	22	81	59-97
TOTAL	**36**	**77**	**56-97**

Source: local point prevalence survey

Table 5 gives details of admission and hospital stay. The average length of stay was 29 days. Fourteen (38 per cent) of the patients were in hospital for 'inappropriate' reasons including: social reasons (no home support, lack of a carer, home adaptation) and rehabilitation that could have been done in the community.

Acute stroke patients from Riverside were managed by 13 different consultant teams on 13 different wards. No patients received care on a stroke unit. No protocols were generally agreed nor guidelines available for managing acute stroke. No general guidelines or care pathways existed for accepting stroke patients from primary care or from A&E departments.

In November 1993 district nurses undertook a community point prevalence survey of care for stroke patients in Riverside. Details of the results are shown in Tables 6 and 7. Of the stroke patients seen in the community point prevalence survey, 15 per cent had swallowing difficulties, 22 per cent had problems with understanding, and 38 per cent had speech or language problems.

The hospital point prevalence study for acute stroke indicated at least 38 per cent of acute stroke patients in hospital could be managed in the community. This finding supports suggestions that rates of hospital admission are high. Delayed discharge of these patients was due to a need to provide adequate social care and rehabilitation in the community.

The community point prevalence study of the primary care of stroke patients showed only eight per cent of patients had suffered an acute stroke within the previous six months. These data further reinforce the presumption that a predominantly hospital-based pattern of care for acute stroke patients exists currently in Riverside. Primary care services are providing for the long-term sequelae of stroke and not for short-term care and rehabilitation. Neither primary care nor hospital wards are providing an integrated and co-ordinated service to manage strokes. Scope therefore exists to develop a stroke unit, linking it to primary care support and rehabilitation services. A service such as this offers general practice an infrastructure to support and manage acute stroke patients in a primary care setting.

Table 5: Admission details of point prevalence of acute stroke patients in a major local acute hospital provider in October 1993

	ALOS[1]	RANGE OF ALOS	DELAY DISCHARGE
Male	26 days	1-78 days	5
Female	33 days	1-120 days	9
Total	**29 days**	**1-120 days**	**14**

1 ALOS = length of stay

Source: local point prevalence survey

Table 6: Community stroke point prevalence survey in Riverside: patient data

SEX	NUMBER	AVERAGE AGE RANGE	STROKE LEFT	STROKE RIGHT
Male	13	76(61-86)	4	9
Female	24	79(54-92)	13	11
TOTAL	**37**	**78(54-92)**	**17**	**20**

Source: local point prevalence survey

Table 7: Community stroke point prevalence survey: time elapsed since onset of stroke

SEX	NUMBER	0-6 MONTHS	0-12 MONTHS	>12 MONTHS
Male	13	0	3	10
Female	24	3	1	20
TOTAL	**37**	**3**	**4**	**30**

Source: local point prevalence survey

These data provide a broad view of stroke care that is compatible with the premise of effecting a transfer in the balance of care from acute hospital to primary care in Riverside. Accepting this process is one thing, determining how to achieve it, is another. Changing the configuration of stroke services in Riverside involves considerations beyond the important, although narrow, boundaries between acute and primary health care services.

The average age of stroke patients in the point prevalence studies was 77 years. Younger and fitter stroke patients, having only social care or support from a carer, may not be included. Failure to include patients receiving support other than formal health care services may give a biased view of the age of stroke patients. This possible influence withstanding, the age of acute stroke patients is an important consideration in how to provide stroke services. Factors that can influence how well acute stroke patients can manage in the community

include good social support, a carer who can cope, and adequate home circumstances. An 87 year-old man with osteoarthritis, caring for his 85 year-old wife, after her recent stroke, living in a second floor flat in a poorly heated Victorian house, presents intractable social problems with which to cope, irrespective of how good primary and secondary health care services may be.

Two Purchasing Agencies and three Social Services Departments commission the formal care provided to stroke patients/clients in Riverside. Currently, contracts for the hospital care of acute stroke patients lie within larger block contracts for General Medicine. The community health care components of care for stroke patients are contained in block contracts for district nursing, speech therapy, physiotherapy and occupational therapy. Social care of stroke patients lies within the Social Services budget and many stroke patients require complex needs assessment. Changing the configuration of services for acute stroke patients in Riverside means altering how services are organised, the skill-mix of staff, and the places where care is provided. This process will mean developing new contractual relationships to support the management of patients in the community.

Conclusion

This analysis of the care of acute stroke patients in Riverside does not provide uncritical support for the establishment of a large community-based stroke care team. The requirements necessary to reduce hospital admission and maintain these patients in the community are unclear. The findings support a strategy of developing a collaborative approach to managing stroke, between local health care providers, Health Care Commissioning Agencies and Social Services Departments. Important elements of this strategy include:

- establishing a community-based stroke assessment team to help establish the need for the stroke services;
- encouraging local acute hospital providers to develop stroke units;
- integrating stroke care management in both primary and acute hospital settings, and ensuring this care is patient-focused;
- developing guidelines for referral of stroke patients from primary care to secondary care, and from secondary care back to primary care;
- developing close associations with Social Services Departments and an integrated multi-agency approach to stroke care;
- exploring the possibility of developing joint contracts between community and acute hospital trusts for the provision of stroke services, with an aim of providing a seamless service.

In April 1994 the London Implementation Group (LIG) funded a 'change management' project aimed at promoting the transfer of care of acute stroke patients from secondary to primary care in Riverside. This two year project will seek to look at the organisational and skill-mix changes involved in developing a comprehensive, cost-effective stroke care service. Primary and secondary care services will be integrated, where appropriate, and the intention is to develop a joint contract for stroke services to maintain this newly organised service into the future.

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INVOLVING THE COMMUNITY IN DECISIONS ABOUT CHANGE

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Introduction

During the last year, there have been many references to the importance of listening to users, the valuable role of the voluntary sector, and the role of Community Health Councils (CHCs). This article sets out some thoughts on making change happen in London from the perspectives of 'ordinary people' and their organisations.

For the sake of brevity, we use the terms 'community perspectives' and 'voluntary sector'. It is essential to remember at all times that these are merely convenient terms to encompass a huge range of disparate views, and it is not the thesis here that all users, potential users, voluntary organisations and CHCs share a unified view of the world. Nevertheless, many themes emerge time and time again, and it is those recurring themes that are presented here.

Much of what follows is distilled from the involvement that the Greater London Association of Community Health Councils (GLACHC) has with its member CHCs, and with a range of Londonwide voluntary organisations which it meets through the London Health Alliance.

In search of consensus

The very idea of making change happen presupposes that there is some widely shared consensus on what constitutes positive change. However, increasingly, it seems that consensus building has been focused on a narrow view of what the direction of change should be. The consequence is that many of the issues that perturb Londoners have been swept aside. It is sometimes hard to tell whether the relentless insistence from politicians, policy analysts and senior managers that we all share a vision for the NHS in London betokens supreme confidence or extreme insecurity on their part.

As a result of this devotion to building a particular consensus, much of the management effort that should go into dialogues with the community is actually harnessed to the production of propaganda, rather than exploring where there is agreement, and where there is disagreement on the desired direction of change. In an NHS starved of resources (another community perspective often not shared – at least in public – by most NHS managers), there has been no apparent lack of money for spreading good news about changes in the NHS.

An example of this is the London Implementation Group's Faxnet which certainly increased GLACHC's fax-paper bill. The first Faxnet communication, in November 1993, stated that it had been set up 'to enable fast communication on developments relating to *Making London Better.*' Clearly it was an unashamed attempt to spread the word about change, and, presumably to help counter the gloom and doom of those who could not see the evidence.

Similarly, the ill-conceived leaflet, *Answers to the questions you've been asking*, of which 3.5 million copies were distributed to households within the boundaries of the M25 at a cost of £150,000, did not actually answer the questions that people had been asking. It merely reproduced their questions, and offered by way of reply a series of bland platitudes, or rosy pictures of how changes would occur in the future. Moreover, the leaflet gave a phone number for the Health Information Service *"for more information about NHS changes in London"*. Many people called that number, only to find that increasingly exasperated staff had no information to give, other than waiting list information.

The Secretary of State is also convinced that a key issue is communicating better on the achievements of the NHS. This was cited as one of her main concerns when she met with all the Chairmen of health authorities in North Thames in August 1994 (see Chairman's report to Redbridge and Waltham Forest FHSA, 22 September 1994).

Even now, rarely a post delivery passes without another glossy NHS publication sharing the good news about change. Interestingly, many of these publications last only for one or two issues, soon to be replaced by another title that will not be missed when it goes. It is rather reminiscent of the publications in the newsagent for macrame, or do-it-yourself decorating, launched with great fanfare, only to sink without trace when another fad has its day.

The serious point here is that there is still a debate to be had – as there always will be – on how and where changes should be made, and whether they are indeed working in the interests of those

for whom they are ostensibly introduced. The emphasis should shift from trying to persuade the community to like what they are getting, in favour of trying to get to know what they would like.

Also, if the mission to communicate needs an outlet, it might be best channelled at a local level to explain how the health service works and how it is funded in London. It is GLACHC's experience that many people in the voluntary sector, and, lamentably even some members in CHCs, have only the haziest grasp of NHS structures, and certainly an inadequate understanding of how they might direct their own activities to maximum impact within those structures.

The market or planned change?

Leaving aside ideological disputes, there are many reservations in the community about the impact of the internal market on changes in the health service. First and foremost, there is a widespread view in the voluntary sector and in many CHCs that London suffers through not having a strategic body for introducing and overseeing planned change to London.

For example, the memory of the way in which Camden and Islington health authority's purchasing intentions seemed to threaten the viability of University College Hospital in 1993 (see, for example, *Services Strategy 1994/5 and beyond – a discussion paper*, report to Camden and Islington Health Authority, 20 July 1993) remains with us. At the same time, the purchaser/provider split is not seen to deliver all that it promises. Purchasers do not yet seem to have the muscle to impose their contract specifications on providers, nor the will to involve CHCs, for example, at all stages of the purchasing cycle, in an optimal way (Joule, 1993).

Also, the promise that money would follow the patient in the internal market has been seen to be untrue, as the patient has to follow the money – if there is any left – to a diminishing number of providers with whom his or her health authority holds a contract. In so far as there is a community view it is one of mistrust that the market can safely deliver a service that is targeted to meet need. Alongside this is a conviction that services need to be planned for London as a whole.

The bidding merry-go-round

The market culture in the NHS is not only characterised by competition for business on the part of providers, but also, increasingly, by competition for resources on the part of purchasers and voluntary agencies. Community perspectives on both aspects of this phenomenon are frequently less than enthusiastic.

Health agencies

It often seems to be the case that staff in health agencies have to devote a lot of time to preparing bids for money that is desperately needed for local initiatives. In fact, unless they can make out a case for desperate need, they will not 'win' the money. But if the need is indeed so great, it seems strange to have to make out a case for each and every development if funding is to be obtained. GLACHC's links with CHCs and others indicate that there would be a great preference in local communities for making change happen in a more strategic way, rather than by rewarding those health agencies that get lucky in the lottery of writing successful bids.

It also seems that staff at a local level are exhausted by the relentless attempt to get small new projects up and running. A wry tale that was doing the rounds a few months ago told of two FHSA Chief Executives talking to each other, one of whom has received twice as much money for primary care developments as the other. It is the one who has been given the least money who receives the envy and congratulations of the other! If this appears to be an apocryphal story, it is worth noting that a recent report in the papers of a London FHSA (Chief Executive's report to Enfield and Haringey FHSA, 29 September 1994) refers to a problem that the FHSA has in spending London Initiative Zone (LIZ) money in time, as it was originally thought that the bid was unlikely to succeed, and therefore the FHSA was not fully prepared when it did so.

Voluntary agencies

If endless bidding is a problem for statutory agencies, it is a veritable nightmare for the voluntary sector. A relatively small amount, £7.5 million, was set aside for the voluntary sector as part of the *Making London Better* package. The procedure through which groups learned of the opportunity to bid was patchy, and the timescale for putting in the bids was widely acknowledged, in retrospect at least, to be unrealistic. Nevertheless, a large number of groups did put in bids and some useful schemes were funded.

However, there are a number of serious problems for the voluntary sector in making change happen in this way:

- strains on resources
- inequity
- the fiction behind successful bidding
- campaigning and advocacy
- the need for infrastructure

Strains on resources

The problem with what we have termed the bidding merry-go-round is that by its very nature, there will tend to be more losers than winners. The waste of resources that is caused by having to make repeated bids, only a minority of which are likely to succeed even if they are very worthy, is enormous. The cost of these abortive bids has to be included in all bids so that successful bids can underwrite the costs of the time taken to prepare the others.

The problem also arises that when a voluntary organisation has to get funds from many sources, as most do, the cost of raising funds can become disproportionate to the time spent in carrying out its purpose. No-one expects that the voluntary sector should not have to be accountable for the money it receives. However, in a bad week, it can seem as though one third of an organisation's time is spent on fundraising, one third on being monitored to ensure that funds are being applied properly, and one third on 'real work'. This does not seem to be the most sensible way to make change happen.

Inequity

This proliferation of opportunities to bid for small amounts of funding inevitably favours established groups, who can devote a worker to preparing bids, and who can develop some expertise in writing them. It is, therefore, no surprise that in the first tranche of voluntary sector projects approved by LIG, the list included several charities which probably pulled existing bids off the shelf for opportunistic funding. This is not a bad thing to do from their point of view, and no doubt they were assisted to deliver some useful services.

However, the problem is that newer, poorly resourced groups would not have been able to grasp the opportunities with such alacrity, even though their ideas for change may have been more creative and worthwhile. It is a matter of concern that those sections of the community that are most disadvantaged, for example, Black and Minority Ethnic people and people with disabilities, are those whose groups are small and historically underfunded. In the competitive bidding culture, the weak go to the wall, while the stronger, more established groups prosper. In order to target change to where it is most needed, and to involve the community as fully as possible, there must be more help available at the development stage to groups who wish to develop useful projects.

The fiction behind successful bidding

When Dr Mawhinney, then Minister of Health, announced that £7.5 million during a three-year period would be made available to the voluntary sector, he said:

> *It is our intention that successful schemes will make a practical difference to the use of hospital beds in London. I want to see the build up of community based projects which will either enable prompt discharge of patients when there is no clinical need for them to remain in hospital or prevent hospital admission in the first place.*
> (Department of Health Press Release, 16 March 1993)

In order to have a chance of getting money to bring about changes in the NHS, voluntary organisations had to persuade LIG that they would be able to provide a service that reduced the demand on acute beds. Rarely has there been such an invitation to break the commandment *'Thou shalt not lie'*.

In private conversation, many voluntary organisations admitted that they hadn't a clue how many beds their schemes might 'save'. In unguarded moments, those assessing their bids came close to admitting that, in any case, they would not know how to assess the claims of the voluntary sector on this score either. Nevertheless, that was the basis on which money for change was ostensibly allocated.

Campaigning and advocacy

It is essential to find ways to fund the voluntary sector to continue its valuable role in advocating and campaigning on behalf of groups of people, rather than simply funding voluntary organisations to provide services to people as individuals. Contract culture has yet to get to grips with this fundamental issue.

The need for infrastructure

To bring about effective change, it is strongly felt by voluntary and community groups that funding must be made available to the voluntary sector for more than just front-line service delivery. No health authority is expected to function without research and development input, without training budgets for staff, without proper IT support or administrative assistance. Many voluntary bodies have to do so.

Some, though not all, of these deficits can be made good by support through second-tier, co-ordinating bodies – and here, of course, GLACHC must declare an interest. However, it is almost impossible to persuade funding bodies properly to fund the costs of supporting the voluntary sector to do its work well. The London Boroughs Grants Committee is one of the few funders that explicitly recognises these needs, but their capacity to meet them is extremely limited.

A community perspective on change

So far, this account may seem all too familiar to those in the voluntary sector who are responding to change after change in London. Yet we are not arguing here against change, but in favour of doing it well and ensuring that it is motivated by a clear strategy to improve services for the communities of London, based on an understanding of what is needed.

There are four ways in which current efforts might be improved:

- involving the community
- integrating services
- clarifying the benefits of change
- identifying the need for some stability

Involving the community

If there is a real desire to involve people in the changes happening to health services in London and to ensure that the structure of services is based on an understanding of local community perspectives, then four issues must be addressed:

- more high quality information
- less use of jargon
- organisational honesty and openness
- genuine dialogue and consultation

More high quality information

In contrast to the propaganda machine described above, high quality information is essential. A recent study from GLACHC (Joule, 1994), shows that the extent and nature of information available to CHCs and the community about actual DHA contracts is extremely variable. Generally there are still complaints about quality, quantity, timing, presentation of material, not to mention its scant availability in media other than written English.

In addition, the fragmentation of information, and the secrecy that surround so much information for reasons of commercial confidentiality is unhelpful to the community when it tries to make change happen.

Less use of jargon

The use of jargon still mystifies, whether it is a prize-winning phrase like 'negative performance indicators' – meaning complaints – or a common phrase like 'primary care', which means little to ordinary people, and perhaps not much more to some of those who use the phrase.

Honesty and openness

Making change happen often seems difficult from a community perspective, as the atmosphere is not always as open as it might be. Contrast the draft Code of Practice on Openness in the NHS issued by the Secretary of State in the autumn of 1994 with the fact that in September 1994, GLACHC had to rely on an anonymously leaked document to learn that LIG had organised a seminar on primary care and the involvement of private finance.

Genuine dialogue and consultation

CHCs in particular have little enthusiasm for set-piece formal consultations, the outcome of which is seemingly unshakeable. Such exercises rarely justify the demands that they make on staff and member time. There is much more enthusiasm for ongoing, genuine dialogue on issues where there is still a decision to be taken, and where there can be a real opportunity to involve people in the direction of change. What is clear is that feedback is essential, as is a sense of realism, on all sides, about what can be changed, and when.

An integrated service

In order to make change happen, it is essential that a patient-centred view prevails. Change cannot take place easily if the services, as they are actually experienced by users, are patchy. The NHS is as good as its weakest link, and change needs to permeate through the NHS in order to impact on any part of it to maximum benefit.

The rhetoric of change in recent years has focused on primary care. There are many reasons why this should be so, and it is not necessary to rehearse here the persuasive arguments about the poor standards of London's primary care. However, if the impetus to improve primary care is motivated by a squeeze on acute services, then the very idea of change will be mistrusted. Moreover, while it is true that the capital's primary care is inadequate, few Londoners agree that all is well in the acute sector, at least while they or their friends continue to wait for routine in-patient treatment, or languish on trolleys in Accident and Emergency departments, waiting for a bed to become available. The anecdotal evidence for these serious shortcomings has been repeatedly confirmed by the 'Casualty Watch' surveys, pioneered by Southwark CHC, and now carried out widely by London CHCs on a monthly basis.

The community perspective on health care is essentially integrated in nature, rooted in the experience of people who need to use services, with little time for the administrative niceties of whether it is primary care or secondary care which they need. Nor do people greatly care, on an everyday level, whether a particular service is an NHS or a local authority responsibility.

A voluntary sector colleague is fond of remarking that if she needs a bath, she does not mind if it is called a 'health' bath or a 'social' bath, so long as she can get clean. Therefore, in order to make change happen, at a pace that is acceptable and affordable, it is absolutely necessary not to see progress in one part of the system as being contingent on destruction in another part.

Clarifying the benefits of change

If people have been unwilling to embrace *Making London Better*, it is, in part, because they are being asked to support change that is perceived to take something away before much can be seen in its place. If there are benefits, these have not been made clear, and the answer does not lie in another dose of propaganda leaflets. People need not only to be convinced that primary care can be developed in London in a reasonable time-frame, but also that once it has been developed, it can make a difference to the issues that matter to them.

Thus, while it may be beneficial for a health centre to install a ramp and a new washbasin, in themselves, those improvements are no guarantee that the service will be what is needed. Nor is there any persuasive evidence that the resulting improved access to primary services will diminish the need for an acute hospital bed.

This is not an argument to proceed at the pace of the slowest. It is an argument in favour of demonstrating that change is worth having, and not merely giving reassurances that it will be. That should not be an insuperable challenge. Community perspectives are not inherently conservative, although they are sometimes portrayed that way.

To give just a few examples of the willingness of people to change their views in line with real opportunities for progress, changes in patterns of care for terminally ill people, from hospital acute wards to hospices or home-based care have been warmly welcomed, once the benefits of change became apparent. Another example would be that the key principles of *Changing Childbirth*, the report of the expert maternity group in 1993, with its emphasis on woman-centred care and continuity of care, owe an enormous amount to years of active campaigning by women for change, that found little support among clinicians until relatively recently.

Community perspectives are not necessarily conservative; they are, however, inclined to take promises with a pinch of salt, and who can blame them?

The need for stability

Paradoxically, one of the greatest needs if we are to bring about change which is acceptable to the community at large, is a period of organisational stability. As the NHS has been rocked by a series of seismic changes, so it has become increasingly difficult for community perspectives to be incorporated into official NHS business. Partly, this is because health agencies do not actually have the personnel available for the time-consuming business of engaging with the community in its multifarious guises. Partly, it is simply difficult to keep abreast of whom to talk to, about what.

If the process of change is to include the perspectives of a broad range of people, then structures must be in place for long enough so that community groups are able to get to grips with them. The expectation now is that major change can happen if one turns one's back for a moment.

Staff too might be better able to facilitate positive change if they expected to be around to see through the consequences of their actions. The likelihood of having to clear up one's own mess is a considerable incentive not to make too much mess in the first place.

Conclusion

Change may be necessary and inevitable in London. This is not an excuse for insisting that everything must change or that there should be a continual process of change. Changes in London's health services are more likely to succeed if they are based on trust and openness, and if community perspectives can be integrated as fully as possible. This requires the active participation of people working through Community Health Councils and voluntary organisations. A modest investment of time and a large change in entrenched attitudes, in the minds of both politicians and clinicians, could be the keys to making change happen.

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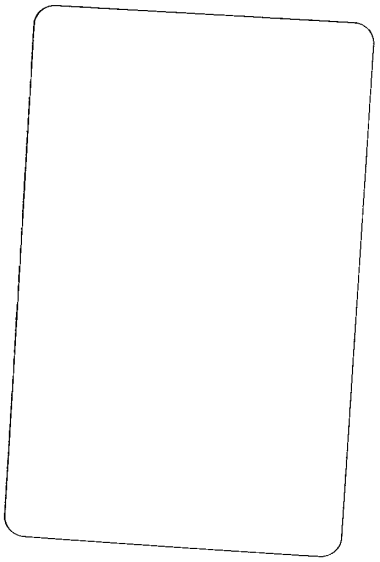

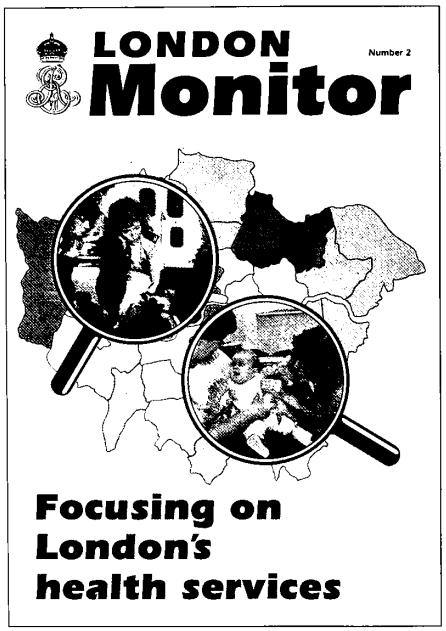

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