THE KING'S FUND

ANNUAL REPORT 1992

KING EDWARD'S
HOSPITAL FUND
FOR LONDON

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Treasurer
William Backhouse

Chairman of the Management Committee
Marius Gray FCA

Secretary and Chief Executive Officer
Robert J Maxwell JP PhD

2 Palace Court, London W2 4HS
Telephone: 071-727 0581

KING EDWARD'S HOSPITAL FUND
FOR LONDON

THE KING'S FUND

ITS ORIGINS AND HISTORY

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

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

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

Grantmaking ranges from sums of a few hundred pounds to major schemes costing more than £1m, such as the sustained drive to raise standards of care for people with learning disabilities in the 1970s, and, in the 1980s, work on primary care in London, on which, to date, some £1,570,000 has been spent. Other recent ventures concern the assessment and promotion of quality in health care and the London Commission.

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

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

The **King's Fund Institute** was established at the beginning of 1986, and until June 1993 is located at the King's Fund Centre in Camden. After that time it moves to 14 Palace Court W2. The Institute seeks to improve the quality of public debate about health policy through impartial analysis.

The **Organisational Audit Programme**, based at No 10 Palace Court, now has contact with about one quarter of all UK acute hospitals and carries out systematic reviews of their management arrangements. It has recently begun a similar programme in health centres.

The **London Commission**, which reported in 1992, proposed radical long-term changes in London's health services.

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CHIEF EXECUTIVE'S INTRODUCTION

Up to the general election in May 1992, most commentators anticipated a change of government in Britain and a reversal of the structural and financing alterations to the National Health Service that had stemmed from the review ordered by the former Prime Minister, Mrs Thatcher. Trusts would be scrapped, the purchaser/provider split would be replaced by some form of performance-related financial allocation for local health authorities, and general practitioner fundholding would end. The direction of NHS development would change dramatically. What had occurred in the previous year would become a footnote to history.

But that did not happen. Instead the Conservatives were re-elected and their restructuring of the NHS continues. Assuming that the Government runs to something like its full term, virtually all major hospitals and community units will have become trusts by the time of the next election. Health authorities will have been transformed into commissioners of health care and there will probably be little point in trying to change them back into providers. At all events, there will be some depth of experience on which to base a decision. It will be increasingly obvious that district health authorities and family health service authorities need to merge. Quite possibly a Labour administration would want to pass the whole commissioning function to local government.

What the position will be in general practice by then is less clear. Fundholding seems likely to remain controversial, attracting some enthusiastic experiments but probably remaining a minority taste in many areas. What alternative is there to encourage non-fundholders to use their leverage across the whole range of services, and what impact will this have on district health authorities as commissioners of care? Can the demand function be represented simultaneously by general practitioners on behalf of their patients and by public authorities commissioning health care for whole populations?

In the long run questions like these will have to be answered. Meanwhile, however, the statutory framework for the NHS is clear for most of the 1990s and we can concentrate on trying to provide good care within it. This, after all, is what matters to patients, families and NHS staff, day in and day out. Management is only a support – or at its worst a hindrance – and not an end in itself. We badly need to rebuild public, professional and staff confidence in the skill, integrity and compassion of NHS practice, however organised. Problems like those over extra-contractual referrals and delayed admissions do great harm to confidence.

The new community care arrangements come into effect in April 1993. Under these, the social service departments of local authorities become the lead agencies in assessing who needs what level of residential and other support. There are sharp differences of view about how well this will work, granted tight funding constraints and possibilities of dispute between authorities about their respective responsibilities. Again, there is an overwhelming duty to try to work through these difficulties, while acting firmly on behalf of individuals who desperately need help and must not be penalised by uncertainty.

In London, which is the Fund's special concern, there are of course particular problems as a result of the NHS financing changes. Fewer hospital referrals are coming into central London and London capitation rates (the amounts allocated per head for hospital and community services for London residents) are

being brought more nearly into line with the rest of the country. The result is dramatic destabilisation for the hospitals of central London.

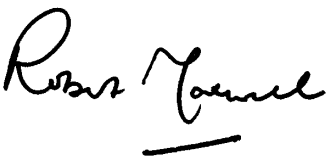
We foresaw this three years ago, and established a Commission to develop a coherent view of what pattern of health service would make sense for London in, say, 20 years' time. The point was to try to ensure, in a period of sharp reductions in funding, that there should be some logic beyond piecemeal budgetary cuts. The King's Fund Commission issued a report, *London Health Care 2010: Changing the future of services in the capital*, in June 1992, just after the general election. It was followed in the autumn by Sir Bernard Tomlinson's *Report of the Inquiry into London's Health Service, Medical Education and Research* for the Government. Sir Bernard's remit was more preoccupied than our Commission's with immediate issues facing government, particularly choices among institutions, and less concerned with long-term vision. Nevertheless the two reports were in general compatible and were in strong agreement about the urgent need to strengthen primary and community care in London, to bring specialist services like cardiothoracic and neurosciences into fewer centres, and to create strong groupings of hospitals and basic sciences for tertiary referral and medical research.

In February 1993, the Secretary of State announced the Government's response to the Tomlinson report, accepting the majority of his recommendations. At the time of writing, the position about particular hospitals is still somewhat confused – the more so because the Special Health Authority hospitals like the Brompton, Great Ormond Street and the Royal Marsden are soon to become subject to similar financing arrangements to the rest of the NHS – but the position will become clearer during 1993. An important element will be the reviews of six specialties which have been commissioned by the Government at breakneck pace for report by mid-year. Meanwhile, there is an enormous agenda to tackle in working through the implications of the various hospital mergers, in an attempt to provide the best value for patients within the sums available from the commissioning authorities in London and outside. Equally, there is the task of laying the foundations for sustained development and innovation in primary health care – broadly defined – in London (and indeed in other UK cities) through the next decade.

The King's Fund will try to help wherever we can within our relatively small resources. What London is trying to do is probably a 'world first' because no major city anywhere yet provides a good model of effective economical primary health care combined with international excellence in hospital medicine and medical research. It is a tough proposition, but an appropriate and necessary one for the NHS – and indeed for the King's Fund.

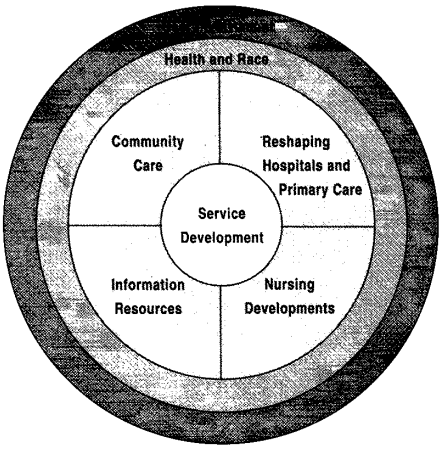
Nor is that all for, as this Annual Report illustrates, there is also a massive continuing range of activities in the Fund, from nursing development to health policy, and from hospital standards to purchasing for health. Progress and plans are described in the Report, which also reviews some current issues of major importance in the UK health scene, namely the next chapter in the development of London's health services; health services for Black populations; homelessness and health; the state of purchasing (or commissioning); and finally community care.

Lastly, may I pay a warm tribute to Sir Robin Dent, who has served in an honorary capacity as the Fund's Treasurer for the past 18 years. Sir Robin combines firmness with kindness, and an immense capacity for detail with devotion to the Fund and its purposes. He leaves the Fund's finances in excellent shape and from the vantage point of the General Council will continue to give his support to us all, including Mr William Backhouse, his successor. Her Majesty's award to Sir Robin of the KCVO was a recognition of his immense personal contribution and gave very great pleasure.



Robert Maxwell

KING'S FUND CENTRE



In 1992, we reshaped into the wider groupings shown above, reflecting changing approaches in the field. The outer rings on health and race and on user involvement are built into all the teams' work.

NURSING DEVELOPMENTS

With £3.2 million from the Department of Health, we were able to make grants to 30 Nursing Development Units across the country, which focus on the development of nursing practice and on the development of nurses themselves. We had over 200 excellent applications, showing how much initiative there is in nursing in the NHS. Even without funds, all these units will get some support from the Centre through the new Nursing Developments Network and newsletter. The Primary Nursing Network will combine with the Network in 1993. While nurses themselves are enthused by their ability to develop practice, there is still a need to convince managers of the importance of nursing developments to them.

ACUTE AND PRIMARY CARE

Staff in the Centre were heavily involved with work on the London Commission, both prior to its launch and subsequently in promoting the vision of health care for Londoners. There is a growing recognition that shifts of acute care into primary and community services are happening, and requests came in for presentations and advice from across the UK.

The Primary Care Group also launched a joint programme with the King's Fund College on Community Oriented Primary Care in 1992. Grants-supported projects on GP services in A and E at King's College Hospital and on care for homeless people at Charing Cross A and E came to fruition. In both cases, part of the initiative was working with purchasers to help write service specifications for this kind of primary care. *Audit and Development in Primary Care* was published in December, with a major conference planned for February 1993.

David Costain left at the end of 1992 and Christine Farrell, the new Programme Director, took up her post in January 1993.

COMMUNITY CARE

We continued to focus on providing better services for people with mental health problems, physical disabilities and learning disabilities. We received grants from the Department of Health for further work on the Living Options project with The Prince of Wales' Advisory Group on Disability, and for Black mental health issues, particularly the development of 'sanctuaries' or crisis centres in the community.

The Carers Unit received a new impetus this year with the establishment and funding of the Carers Impact Group, which we manage on behalf of a consortium of health and social care agencies. To help develop health and social services for carers, consultancy will be provided by managers and other professional staff from other authorities. Work on the needs of Black carers also took off this year.

Roger Blunden left this year and Janice Robinson was appointed to the post of Director of the new combined Community Care Group in January 1993. We were sorry to lose Diana Twitchin, who left the Fund after 16 years of contributing to services for disabled people.

INFORMATION RESOURCES

The library and specific subject information services are operating well and moved into a

new phase in 1993. We intend to do more to help develop information services in the NHS and we began this with an information audit in North East Thames Region. There is much concern in the NHS and within various information provider bodies about duplication of effort and the lack of integration of textual and statistical information. We have set up a variety of groups to look at promoting a more strategic approach to the totality of information management. More specifically, we have become part of a consortium of libraries, including the DoH and Nuffield Institute, with the aim of reducing duplication and sharing some resources.

Health and race

We are pleased that health and race is now becoming a major issue for the NHS with the support of Ministers. We made a strong contribution to this effort in 1992, creating checklists for purchasers, providers and regional managers which will be published in 1993 by the NHS Management Executive. We will also report in early 1993 on the first four localities in our project on purchasing for Black populations. This work has begun to demonstrate both how Black communities can be involved in purchasing and how their needs can be built into service specifications. We received further DoH funding for this project in 1992 and were also able to make another King's Fund grant to health authorities at the end of the year. **Share**, our health and race information exchange, focused in 1992 on older people, ethnic monitoring and purchasing.

After a successful workshop in November, attended by over thirty Black members and chairs of health authorities and trusts, we will establish a working group with NAHAT to look at barriers to the appointment of Black members and what can be done to overcome them. The establishment of this group follows an earlier joint effort looking at barriers to women's appointment. That report, *Where are the Good Women?* was launched in 1992 and has proved to be a helpful and practical guide to Opportunity 2000 targets.

User involvement

Our commitment to user involvement includes encouraging community participation; working with user groups to incorporate their views into the planning of services, especially people with long-term care needs; and involving patients in clinical decisions about their care. In 1992 we began to develop this third area by experimenting with US-produced interactive videos (see below). We are evaluating not only acceptability to patients, but also patient outcomes.

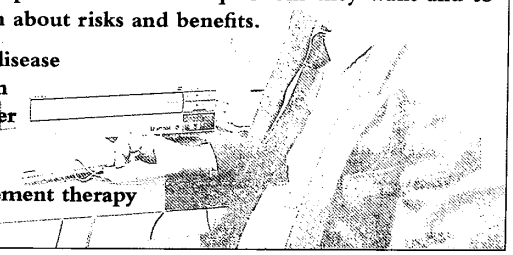
In summary, the year was a very successful one. Our efforts are now making an impact across a wide front, and some of the issues that we have been struggling to get on to the agenda are increasingly being recognised.

User Involvement

Increasingly the pattern of disease includes chronic conditions which can be alleviated, but not necessarily cured.

Treatment options for each condition widen as medicine explores new diagnostic and therapeutic approaches. The various options present different risks and benefits, about which there often is substantial statistical information that it is quite hard for specialists to master, let alone GPs and patients. Yet, when there is a balance of risks and benefits across a range of treatment options, patients ought, in principle, to have the right to make an informed choice. Interactive videos enable patients to ask the questions they want and to access the statistics for reliable information about risks and benefits.

Trials in progress:	**Benign prostate disease**
	Mild hypertension
Trials being developed:	**Early breast cancer**
	Low back pain
Further trials proposed:	**Hysterectomy**
	Hormone replacement therapy
	Obstetric care



KING'S FUND COLLEGE

One of the most difficult shifts for those managing the NHS in 1992 has been the transition to the post-election period after more than a year of political party debate on the reforms. In this time it has become critically important for managers and health professionals to evaluate the effects of the proposed changes on their organisations and on the ability of the NHS to deliver effective, high-quality patient care.

For many, this has been more of a challenge than might have been imagined – a real shift in orientation from a high-pressured implementation of recognisable structural changes such as the creation of trusts, purchasing authorities and fundholding practices, to using the framework of the reforms to manage these entities most effectively.

This process has often revealed a real implementation gap between ideas and practice. Terms like purchaser/provider split, contract culture, and clinical resources management are understood by top management and may be reflected in documents, business plans and guidance, but they often have little relation to change in the behaviour of middle management or staff working directly with patients.

The need to close this gap has been reflected in the continuing buoyancy of demand for our fieldwork activities. These have been particularly wide-ranging, involving community units, social services, GP practices, hospitals and medical schools, as well as our work with FHSAs, DHAs, regions, the NHS Management Executive and the Department of Health. Some examples are:

- developing purchaser networks throughout England and Scotland in which purchasers develop ideas and strategies;
- region-wide management development for consultants' programmes featuring workshops for clinical directors in all acute units;
- work with social services departments, acute and community providers, purchasers, users and carers in implementing the Community Care Act;
- orientation sessions for new chairs and non-executive members of boards and in-depth work on individual board development;
- an organisational development programme, 'Community Oriented Primary Care', linking GPs, DHAs and FHSAs in joint training for effective community health needs assessment from the GP practice base that will eventually inform purchasing decisions at the Health Authority level.

Since July 1991 we have managed over 20 projects directly commissioned by the NHS Management Executive. These are particularly important for their potential to influence the shape of health policy in various aspects of the reforms.

We have also had an excellent response to certain targeted educational programmes such as 'From UGM to CEO' – a programme for individuals leading trusts – which regularly runs at full capacity as chief executives struggle with the huge development agenda that trust status brings. Special programmes for purchasers, both strategic and operational, and an array of management programmes for health professionals in management have continued to be well subscribed.

We have been particularly pleased at significant progress towards our goal of becoming a leading provider of executive development for present and future nurse leaders. Among these activities was an invitational consensus conference, funded by the Department of Health, on 'Nurses' Role in Purchasing', which identified new, creative roles at the executive and operational levels. The College also organised and directed two conferences for 120 nurse executives in third wave trusts. Our Development Sets for nurse leaders and the 'Nurse Executive Skills' programme have continued to be well subscribed. This considerable body of work demonstrates the College's conviction that developing nurses and nursing is vital to the changing culture of the NHS.

The College has been very much involved

in design of programmes in response to the Opportunity 2000 initiative of the NHSME. Early December saw the launch of a personal and professional development programme for the most senior women in the NHS – trust and health authority chief executives and board-level managers and health professionals. About 30 senior women will be involved in this first round of 'Leadership 2000'. The College is also sponsoring Opportunity 2000-funded programmes for women consultants and middle managers.

We joined with the King's Fund Centre to offer training in organisational development to Black managers in the statutory, voluntary and community agencies. This programme responds to the commitment to assist Black people, many of whom are highly qualified for more senior positions, to overcome institutional barriers to career advancement. It also seeks to address the change necessary to ensure the full use of all human potential in a varied workforce. The first programme was very well received and it will be repeated during 1993.

Our international work has centred on continuing partnerships with major Western European organisations and educational institutions of management development and public health to permit active exchange of information. Jointly sponsored educational efforts in 1992 included the European Leadership Programme (with Spanish and Swedish partners for the most senior health service managers from the three countries as well as Holland and Italy) and Purchaser-Provider Roles and Relations (two learning networks among United Kingdom, Scandinavian and European purchasers and providers). The College continued to play a major role in the King's Fund International Seminar held in Australia during the year, maintaining our strong links with health-care leaders in North America and Australasia.

We have worked with European partners in our major development programmes in Romania (a comprehensive policy development project for the future of the Romanian health care system funded by the World Bank) and in the Czech and Slovak republics (a national health services management development strategy funded by the PHARE programme of the EC). We recently initiated two smaller projects, one in Hungary to assist Semmelweiss University School of Medicine to develop health services management training for doctors, and the other with schools of nursing in Krakow and Budapest for executive development for nurses. We also led a consortium funded by the Overseas Development Agency to advise on the strategic use of the Government's 'Know-How' funds in the former Soviet Union.

London's health services now face major changes, whose exact nature remains controversial and uncertain as we go to press.

The distinctive role of the College lies in its work with managers, professional leaders and policy-makers at all levels to enhance their capacity to think clearly and to implement change in the interests of Londoners and other health service users. The College believes that effective implementation includes recognising and addressing the needs of people who work in health service organisations, paying close attention to political and financial realities as well as to health care needs.

It is relatively easy to agree on the following:

- Primary and community care need significant and imaginative development.
- Secondary and tertiary care services need re-thinking and changes must be managed carefully if quality is to be maintained and enhanced. The forces of history and the marketplace alone are insufficient and potentially devastating.
- Clinical research and training in medicine and other professions need both some safeguarding and a process of creative development.
- Londoners need actively to be consulted.

The King's Fund as a whole believes that movement into new patterns of service cannot be designed blueprint-fashion in advance. There are many different agendas and concerns in London and genuine constraints. Differentiating which of those constraints must be accepted from those which can be questioned is hard. All this is likely to make sensitive strategy development, especially at local levels, very challenging. The College is clear about its commitment to working with the Service and related organisations from its independent position and looks forward in 1993 to a major commitment to working in London.

KING'S FUND INSTITUTE

During 1992, the Institute was able to build on the opportunities offered by a number of new appointments made in the previous year and, with a settled team, develop a strategic programme of work. This has adopted twin foci:

- contributing to the Fund's efforts to re-shape the capital's health services by monitoring the health and health care of Londoners; and
- evaluating the strategic development of British health policy in an international context.

LONDON

The Institute, on behalf of the Fund, has assumed primary responsibility for developing the capacity to monitor the health and health care of Londoners. The aim of the Institute is to extend analytic thinking on London and, as a product of this process, it has started to establish a database covering various aspects of health and health services in London.

At the beginning of the year, the Institute made a major contribution to the King's Fund London Commission report, *London Health Care 2010*, through its two research reports, *The Health Status of Londoners* and *Acute Services in London*. The Institute also produced analyses of public opinion data about health care which showed that Londoners are significantly more dissatisfied with the services available to them than people in most other parts of the country. Subsequently, we were called upon to brief a number of audiences, including the Tomlinson Inquiry. Since then, work has started on an annual publication on London health care, tentatively titled 'London Monitor', the first edition of which will be published in 1993.

NATIONAL HEALTH POLICY

The Institute has always taken a strong interest in the development of national health policy and a number of publications in 1992 addressed issues of considerable topical importance. *Health Care UK 1991* analysed a wide variety of issues and drew particular attention to the *de facto* privatisation of long-term care. *Foothold for Fundholding* provided a systematic analysis of the first year of GP fundholding, carefully documenting its strengths and weaknesses. *Through a Glass Darkly* examined policies on community care for elderly people and raised a number of issues of particular concern in the run-up to the implementation of new community care arrangements in April 1993. *Ethics and Health Care* examined the role of research ethics committees in the United Kingdom. It concluded that there was much good intent and practice, but that the guidelines published by the Government as part of the *Citizen's Charter* lack teeth and cannot ensure that people are genuinely protected from unethical research. *Too Many Cooks?* reported the results of a study into the response of the emergency services to major incidents in London. Following examination of five major incidents – including the King's Cross underground fire and the Clapham Junction railway accident – it concluded that the health service response is often uncertain and confused. Positive proposals for improving this response were put forward.

In connection with national health policy, the Institute has also been involved in co-ordinating two major programmes of work on behalf of the Fund. 'Hospitals and health services: into the next century' is a policy review being undertaken jointly by the Fund and the Milbank Memorial Fund of New York. As well as commissioning research papers from outside contributors, the Institute has been undertaking considerable in-house policy analysis and research and is committed to contributing towards the end-of-project publication. 'Evaluating the NHS Reforms' is a King's Fund Major Grants programme through which seven research teams have been monitoring the introduction of different aspects of the reforms over the last two to three years. During 1992, the Institute organised a workshop at which the research teams shared

experiences and ideas. In 1993, the Institute will publish a book based upon the research findings.

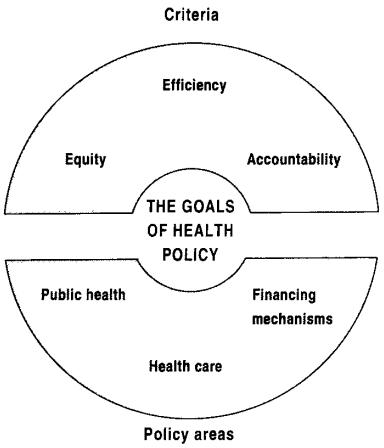
FUTURE STRATEGY

The Institute intends maintaining its interest in national health policy but is seeking to give this work greater coherence. It aims to achieve this by evaluating the performance of British health policy against a set of criteria which are robust enough to have relevance as a framework for most, if not all, First World countries. Using our analyses, as well as those of others, we want to be able to assess British health policy both by synthesising a wide range of relevant evidence and by making specific contributions in important but relatively neglected areas.

Throughout the last decade, British health policy has been dominated by a largely managerialist agenda concerned with ensuring that the NHS is better placed to provide appropriate, effective and responsive services to patients in an efficient manner. Such an objective is highly laudable, but it leaves a number of important questions on the sidelines. The Institute has concluded that the time is ripe to initiate debate about such questions as 'what are the overall goals of health care?' or 'what should be the shape of a new strategic framework?'. We have begun this process by making two sets of basic assumptions, both of which are illustrated in the diagram above.

The first is that the criteria employed to evaluate health policy should include equity and accountability as well as efficiency. The second is that the focus of health policy should extend beyond the functioning of the health and social care delivery system to encompass public health and non-health-care-related policy interventions as well as a comprehensive consideration of alternative forms of financing mechanisms.

The significance of such an approach is that it draws attention to critical questions which extend well beyond the important but relatively narrow one of obtaining better value for money within the National Health Service. For example, relatively neglected questions which might merit closer attention in the future include:



A framework for health policy analysis

- what entitlements can all citizens reasonably expect of the NHS?
- would the interests of users be better served by improved systems of local accountability within the health care system?
- what interventions are most effective in obtaining different kinds of health gain?
- how can all of the resources available within the NHS be distributed more closely in relation to the needs of different areas?

The Institute's priority for new work will be to develop a series of projects which inform our thinking about justice and fairness. Projects already under way investigating how purchasing power in the NHS can be allocated more fairly in relation to the relative needs of different populations represent our first steps in this direction. A significant investment is also being made to investigate variations in the health status of minority ethnic populations and in their access to health care.

GRANTMAKING

During 1992 several important changes were made in the Grants Committee's organisation and activities compared with previous years.

The year was not an easy one financially for the Fund but, as outlined in the last Annual Report, the Grants Committee introduced an innovation in the way it awarded its Major Grant. This grant, which in 1992 totalled £400,000, is not necessarily restricted to the Greater London area provided that we can show that learning from the successful schemes will benefit London. The 1992 competition had the theme of improving health care services for people of Black and other minority ethnic groups. The allocation of funds followed widespread consultations with members of these communities. As a result, two strands of activity received awards.

First, £100,000 was reserved to assess the feasibility of establishing a Black Health Foundation. The idea, which a steering group is examining, is to create an organisation as a focus for information and action across the whole range of issues affecting Black health. It would, for example, seek to provide a focus for information and good practice and assist the development of grass-roots organisations. It would raise money primarily to assist others. It would be national, independent and Black-led.

Under the second part of the 1992 Major Grant, initiatives were sought for projects that would improve access to care for members of Black and other minority ethnic groups, but the applicants' proposals had to show evidence that both the local members of those communities, perhaps in voluntary groups, and the statutory authorities had developed their proposals together. The advertisement made it clear that the Fund would provide a planning grant of £5,500 to each of 10 shortlisted applicants and that three final winners would each receive £80,000, making a total, with £5,000 incidental expenses, of £300,000. The response was overwhelming, with over one hundred entries. By itself, this number once again provides encouraging evidence that the Fund's Major Grant scheme can help to bring about desirable change in the NHS by encouraging many more initiatives to be developed than we can ever hope to finance. We know that the preparation of many of the applications influences local thinking; indeed in a number of local examples over the years we have seen that some very similar initiatives are introduced later because the thinking has been done earlier as a result of a bid to the Fund, even though the particular application failed to receive one of our Major Grants.

In this instance, the Grants Committee set up a special sub-committee, with members from several Black and other minority ethnic groups, to make the selections. During the planning phase, the 10 short-listed applicants were visited to see how they were progressing and whether they could be helped to strengthen their bids. It was a good example of cross-Fund co-operation in that Dr Jo Boufford, Director of the College, and several people from the Centre, were considerably involved. The shortlisted and final winners are shown on page 13 and in the full list of grants made.

The Fund has become increasingly concerned that a 'health care underclass' should not develop in London. Therefore we attempt to ensure that less privileged individuals and groups in London are helped to obtain good health care. These groups sometimes include recent immigrants, but not always. In pursuance of this aim, the 1992 Grants included an allocation of £15,000 to the Community Asian Project to provide home support and an outreach service designed to prevent mental health breakdowns. In four other instances, £24,910 was awarded to the Haringey Women and Health Resource Centre to set up a counselling and support service for young African-Caribbean women with alcohol problems, £24,000 was given towards the cost of two health advocacy workers for the Somali London Community and Cultural Association, £60,000 was allocated to Chiswick Family Rescue to support a programme for children

affected by domestic violence, and £10,000 was provided to help establish an information database for the London Chinese Health Resource.

How to evaluate the effects of our grantmaking is a continual theme within the Fund. It is undoubtedly difficult. In 1992, £20,000 was awarded to finance an external evaluation of the seven projects for elderly people which comprised the 1991 Major Grant, and £16,900 to evaluate one of the community care projects supported in the 1990 Major Grant.

The Grants Committee membership has changed again this year. We were sorry to see Joanna Pitts and Sir Samuel Roberts leave at the end of their five-year terms, but we welcome Professor Brian Jarman and Professor Albert Weale in their places. Helena Whittaker also left the Grants Office, having been appointed to a post in the South West Regional Health Authority. The Grants Committee has now been given the responsibility for allocating all of the Fund's grant monies, except for educational bursaries and some financing delegated to the Centre Committee for specific service developments. A new Grants Director, Ms Susan Elizabeth, starts in May, having worked previously for the National Council for One Parent Families. We welcome her.

Finalists for Major Grant Award 1992

Recipients of Planning Awards and Major Grant Awards

Improving Access to Primary Care for Black People, London	**£80,000**
Improving Access for Black People, South Glamorgan	**£80,000**
Improving Access for People from Ethnic Minority Backgrounds, Leicester	**£40,000**
Timeout, Nottingham	**£40,000**

Recipients of Planning Awards Only:

Assessment Centre for Black People Experiencing Mental Ill Health, Birmingham
Improving Access to Preventive Health Care for the Bengali-Speaking Population, London
Opportunities to Provide Ethnically Needed Education on Diabetes, London
Serving the Chinese Community, London
Rochdale Working in Partnership
Traumatic Stress Clinic for Refugees

ORGANISATIONAL AUDIT

Organisational Audit carrying out a survey

Nineteen ninety-two was the first year in which the Organisational Audit Programme operated as a free-standing King's Fund unit, based at 10 Palace Court. It has been a year of considerable growth for the programme – in the number of hospitals taking part in organisational audit, the range of activities undertaken and the number of staff employed to support this activity.

Our work with acute hospitals continued to expand. A total of 29 hospitals were surveyed during the year, with a further 35 preparing for survey in 1993. The original eight hospitals which had participated in the pilot project also undertook their second survey during the year, which provided a satisfying completion to this phase of the programme.

In addition, we have been active in the field of primary health care over the past year, piloting a project in general practices and health centres. Nine sites worked with us to develop standards and these sites will undergo an independent survey in the spring of 1993. The standards concentrate on the organisational arrangements for primary health care services, including dentistry, community psychiatric nursing, chiropody, health visiting, social work and general medical practice.

During the year we examined the feasibility of developing an organisational audit approach for use in the residential care setting and it is likely that this work will be pursued further during 1993. We also explored new methods of working with other organisations, for example in partnership with Wessex Regional Health Authority, to develop the organisational audit process for services for people with learning difficulties. Further expansion is likely to draw us into the field of community care and community hospitals.

In August 1992 *The Consumer Checklist* was published. This document forms the basis of an innovative approach to the involvement of consumers in the measurement of quality in acute hospitals, an approach which will be extended to other services.

In the latter months of 1992 we appointed a part-time member of staff to establish a standards library. This work was undertaken in conjunction with the Information Resources department at the King's Fund Centre. The intention is that it evolve into a standards database to which internal and external users may gain access.

During 1992 we also concentrated on improving the process of organisational audit and the training which we offer, both to surveyors and to co-ordinators within participating units. We were delighted to host our first annual meeting of surveyors, which was well attended and enthusiastically supported.

Future activity

In 1993 we shall continue to develop both the range and quality of the services we provide. In particular, we hope to develop our relationship not only with our immediate clients in the shape of provider units, but also with those commissioners of services who regard organisational audit as an important mechanism in the assurance of the existence of quality systems on the part of providers.

We are also in the process of developing sound management and financial systems to ensure the long-term viability of the unit as it expands. While it can reasonably look to the Fund and others to finance development activities, there is no reason why its core services should not be self-financing.

COMMISSION ON LONDON

The work of the King's Fund Commission on London culminated in June 1992 in the publication of *London Health Care 2010: Changing the future of services in the capital*, the Commission's strategy for the future of health care, medical education and research in the capital. Its proposals for a major reorientation of health care in the capital centred on focusing care on the needs of Londoners. In addressing the capital's over-concentration on specialty provision, the report advocated a shift to primary care.

LONDON HEALTH CARE 2010

Changing the future of services in the capital

KING'S FUND COMMISSION ON THE FUTURE OF LONDON'S ACUTE HEALTH SERVICES

The report which preceded the Tomlinson inquiry

London Health Care 2010 attracted a great deal of attention in policy circles and the media. Its central thrust was consonant with the recommendations of the report made by Sir Bernard Tomlinson, special advisor to the Secretaries of State for Health and Education. His *Report of the Inquiry into London's Health Service, Medical Education and Research* was published in October 1992. It made extensive use of the data on the health status of Londoners and health services in the capital collected for the Commission's work and published in its report and the working paper series.

The London Initiative, which co-ordinates work on change in the capital across the Fund, followed the publication of the Commission's report with a programme of dissemination. This has involved presentations on its findings and recommendations to a very wide range of audiences, both inside and outside the health service, across London and nationwide. As the debate on the future of health services in London has continued, the London Initiative – and the wider Fund – has continued its attempt to influence the process and management of change in the capital's health services.

SELECTED ISSUES

LONDON'S HEALTH SERVICES: WHAT NEXT?

Following the Tomlinson report and the Secretary of State's response, it is becoming clearer what the strategic response is to the financial pressures on London's hospitals. These pressures stem from two sources: first, the sharp reduction of referrals coming into central London from elsewhere, now that health authorities have much more influence over the flow of patients and the incentive to control it; and second, lower capitation rates for London residents. The two factors combined are already destabilising the financial position of most of the central London hospitals (except for the Special Health Authorities, which are insulated from it until April 1994). While 'the NHS reforms' are blamed for this destabilisation, what they have done in effect is to speed up a videotape that was already running. Most people involved in the NHS outside London would claim that London has been protected for far too long and that the process of adjustment was moving much too slowly.

Despite our special concern for London, we have taken the view that London's health services must change radically, partly for the sake of the NHS elsewhere and partly to give Londoners a better deal. There are, however, some caveats. First, for example, much work is still needed to establish what is a proper capitation rate for Londoners' health services, and the King's Fund Institute will be trying to contribute objectively to answering that question. Secondly, in the context of a market of a kind for health services, how can the appropriate funding of medical research be secured? This is a national (and indeed an international) issue rather than a matter of protecting London institutions, and there should be no assumption that research centres should be based in London rather than somewhere else. But how it is answered will affect many London hospitals and medical schools. Thirdly, can strong primary and community-based care be developed for all sections of the population in a city like London?

Without strategic intervention, the next few years looked very bleak indeed for London's health services and for Londoners. Hospitals which had balanced their books with difficulty in 1992/93 were faced with substantial budget reductions for 1993/94 and progressively thereafter.

The Tomlinson recommendations, modified by the Secretary of State's response, include:

- a commitment to strengthen primary health care, with an initial investment of £43 million;
- urgent reviews of six specialties (cancer, cardiothoracic, neurosciences, plastic surgery and burns, paediatrics and renal services) to determine the best future pattern for their development on fewer sites in London;
- some major rationalisations of hospitals, concentrating on Guy's and St Thomas', Charing Cross and some of the other West London hospitals, UCH Middlesex and Bart's and the London; and
- strengthening of the links between major London hospitals and medical schools along with the science faculties of Imperial College, King's College, Queen Mary/Westfield College and University College.

In the King's Fund we support these moves, although we are worried that the specialty reviews may be too rushed to do the job required of them. We expect to be particularly involved in primary care development, especially the shifting interface between hospital and primary care. We may decide to undertake our own reviews of accident and emergency services and of mental health, neither of which is covered by the Government's specialty reviews. We will try to help any London purchaser or provider wanting our assistance in tackling rationalisation in a way that safeguards services and yet takes out the order of

These photographs are taken from The Whole Question of Health, *a report which examines the underlying premises of contemporary health care and health care architecture, and in addition takes a specific look at one important element of health care buildings, the treatment of the entrance. The preparation of this report has been funded by the King's Fund, and is published by The Prince of Wales' Institute of Architecture.*

A space almost worthy of Sir Christopher Wren, this glorious and gracious and subtly colourful entrance colonnade positively welcomes the visitor or patient, and offers an enriching experience that can uplift and even en-trance

In contrast, here a black and white zebra crossing guides the visitor or patient through the gloomy and polluted 'underworld' of roadway and car parking to this parody of a classical doorway that is the main entrance to one of London's largest and most prestigious hospitals

magnitude savings that look like being imposed in the next few years. And we will, through the King's Fund Institute, be working on capitation rates and on trying to assess the effect of the changes made.

Whatever happens, the next several years will be difficult for the NHS in London. Everything possible must be done to maintain services for patients and at the same time to build a robust base for future development.

Health services for Black populations

At long last the NHS seems to be awakening to the need to make its services more appropriate and accessible to people from Black and other minority ethnic groups. The Secretary of State's equal opportunities initiative focuses on employment and on how to get Black people into the top levels of NHS decision-making. This will help us change the thinking of the NHS – as long as those concerned are not marginalised nor expected to become the sole champions of Black people in their communities. Getting Black people moving up through the service hierarchies is one thing. Getting the services themselves changed is even more difficult.

When the health needs of Black and other minority ethnic groups are first raised, the immediate responses tend to fall into two categories: 'Yes, they have specific health conditions such as sickle-cell diseases or the thalassaemias and we must deal with them' or 'Why should we be unduly concerned? We treat all our patients equally'. These responses are not good enough. We must face up to the fact that there is racism in the NHS, not only in NHS staff attitudes to treating patients, but also patients' attitudes to one another or to Black staff. NHS staff need to set the example of how Black and other minority ethnic groups should be treated – with dignity and respect.

Much more difficult, though, is the institutional racism which exists in the assumptions of the indigenous White and often male-centred culture of the NHS. To understand how off-putting these cultural assumptions can be requires placing yourself in the position of the other person. For example, how would you feel as a Moslem woman coming into an antenatal clinic, when your custom dictates that no-one other than your husband is permitted to see your legs, and suddenly being given a short robe to wear and being examined by several people, almost certainly including a man? Imagine the discomfort of being in a hospital ward not wanting to cause any fuss but not being sure whether your religion allows you to eat the meal put in front of you.

Even understanding these cultural differences does not always make people want to change services. The response is often: 'These Black people are in our country, so they should conform to our culture.' This ignores the fact that many Black people have been in the country for several generations, paying taxes, and are as entitled to accessible health care as anyone else. This response is also rather beside the point. If we are to improve the health status of the population, as we are rightly urged to do in *The Health of the Nation*, we shall never achieve it if large sections of our population find our services uncomfortable or even degrading to use.

Fortunately, many professional staff and purchaser and provider managers now recognise that change is needed, but they are often at a loss as to where to start. In fact, quite a lot is known about what would make services appropriate and accessible to people from Black and other minority ethnic groups. Any manager would be wise, however, to check out with her or his local population what they want. That is the first lesson: it is very important to get to know the community itself, not just its nominated representatives but also the variety of formal and informal groups that exist. What is appropriate for the Moslem community in Bradford may not be entirely the same for the Bangladeshi community in Tower Hamlets.

Community involvement will identify where the major concerns are. But in order to provide good quality services, provider units will need to address such issues as interpretation and translation, appropriate catering for different communities' dietary requirements, and a sensitivity to religious and cultural observances, especially at the critical life events of birth and death. There will be particular needs within individual services: for example, in outpatient departments, making sure people are called by their names correctly (this is not only a matter of courtesy – if it is not done, people may miss their appointments) and in mental health services, examining whether sectioning is being used inappropriately, whether crisis support in the community is available, and perhaps above all, whether counselling, treatment and support services are acceptable to Black people so that the crisis point is not reached.

Because what is needed cuts across all services and because different groups of the

PHOTO: ANDES PRESS AGENCY – CARLOS REYES

Racial plurality: children at a school in London's East End

community have different needs, the task can seem daunting. In fact, it challenges how a large service like the NHS really can respond to the individual's needs. If we can achieve that respect for the individual, it will improve the NHS for everyone.

HOMELESSNESS AND HEALTH

In previous annual reports we have commented on the contemporary tragedy of homelessness. Unfortunately, what was once rare has become all too familiar and those who do not have to endure it are becoming hardened to it as a fact of (other people's) life. In London, visible homelessness is only the tip of the iceberg. The Government's Rough Sleepers initiative has had a deserved measure of success in keeping down the number sleeping on the streets. The figure from the April 1991 Census was 1,275 for London and some 2,700 for England as a whole. Since then we understand that there has been a further drop to around 500 in London, which is still 500 too many.

But the hidden homeless are many times more and their number continues to rise fast. As the table shows, by 1991 there were in England some 60,000 families, or 144,000 people, registered as officially homeless, living in temporary accommodation. The vast majority are families with young children and a fifth of the statutorily homeless are children under 5. While there has been a desirable swing from bed and breakfast to private leased accommodation, this remains a most unsatisfactory setting in which to bring up a young family – usually in very cramped space and uprooted from one's own community.

The health implications are bad in some fairly obvious ways. Accident rates are high among children, respiratory and other physical complaints are prevalent, and depression is common. Through 'Access to Health', our joint programme with the four Thames Regional Health Authorities, we have increased substantially the awareness that homeless people (both individuals and families) have greater than average health needs and that they have typically not been at all well served. Among the results of this greater awareness have been changes in health services funding to reflect more accurately the high needs of homeless people, specific attention to their needs in many NHS contracts, and greater support by the NHS for schemes designed to help them and to draw them into mainline NHS services.

There is still a long way to go before any of us can rest satisfied. Of course, the most important measures are those that reduce or prevent homelessness, for example addressing the lack of affordable housing and providing

NUMBER OF HOUSEHOLDS/PEOPLE IN TEMPORARY ACCOMMODATION IN ENGLAND 1981–1991

	Total households	Number of people	Annual increase in number of people	Percentage annual increase
1981	4,840	11,616		
1982	9,340	22,416	10,800	93%
1983	9,840	23,616	1,200	5%
1984	12,300	29,520	5,904	25%
1985	15,920	38,208	8,688	29%
1986	20,790	49,896	11,688	31%
1987	24,760	59,424	9,528	19%
1988	30,100	72,240	12,816	22%
1989	37,900	90,960	18,720	26%
1990	45,270	108,648	17,688	19%
1991	59,930	143,832	35,184	32%

Source: DoE

In 1991 more than 12 times as many households in England were in temporary accommodation as in 1981.
Between the end of 1990 and the end of 1991 statutory homelessness increased by nearly a third.

PHOTO: JON WALTER/SHELTER

Occupants of bed-and-breakfast lodgings show the hidden side of homelessness

some degree of support for youngsters who have been in the care of local authorities, and for people who have been mentally ill. As a society we are at the moment appallingly neglectful of some of our weakest and most vulnerable members.

Measures to ensure that homeless people are not denied access to health services are more obviously within the purview of the NHS. There are some good examples in London, often in conjunction with the voluntary organisations that provide most of the hostels, day centres and street workers for them.

In strengthening primary health care in London, we must never forget the needs of those who are homeless, whether they are single people or families. That they are well served (which currently they are not) should be one important criterion for assessing progress. Doing that will also make health professionals and health agencies better informed about homeless people, more sympathetic since their situation is often very moving, and better advocates for them in society at large. For most homeless people, better health care is not a top priority until or unless they become seriously ill. Nevertheless this is a group for whom health professionals and institutions can do much, and they have a duty to do everything that they can.

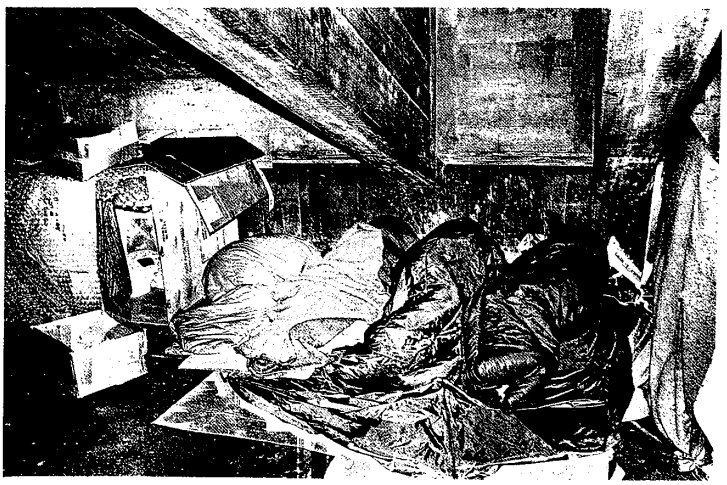


PHOTO: RACHEL MORTON/SHELTER

Some of the visibly homeless, sleeping rough on the Embankment

PURCHASING NOW: WILL CINDERELLA GO TO THE BALL?

Since the introduction of the reforms, the National Health Service Management Executive (NHSME) and the Government have devoted a great deal of effort and attention to providers, especially in assisting the new trusts to work effectively, but not enough investment has been made in the Cinderellas of the new arrangement, namely purchasers. This pattern continues and in 1993 the bids to the NHSME for funds for provider development total £36 million, with only £4 million for purchasing.

Some fundamental principles underpinned the reforms. For example, it was suggested that efficient, responsive hospitals would have an incentive to use spare capacity, because money would follow patients. But, except at the margin, very little of this principle has been seen.

Even more radical was the suggestion that power should shift away from providers in general, and acute clinicians in particular, to purchasing bodies which would act as the expert agents of the public and would champion a new approach to commissioning based on assessed need, working much more closely with GPs. The new service was to be 'needs led' rather than 'supply driven'.

But what does this require of purchasers? They are given their resources based on a population formula. Their authority comes from the law, and in practice from the Secretary of State. In this period their freedom has been substantially constrained due to the initial injunction to purchasers to maintain a 'steady state', that is, not rock the boat in the new market. Continuing ambivalence from the centre has undermined purchasers' confidence at a crucial time when they were not only looking to understand what it meant to be a purchaser in an open, rational way, but were also examining the hidden political message from the centre, namely that the trusts would be 'monitored' but the purchasers 'managed'.

Other things have followed from this statement that have hindered purchasing development. Many districts have still had reluctant Directly Managed Units (DMUs) to protect and have had little time for real purchaser development. Then it was decided that the best way to increase purchasing leverage with powerful providers was to merge authorities and, in some cases, integrate these with the FHSAs. These significant reorganisations have in many instances resulted in the loss of experienced talent and may have delayed purchasing development by up to a year.

In addition, many senior managers in trusts have had their pay doubled. No commensurate rise for purchasers has occurred. Management costs have risen sharply for trusts but many purchasing organisations still work on the 'less eligibility' principle, not even approaching the rule-of-thumb 1 per cent thought appropriate for them to function effectively.

Finally, the role of regions (or the intermediate tier) remains ambiguous. Some have helped young purchasers to develop, but others have not. The regions' role in managing the market has never been clear. This has exacerbated the difficulties that purchasers have in understanding the boundaries of their authority, and hence has limited their effectiveness.

From contracting to purchasing and on to commissioning

The College's experience in the field has led us to envisage three phases in the development of purchasing. The first is contracting, where existing historic patterns of provision are converted into contract form. The second is purchasing proper, defined as an approach to the shape and nature of health care provision for a local population that is demonstrably the result of purchaser deliberation and leadership. The third phase is what we call commissioning and it is a long way off. In this phase the concept of 'health gain' may dominate the agenda, so that resources allocated from the centre may be spent on things that lead to overall social health improvement, and not specifically what we currently understand as health care provision.

In the end, it will be the issue of governance or leadership that will be vital. If the contracting phase is still heavily led by providers, and the purchasing phase led by purchasers, the commissioning phase will need to be led by the people if the further paradigm shift is going to be accomplished. Effective purchasing is critical to an effective NHS, but it will need strong support and advocacy if it is to take its proper place 'at the ball'.

The Health and Social Care Divide: Problems and Solutions

From April 1993, the Community Care part of the 1990 NHS Act takes effect. The intentions are admirable: to seek to ensure that flexibility and imagination are used to deploy appropriate support for people in a community setting, rather than their being forced into permanent residential care.

But there are obstacles. For example:

- Preoccupation with reorganising the NHS and local authorities is distracting agencies from the point of the reforms.
- Responsibility for services is not always clear; all the agencies are short of money and will tend to avoid taking responsibility if they can.
- Despite the Citizen's Charter and the Patient's Charter, rights are few and unclear; people simply do not know what they can reasonably expect from the NHS and Social Services.
- Policy changes in the NHS are hitting social services departments hard: for example, policies for early discharge or non-admission at a time when social services are already overstretched.
- GPs tend to operate outside the community care planning process despite their crucial position at the boundary between health and social care and their potential role for bridging the divide.
- The development of alternative community services in the independent sector has hardly begun.
- Community care is more than health and social care, but other services, such as housing and transport, are almost never seriously involved.

It would be naïve ever to have assumed that the introduction of the Community Care reforms would be smooth and trouble-free. Nevertheless we must strive to make it as trouble-free as possible, otherwise many vulnerable people will suffer and those working to help them will be demoralised.

At all levels, from the general public to central government, there are some things that can be done, including the following.

- For the public at large, people need to be aware of the likely difficulties, involved in tackling them locally and alerted to positive developments and changes. Watchdog organisations like Community Health Councils and carers' organisations should be briefed to monitor what happens and to comment critically and constructively.
- At local level, it will help if local authorities, district health authorities and family health service authorities act together (for example, through strategic commissioning agencies) to avoid 'buck-passing' and yawning gaps in services. They also need to link GPs into the thinking and the action.
- Nationally, it will help if government will clarify people's entitlements and their rights to refuse and appeal against local authority assessments, issue guidance on the boundary between health and social care (who is responsible for what), create a system for arbitration when there are disputes around the boundary, define standards for the quality of care and for adequate levels of service, and build these national benchmarks into the inspectorial process.

While it will not be easy to overcome the problems, Community Care has to work.

FINANCIAL REVIEW

The following pages (25 and 26) contain abridged financial statements extracted from the full accounts of the King's Fund which are available on request.

At 31 December 1992 the valuation of the Fund's net assets was £109.7m, an increase of £4.9m over the year. This increase was attributable to a significant improvement in the stock market during the final months of the year.

The overall value of securities was £84.8m at the year end, an increase of £13.4m over 1991. Other net assets, which include bank balances, declined by £5.8m to £3.5m, because excess liquidity was invested in securities to take advantage of improved market conditions. The value of the Fund's holdings in property, including the Fund's own premises, declined by £2.7m to £21.4m reflecting the depressed UK property market.

Total income for the year amounted to £12.0m of which £5.5m was investment and other income and £6.6m was received by way of grant from other bodies or was generated as fees for services provided by the Fund. This compares with total income of £11.0m in 1991 of which £5.6m represented investment and other income. Total expenditure of the Fund was £12.4m (1991 £11.0m) including grants allocated of £1.5m (1991 £2.0m). The overall deficit of the year of £399,000 was in line with budget and was met from General Fund.

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

BANKERS:

Bank of England
Baring Brothers & Co., Ltd
Midland Bank Plc

AUDITORS:

Coopers & Lybrand

SOLICITORS:

Turner Kenneth Brown

ABRIDGED STATEMENT OF ASSETS AND LIABILITIES

AS AT 31 DECEMBER 1992

	MARKET VALUATION	
	1992	1991
	£'000	£'000
CAPITAL FUND	**36,066**	32,158
GENERAL FUND	**73,638**	72,609
SPECIAL FUNDS	**23**	20
	109,727	104,787
Represented by:		
Capital Fund		
Portfolio investments	**39,920**	31,455
Net current (liabilities)/assets	**(3,854)**	702
	36,066	32,157
General Fund		
King's Fund Premises	**8,785**	10,195
Computer equipment	**526**	589
Portfolio investments	**57,567**	53,864
(inc. property)	**6,760**	7,961
Net current assets		
	73,638	72,609
Special Funds	**23**	20
Portfolio investments		
	109,727	104,786
Net assets		

In our opinion the abridged financial statements on pages 25 and 26 are consistent with the annual accounts of the King Edward's Hospital Fund for London for the year ended 31 December 1992 and comply with the King Edward's Hospital Fund for London Act 1907.

Coopers & Lybrand
Registered Auditors
April 1993

ABRIDGED INCOME AND EXPENDITURE ACCOUNT

FOR THE YEAR ENDED 31 DECEMBER 1992

		INCOME £'000	EXPENDITURE £'000	1992 NET £'000	1991 NET £'000
INVESTMENT AND OTHER INCOME AND RECEIPTS					
Securities and cash assets		**4,668**	**146**	**4,522**	4,768
Properties		**780**	**187**	**593**	645
Donations		**11**	**-**	**11**	10
Available to service the operations of the Fund		**5,459**	**333**	**5,126**	5,423
OPERATIONS OF THE FUND					
	£'000				
King's Fund Centre		**2,322**	**3,234**	**(912)**	(919)
Contribution from DoH	***626***				
Conference fees etc	***480***				
Grants from other bodies	***1,216***				
King's Fund College		**2,545**	**3,863**	**(1,318)**	(958)
Fees and service charges	***2,545***				
King's Fund Institute		**77**	**563**	**(486)**	(452)
Fees and publications	***77***				
Special projects		**1,568**	**1,980**	**(412)**	(214)
Fees for services	***320***				
Grants from other bodies	***1,248***				
Grants allocated		**75**	**1,599**	**(1,524)**	(2,085)
Grants lapsed	***75***				
		6,587	**11,239**		
NET COST OF OPERATIONS				**(4,652)**	(4,628)
ADMINISTRATIVE COSTS					
Head Office staff			**422**	**(422)**	(384)
Head Office other			**175**	**(175)**	(184)
Professional fees			**196**	**(196)**	(163)
Maintenance of premises			**80**	**(80)**	(103)
Total administrative costs			**873**	**(873)**	(834)
Total net expenditure				**(5,525)**	(5,462)
TOTALS OF INCOME AND EXPENDITURE		**12,046**	**12,445**		
EXCESS OF EXPENDITURE OVER INCOME				**(399)**	(39)

Contributors in 1992

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

The Baring Foundation

CASPE

N H Clutton
A H Chester

V Dodson
K Drobig

S M Gray
The Gloucester Charitable Trust

J M Hargreave
Lord Hayter KCVO CBE

Jensen & Son

Roger Klein

F Lee

R J Maxwell
W Maxwell McGuire
Merchant Taylors' Hall
Morgan Grenfell Group Plc

Newry & Mourne Social Services
Peter Norton

G Pampiglione

Albert Reckitt Charitable Trust
Sir Thomas B Robson

O N Senior
Sussman Charitable Trust

V S Walmsley
The Wernher Charitable Trust

Legacies received in 1992 (£24,687.54)

L A Culliford Deceased

Oswald Lord Doverdale Deceased

Edith MacGillivray Deceased

GRANTS MADE IN 1992

MANAGEMENT COMMITTEE

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

£

ACCESS TO HEALTH 65,000
towards the cost of a pan-Thames regional homelessness initiative

COLLEGE OF HEALTH 37,500
towards the cost of an audit project manager

EDUCATIONAL BURSARIES FOR NURSES AND OTHERS 45,000
to continue the scheme for a further year

HOWARD GLENNERSTER 43,260
towards the cost of further work on general practice budget-holding

HEALTH RIGHTS 17,960
to support a project concerning the *Patient's Charter* and patients' rights

KING'S FUND INNOVATION IN MEDICAL EDUCATION 40,000
grants competition on innovation in medical education

KING'S FUND INSTITUTE 23,460
towards the cost of a proposal to take forward the idea of wider participation in organ donation programmes

KING'S FUND INSTITUTE 16,000
towards the cost of a major meeting on 'Tackling Health Inequalities in the 1990s'

KING'S FUND INSTITUTE 12,552
towards the cost of a study on health outcomes

£

KING'S FUND INTERNATIONAL SEMINAR 31,250
to support the cost of the international seminar on 'Hard Choices for Health Systems'

THE PARTNERSHIP TRUST 20,000
to support an award scheme for one year in the fields of medical and nurse education

TRAVELLING FELLOWSHIPS FOR DOCTORS 30,000
to continue the scheme for a further year

WESTMINSTER PASTORAL FOUNDATION 12,434
towards the cost of a diploma course for the deaf in advanced psycho-dynamic counselling

Small Grants

ALICE 2,701
towards the cost of recording an adaptation of *Alice in Wonderland* for health service staff about quality in hospitals

ASSOCIATION FOR IMPROVEMENTS IN MATERNITY SERVICES 1,000
towards the cost of publishing a submission to the House of Commons Select Committee on Health about users' views of maternity care

BARNARDOS AND SICKLE CELL ORGANISATIONS 1,440
towards the cost of a national sickle-cell and thalassaemia conference

THE BLACKTHORN TRUST 3,000
to equip a café to be run by people with severe mental health problems

BBC EDUCATION DEPARTMENT 1,000
towards the cost of a publication entitled *Labelled Disabled*

BRITISH HOME AND HOSPITAL FOR INCURABLES 1,000
to provide anatomical models for the education department

MUKTI JAIN CAMPION 1,000
towards the cost of a study visit to the USA to learn more about parenting and disability

£

CITIZEN ADVOCACY ALLIANCE 2,920
to support an evaluation of a citizen advocacy project

THE CONTINENCE FOUNDATION 10,000
towards the cost of a project officer to help establish the Foundation

RICHARD CORK 3,000
towards the cost of completing a publication on art in hospitals

COUNCIL FOR PEOPLE WITH LEARNING AND SENSORY DISABILITIES 2,000
towards the cost of a learning pack for staff working with people with learning difficulties and sensory impairment

THE DYSPRAXIA TRUST 3,000
to produce a documentary video on dyspraxia

ENURESIS RESOURCE AND INFORMATION CENTRE 8,000
to support the work of the Centre

ERROL FRANCIS 10,000
towards the administrative costs of a Cropwood Fellowship in race, mental disorder and the criminal justice system

INNER LONDON HEALTH AUTHORITIES 5,000
to continue the Fund's involvement with the Inner London Health Authorities Group

INSTITUTE FOR PUBLIC POLICY RESEARCH 10,000
towards the cost of a project to explore a rights-based approach to health care

BARBARA KEENE 150
towards the cost of attending the Hospital Co-operation in Europe conference in Strasbourg

KING'S FUND 4,000
towards the cost of a publication to mark the occasion of Sir George Godber's 85th birthday

KING'S FUND CENTRE 500
towards the cost of a conference on Black older people

KING'S FUND COLLEGE 1,500
towards the cost of a learning set for Prison Governors and Health Service Managers

£

KING'S FUND INSTITUTE 2,130
to analyse the equity implications of the NHS reforms

KING'S FUND/ NATIONAL AIDS TRUST 7,500
towards the cost of a meeting on the health education aspects of AIDS/HIV

KING'S FUND ORGANISATIONAL AUDIT PROGRAMME 1,000
to subsidise a consumer checklist publication for CHCs

MATERNITY ALLIANCE 2,000
towards the cost of a national conference on parenting and disability

EDNA MATHEISON 1,000
towards the cost of completing work on a new MA course in disability studies

NATIONAL EXTENSION COLLEGE 5,000
towards the cost of producing literature about family-based respite care

NATIONAL INSTITUTE FOR SOCIAL WORK 10,000
towards the cost of a training manual to promote race equality and valued social roles for people with learning difficulties

NORTH BEDFORDSHIRE HEALTH AUTHORITY 3,000
towards the cost of an Asian Women's Work Out Programme

JOHN WYN OWEN 1,500
towards the cost of a WHO seminar for European public health administrators

PAINTINGS IN HOSPITALS 500
towards the cost of updating the Paintings in Hospitals catalogue

PRIMARY HEALTH CARE GROUP 300
towards the cost of inter-agency meetings to further primary health care development

MARGARET ROGERS 350
towards the cost of attending an international paediatric nursing conference in Sydney

ROYAL COLLEGE OF GENERAL PRACTITIONERS 5,000
towards the cost of an audit of primary care in areas of inner-city deprivation

£

ROYAL COLLEGE OF NURSING 3,000
towards the cost of undertaking a project on nurse mobility in Europe

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS 10,000
towards the cost of a research project on recruitment and retention

DR DANNY RUTA 709
to present papers at a conference in the USA on outcomes management systems

WOMEN'S DESIGN SERVICE 2,250
towards the cost of a research project concerning the design of hospital ante-natal clinics

£520,866

GRANTS COMMITTEE

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

MAJOR GRANT FOR 1992:

BLACK FOUNDATION £100,000
to assess the feasibility of establishing a Black Foundation

	£
ACCESS FOR BLACK PEOPLE to improve access and reception for Black people within the health service	300,000
Planning grants were made to:	
Improving Access to Primary Care for Black People, London	5,500
Improving Access for Black People, South Glamorgan	5,500
Improving Access for People from Ethnic Minority Backgrounds, Leicester	5,500
Timeout, Nottingham	5,500
Assessment Centre for Black People Experiencing Mental Ill Health, Birmingham	5,500
Improving Access to Preventive Health Care for Bengali Speaking Population, London	5,500
Opportunities to Provide Ethnically Needed Education on Diabetes, London	5,500
Serving the Chinese Community, London	5,500
Traumatic Stress Clinic for Refugees, London	5,500
Rochdale Working in Partnership	5,500
	£55,000
Completion grants were made to:	
Improving Access to Primary Care for Black People, London	80,000
Improving Access for Black People, South Glamorgan	80,000
Improving Access for People from Ethnic Minority Backgrounds, Leicester	40,000
Timeout, Nottingham	40,000
	£240,000
Miscellaneous support costs	£5,000
	£400,000

THE BRANDON CENTRE 13,000
to provide advisory support and group counselling for young mothers

BROOK ADVISORY CENTRE 20,000
to help set up a Brook clinic for homeless men at a Centrepoint hostel

CHISWICK FAMILY RESCUE 60,000
towards the cost of a co-ordinator of a children's programme at a centre for victims of domestic violence

COMMUNITY AID ASIAN PROJECT 15,000
towards a home support and outreach service to prevent mental health breakdown

CORE TRUST 18,000
towards the cost of a therapy co-ordinator

DRINK CRISIS CENTRE 15,589
to support an evaluation and quality assurance programme

ELDERLY MAJOR GRANT EVALUATION 20,000
for an external evaluation of the seven projects funded as part of the 1991 Major Grant programme on services for elderly people

£

HARINGEY SOCIAL SERVICES, ON CALL SUPPORT PROJECT 15,000
interim funding for one of the 1990 Major Grant projects on community care

HARINGEY WOMEN AND HEALTH RESOURCE CENTRE 24,910
to set up a counselling and support service for young African-Caribbean women with alcohol problems

HEALTHY EASTENDERS PROJECT 15,000
towards the cost of a randomised trial to assess the value of using link workers in a primary health care team

LONDON BOROUGH OF SUTTON 20,000
towards the cost of a project worker and assistant to improve GP response to the needs of carers

MYATTS COMMUNITY PROJECT 25,488
to train volunteers in counselling skills at a housing estate resource centre

NORTH MIDDLESEX HOSPITAL 22,500
to fund a registered sick children's nurse in the A and E department

REFUGEE SUPPORT CENTRE 20,000
to support a full-time counsellor

SCHOOL FOR ADVANCED URBAN STUDIES 16,900
to evaluate one of the community care Major Grant projects funded by the Committee in 1990

SOMALI LONDON COMMUNITY AND CULTURAL ASSOCIATION 24,000
towards the cost of two full-time health advocacy workers

Small Grants

ACCESS TO HEALTH, TRACEY STEIN 500
towards the cost of attending a conference on community care in the USA

£

BLACK FOUNDATION 5,000
to support the costs of a consultation meeting

BRENT MIND 1,500
to expand Brent MIND's information service for users

CARIB THEATRE PRODUCTIONS 2,500
towards the cost of a tour of London secondary schools to raise awareness about HIV/AIDS

CHARITIES EVALUATION SERVICE 700
towards the cost of a conference on evaluation

CITY & HACKNEY MIND 6,000
towards expenses for volunteer advocates

CITY UNIVERSITY, DR D PILLING 2,500
towards the cost of a two-day conference on programme analysis of service systems

EALING LEAP CENTRE 1,000
towards the cost of equipping an academic and life skills department in a centre for autistic people

FRIENDS OF SPRINGHALLOW 2,000
towards the cost of a new play area

GLACHC 5,000
towards running costs

GREENWICH ASSOCIATION OF DISABLED PEOPLE'S CENTRE 2,500
towards the cost of a conference on independent living

GREENWICH MIND 1,000
to support a community-based mental health counselling project

HAMPTON AND HAMPTON HILL COMMUNITY CARE GROUP 2,000
towards pump-priming costs

HEADWAY SE LONDON 550
towards the cost of an electronic piano for people who have suffered head injuries

INNISFREE HOUSING 1,500
towards the cost of an Irish mental health conference

ISLINGTON MIND 2,000
towards the cost of running a Black friends and relatives group

	£
KING'S COLLEGE LONDON, DEPARTMENT OF NURSING	2,000
towards the cost of a project on the ethical issues of breast cancer screening	
LIVING SPACE	3,000
towards the cost of kitchen fittings for a home for people with mental health problems and serious challenging behaviour	
LONDON CHINESE HEALTH RESOURCE	10,000
to establish an information database on resources available to carers of disabled Chinese people	
MEDICAL CAMPAIGN PROJECT	1,300
towards the cost of producing a guide to the health service for those working with homeless people	
MIND IN CAMDEN	4,944
towards the cost of office equipment for new premises	
MIND IN KINGSTON	500
to produce a local magazine for mental health users	
NEWHAM ALCOHOL ADVISORY SERVICE	5,000
to develop an information and advice service on alcohol problems in Black and ethnic minority groups	
OFF-CENTRE	10,000
towards the cost of a counsellor at a centre for young people who have been sexually abused and who self-harm	
ORMOND ROAD WORKSHOPS	2,000
towards the cost of integrating workshops for people with learning difficulties and people with mental health problems	
PARTIALLY SIGHTED SOCIETY	5,000
towards the rent costs of a London Sight Centre	
POSITIVE THEATRE	500
towards the cost of an autumn tour to raise awareness about HIV/AIDS	
RED ADMIRAL PROJECT	2,000
towards the cost of a women's counsellor	
MARILYNN ROSENTHAL	5,000
to complete a publication, *Coping with Incompetent Doctors*	
RUGBY HOUSE PROJECT	6,000
towards the cost of an evaluation of a mobile alcohol service	
ST FRANCIS HOSPICE	5,000
towards the cost of furnishing and equipping a day centre	
ST MUNGO HOUSING	5,000
towards the cost of minor surgical and medical treatment for homeless people at a residential care home	
ST THOMAS' HOSPITAL, EMPLOYMENT DEVELOPMENT TEAM	1,000
towards the cost of a disability etiquette guide for hospitals	
THE SANCTUARY	1,000
towards the costs of counselling and support service for women who have been victims of rape or sexual assault	
SELBY HOUSES	1,000
towards the cost of staff training at this independent housing project for people with learning disabilities	
SIDINGS COMMUNITY ASSOCIATION	2,981
towards the cost of a women's health project	
STRUTTON HOUSING ASSOCIATION	4,889
towards the cost of furnishings at a home for people with HIV/AIDS	
TEAM ASSESSMENT PSYCHIATRIC SERVICE	2,000
towards the cost of publishing research findings	
UNIVERSITY OF KENT, CENTRE FOR THE APPLIED PSYCHOLOGY OF SOCIAL CARE	6,620
towards the costs of completing a project on quality in residential services for people with severe mental health problems	
WALTHAM FOREST BLACK PEOPLE'S MENTAL HEALTH	2,000
towards the cost of carpeting for new premises	
WEST LAMBETH ARTS LINK	10,000
toward the cost of an arts link project	
	£880,371

London Primary Care Committee

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

£

Family planning services – Parkside Health Authority 42,500
to develop the joint purchasing of family planning services with the aim of offering a comprehensive basic service provided by GPs and a complementary, specialised service provided by the authority; part of the task of the development worker is to record and analyse the process of joint commissioning as well as the development of services

Audit and Service Development 2,500
a further grant to cover the costs of publication and dissemination of information on this project

Shifting services from hospitals to primary care 5,000
to take forward the work started in 'Optimal Balance' to search for and describe examples of the ways in which local acute specialties are already moving from hospital to community-based services

£50,000

King's Fund Centre Committee

£

Better Futures Project 60,000
the second part of a two-year initiative to improve opportunities and services for people with serious or long-term mental health problems and their families: 1992 allocations made to the localities of Clwyd (to be used in a number of small initiatives), Swindon and Tower Hamlets

Manchester Afro-Caribbean Mental Health Project 10,000
a contribution to the funding required for the third year (final allocation)

£

Mental health 'sanctuaries' 40,000
to support a development worker in the West Lambeth district over a two-year period to develop an alternative to hospital for Black people: this will take the form of a community-based place of safety managed by Black people in collaboration with statutory authorities and a range of therapies and support will be available

Survivors Speak Out 5,539
to develop the capacity of Survivors Speak Out to act as an effective resource for service users and service user groups involved in mental health advocacy and self-advocacy (shortfall from 1991 grant)

Small Grants

London Interpreting Project	1,000
Contribution to attend international meeting in Canada for physically disabled	1,000
Contribution towards expenses for attending TASH conference in Washington DC for *Double Discrimination* project	400
Presentation of *Double Discrimination* report	400
Community Arts Project	300
Donation towards training Cantonese-speaking volunteer home helps for the elderly	600
Home Help for the Elderly	600
Bereavement – Voluntary Visitors (Hackney)	950
Haringey Health Service – Weaning in a Multi-Cultural Society	200
Southwark Mental Health Forum	250
National Assn for Limbless Disabled	250
Wandsworth Carers Forum	300
Living Options Final Event 13.5.92	566
Employers Forum on Disability	590
Pam Clifford: Gloucester Carers Forum	200
Coventry 'One Voice One Future'	300
Medway Towns and District Spastics Society	200
Association of Black Psychologists	400
The Terrace Centre	285
The Sanctuary	1,000
Brixton Community Sanctuary	1,000
BCOPD publication	1,000
Islamic Community Education Project	500

	£
MIND: Employment and Mental Health – one-day seminar	750
Leicester Asian Elderly Health Forum	250
King George VI and Queen Elizabeth Foundation of St Catharine's	1,000
Victims' Help Line – a workshop in deaf awareness and sign language training	300
Relatives Association pamphlet about relatives working in partnership with homes caring for elderly residents	870
	£130,000
TOTAL GRANTS MADE IN 1992	£1,524,000

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King Edward's Hospital Fund for London

2 Palace Court
London W2 4HS
Telephone: 071-727 0581
Fax: 071-727 7603

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10 Palace Court
London W2 4HT
Telephone: 071-221 7141
Fax: 071-221 1266

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Commission on London

2 Palace Court
London W2 4HT
Telephone: 071-727 0581
Fax: 071-792 3787

Director
Virginia Beardshaw MA DSA

King's Fund Centre

126 Albert Street
London NW1 7NF
Telephone 071-267 6111
Fax 071-267 6108

Director
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Community Care Group
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KING'S FUND COLLEGE

2 Palace Court
London W2 4HS
Telephone: 071 727 0581
Fax: 071-272 7603

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KING'S FUND INSTITUTE

126 Albert Street
London NW1 7NF
Telephone: 071-485 9589
Fax: 071-482 3584

From June 1993:
14 Palace Court
London W2 4HT

Director

Ken Judge MA(Cantab)

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