LONDON Monitor

Number 1

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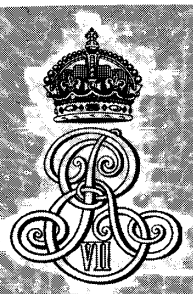
Focusing on London's health services



KING'S FUND

14 Palace Court
London W2 4HT

Telephone 071-243 8848

ISBN 0 9518892 8 1

Editor
Seán Boyle

Price £4.95

Cover photograph
Melanie Friend/Format

Design and print
Intertype

LONDON Monitor

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2 Acknowledgements

I would like to acknowledge the support of a number of people who have made the London Monitor possible.

My thanks are due to Robert Maxwell and Ken Judge who conceived the idea of a monitor of health and health care in London and encouraged my efforts to make the idea a reality. I would also like to thank colleagues and members of the King's Fund Institute's Advisory Committee, who have helped and commented in various ways. I owe a special debt to Anthony Harrison who has been down this stony path many times himself.

I would like to thank the King's Fund library staff who have provided material for the calendar of events in London. I would also like to thank colleagues in the Department of Health for providing data, and Roselyn Wilkinson who has brought her censal talents to bear on my behalf. My thanks are due to Joy Cordwell and Bernadette Alves for providing me with technical assistance, and finally Martyn Partridge has kept my design notions on the straight and narrow.

Seán Boyle
Editor

FOREWORD

This is an exceptionally difficult, uncomfortable and controversial time for London's health care services. The need for change has been the persistent theme of a series of reports about London over the last 100 years. Suddenly change is beginning to happen and it looks like being dramatic. Already, at the tail-end of 1993, the Secretary of State has signalled a transformation in the role of St Bartholomew's hospital by announcing the closure of its A&E Department from October 1994. If Bart's, London's oldest hospital and one of its best-loved, is not sacrosanct, what institution is safe?

From its inception in 1897, the role of the King Edward's Hospital Fund for London (the King's Fund) has been to support the provision of health services by the capital's hospitals. It is apt therefore that at such a momentous point in the history of these hospitals, the King's Fund Institute should choose to publish the first issue of what is intended to be a regular feature, the *London Monitor*, focusing on information and debate about health and health care in the capital. I congratulate Seán Boyle, its editor, on it.

In 1990, the King's Fund established its Commission on the Future of Acute Services in London. A large programme of work culminated in the publication, in July 1992, of the Fund's vision for health services in London in the 21st Century – *London Health Care 2010: Changing the future of services in the capital*. Inevitably it did not please everyone, but it highlighted what was about to become a major crisis for London's hospitals because of changes in their funding, and it set the framework for a high level of public debate. However, this is a beginning rather than an end.

The King's Fund has a continuing role to maintain a watchful eye on the progress of developments in London's health services. This publication represents part of that process.

There is considerable controversy surrounding the changes which are taking place in London. Nobody has all the answers. To promote public understanding and debate around these issues requires an openness and candour, both in the discussion of policy issues and in the evidential basis underlying analysis and decisions.

I believe that the *London Monitor* can contribute to the debate by providing three things:

- information about health and health care on a London-wide basis;
- informed and detailed commentary on developments in London's health services;
- a forum for discussion of issues relating to the management of London's health services and, more generally, health and health care in London.

It is important that a full and informed debate occurs whenever far-reaching changes are envisaged, whether it be the transformation or merger of a large teaching hospital or the development of an alternative way of providing primary and community services.

Similarly, and of equal importance, there is the need to have available a source of continuing statistics for the purpose of analysing, monitoring and evaluating what actually happens, including the impact of the changes. There has been a disturbing and dangerous trend in recent years for the availability of relevant data to decline to the point where informed and independent comment becomes almost impossible.

In the case of London, where no individual agency holds overall responsibility, information is at even more of a premium. The King's Fund Commission was able to draw on briefing papers from a variety of sources on which to base its findings. Just two years on that information badly needs updating and maintaining into the future.

It is the intention of the King's Fund, through the *London Monitor*, to continue to provide such evidence as is available on London's health and health care. We will try to do that accurately and objectively, so that fruitless arguments around the misrepresentation of facts and figures can be avoided. While the topics to be covered are too important to be uncontroversial, we will try to ensure that a variety of views are included and that our own views are based on responsible discussion of the available data.

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

CALENDAR

The last 15 months have been probably the most turbulent period in the history of health care services in London. We present here a calendar of important events during this period and a brief commentary on each one.

4

October 1992

1 **The London Ambulance Service** is increasingly subject to criticism for failure to meet Patient's Charter performance standards.

5 **As a result of retrenchment** by Camden local authority, Royal Free Hospital School in Hampstead faces a £200,000 cut in its spending on education for children recovering from physical or psychological illness.

6 **St George's hospital,** Tooting, outlines need for £2 million efficiency savings in 1993/94 as income is expected to fall by between £3.5 million and £5.8 million – up to five per cent of the hospital's budget of £140 million.

7 **The chief executive** of St Bartholomew's hospital, Ken Grant, resigns. The Bart's group of hospitals, which have forecast a deficit of £12.2 million this year, come under threat of closure.

8 **London teaching hospitals** are criticised for using funds to promote their case for survival rather than on patient care. St Thomas's hospital in particular is singled out for criticism.

13 **The Royal College of Nursing** publishes a report, *London Needs All its Nurses*, which highlights the need to develop community-based facilities in London before hospital closures take place.

15 **The Labour party** issues a policy statement giving backing to the closure of hospitals in London conditional on adequate investment in community and primary services.

20 **Professor Michael Besser** becomes chief executive of St Bartholomew's hospital with a pledge to defend it against closure.

21 **The Guy's and Lewisham trust** announces a trading surplus, for the year 1991/92, of £2.7 million on a total income of £180 million. Just £87,000 will be carried forward after payment of dividends and other adjustments. The trust failed to meet the statutory deadline for publication of these annual accounts.

23 **The report of the Inquiry into London's Health Service,** Medical Education and Research is published. The inquiry was carried out on behalf of the Government by a team chaired by Sir Bernard Tomlinson. The Tomlinson report recommends the closure of several London teaching hospitals, the merger of medical schools and postgraduate institutes into four faculties of medicine, and investment in the development of primary and community services.

23 **The Secretary of State,** Virginia Bottomley, announces the publication of the Tomlinson report in the Commons, and accepts the broad thrust of its recommendations, amidst widespread cross-party condemnation from London MPs.

23 **Sir Tim Chessells,** chair of North East Thames RHA, is appointed to chair the group responsible for implementing the Tomlinson recommendations.

25 **The health service union, NUPE,** warns of the possibility of a catastrophic breakdown in the new computer system which controls the London Ambulance Service (LAS). It is claimed that this may be a contributory factor in deaths due to delays. The Secretary of State orders an urgent report on the situation from the chairman of the LAS board, Jim Harris.

27 **The LAS's new computer-aided dispatch system** is shut down temporarily after reports of chaos the previous day, the first fully operational day for the system, which has been introduced gradually since January 1992. Extreme delays in ambulance attendance are reported.

27 **Unions and pressure groups** launch a campaign to resist the closure of London hospitals.

27 **The Royal Brompton hospital** announces that it is employing management consultants to help prepare a case against the Tomlinson proposals.

28 **The chief executive of the LAS, John Wilby,** resigns following claims that several patients have died after delays in meeting emergency calls. The LAS announces an independent inquiry into the £1.5 million computer-aided system which was supposed to allocate emergency calls more efficiently. The results of the inquiry will be made public as soon as possible.

29 **The deputy chief executive of South West Thames RHA, Martin Gorham,** takes over as acting chief executive of the LAS, and promises a speedy review of the computer-aided dispatch system. The LAS has returned to manual call-logging alongside the computerised system.

November 1992

4 **The Health Minister, Dr Brian Mawhinney,** says decisions on the closure or restructuring of London's hospitals will be taken quickly so as to end the uncertainty over threatened hospitals.

5 **Sir William Staveley,** chair of the Royal London trust, is appointed chair of North East Thames RHA.

6 **The Secretary of State appoints Don Page,** chief executive of the South Yorkshire ambulance service, to lead an inquiry into management, computer operations and industrial relations at the LAS following a further breakdown in the computer-aided dispatch system. The inquiry will last three months and its report will be made public.

9 **A report** commissioned jointly by the Royal College of Nursing and the Institute of Health Service Management questions the ability of the Government to fund the program of hospital closures in London.

11 **A National Audit Office** memorandum to the Public Accounts Committee criticises the planning, construction and monitoring of the new Chelsea and Westminster hospital. It reveals that the hospital overran its original 1987 budget estimate by over £130 million, and impacted on North West Thames RHA's capital programme, resulting in the cancellation or postponement of other projects in London, Hertfordshire and Bedfordshire. The chief executive of the NHS Management Executive, Duncan Nichol, defends the project before the Public Accounts Committee.

25 **A ward scheduled for closure at UCH** because of lack of funds is occupied by staff in protest.

26 **Revenue Support Grant** settlement for 1993/94 implies cuts in London local authority budgets.

December 1992

1 **Several hospitals** are forced to reduce activity in order to remain within budget for the year. Forest Healthcare Trust closes two wards at Whipps Cross hospital to prevent a projected £2.4 million overspend on its £115 million budget.

7 **A study commissioned by the Royal Marsden and Royal Brompton hospitals** suggests that the analysis in the Tomlinson report is financially flawed, and that the costs of closing these hospitals have been underestimated.

7 **Speaking at a conference of health service managers,** Sir Bernard Tomlinson says that the Government should not sanction hospital closures until a comprehensive financial analysis is carried out.

8 **The Secretary of State** announces regional financial allocations for 1993/94, which give an increase to the Thames regions of 0.4 per cent above inflation, half the average given to other areas. However, substantial funds have been set aside to improve health services in London.

16 **Sir Bernard Tomlinson** defends his report before the Select Committee on Health, but argues that primary and community services in London will need a cash injection of at least £140 million before changes can be implemented.

30 **A report from the Association of London Authorities** demands that no hospital closures occur in London until there are improvements in primary and community services as part of a planned programme of change.

30 **In an end of year message** to all NHS staff in the capital, the Secretary of State emphasises that the status quo is not an option for London and underlines the Government's determination to press on with controversial changes in health care provision in the capital.

31 **Controversy** over proper community care for those with mental health problems as an ex-patient is savaged by a lion in London Zoo.

January 1993

4 **North West Thames RHA** asks the Queen to grant the new 665-bed Chelsea and Westminster hospital a royal charter, renaming it the Royal Chelsea hospital. Meanwhile a report from the Public Accounts Committee criticising the overspend on the construction of the hospital is due.

7 **The regional general manager of Oxford RHA, Bob Nicholls,** is appointed head of the team overseeing the implementation of the Tomlinson report. Mersey regional medical officer, Peter Simpson, is also seconded to the group. The process of implementation may take as long as five years.

8 **London Emergency Bed Service** issues a 'yellow' alert because of a shortage of beds for emergency admissions in the capital. The warning applies to large parts of north and east London, and hospitals affected are asked to reduce substantially admissions from waiting lists, ensure greater flexibility between specialties, and discharge as many patients as clinically possible.

14 **In the wake of the New Year's Eve incident at London Zoo,** the Secretary of State announces an urgent review of the powers necessary to ensure that those with mental health problems receive adequate care in the community.

14 **Dr Andrew Vallance-Owen,** secretary to the BMA working party on the Tomlinson report, criticises premature talk of hospital closures until sufficient research into patient needs has been carried out.

18 **Speculation** emerges over a possible backdown on plans to close St Bartholomew's hospital, although Government sources refuse to rule out any options.

21 **A report, commissioned by London University,** estimates that the capital costs of restructuring medical education and research, under the Tomlinson report proposals, would far outweigh the revenue available from sales of surplus property. This is the latest of several reports to question the financial aspects of the proposals.

21 **The Emergency Bed Service** 'yellow' alert is withdrawn in North East Thames RHA districts.

21 **The Duke of Gloucester** opens a new £15 million operating theatre suite at St Bartholomew's hospital. This coincides with the Health Minister meeting the hospital's managers to discuss their response to the Tomlinson report's proposed closure of the hospital.

25 **The Chelsea and Westminster hospital** opens its doors to outpatients amidst controversy that it is not now needed. It is scheduled to be fully operational by April.

27 **North East Thames RHA** recommends that St Bartholomew's should not be allowed to become a trust hospital on April 1.

February 1993

2 **Separate reports from the Labour and Liberal Democrat parties** call for extra resources for London health care, and reject the view that London has too many hospital beds. Labour says that up to £1 billion is needed to implement the Tomlinson proposals, and both parties call for substantial investment in primary and community services.

3 **A report from the Directory for Social Change,** an educational research charity, claims that the Government may run into legal challenges from charitable trusts if it tries to close hospitals which have been built partly from public donations. It is estimated that at least £120 million has been allocated to London's teaching hospitals in this way.

16 **The Secretary of State for Health, Virginia Bottomley,** publishes *Making London Better*, her response to the Tomlinson report. In this she accepts the need to reduce the bed stock in London over the next five years by at least 2500 beds. A number of reviews of acute services are set in motion involving a combination of closure and merger, at Bart's and the Royal London, UCH and Middlesex, and Guy's and St Thomas's. Bart's is refused self-governing trust status. A review of six specialist services is announced. An extra £170 million capital is made available for primary services over six years, and £43.5 million extra revenue and capital in 1993/94. These extra funds are to be applied within the newly defined London Initiative Zone which incorporates inner city areas in particular need of primary care development.

17 **The chief executive of St Bartholomew's hospital, Professor Michael Besser,** announces that the hospital will seek a merger with the Royal London hospital as the only reasonable alternative left open by the Secretary of State's recent proposals in response to the Tomlinson report.

18 **The Minister for Health, Dr Brian Mawhinney,** announces details of six specialty reviews to be carried out as part of the Government's response to the Tomlinson report. The reviews, to be coordinated by the London Implementation Group, will be led by a distinguished clinician and the manager of a London purchasing authority, and are expected to report by the end of May 1993.

24 **The London Implementation Group (LIG)** is formally launched to take forward the implementation of the Secretary of State's response to the Tomlinson report. LIG will be part of the NHS Management Executive, with Bob Nicholls, formerly regional general manager at Oxford RHA, as executive director, and Dr Peter Simpson, formerly regional medical officer at Mersey RHA, and Ainna Fawcett-Henesy, director of nursing at South East Thames RHA, joining the LIG executive.

25 **The London Ambulance Service** inquiry reports flaws in management which led to the collapse of the LAS's computer system in October and November 1992. Jim Harris, chair of the LAS board, resigns.

March 1993

1 **Tim Matthews,** currently chief executive of St Thomas's hospital is appointed as chief executive designate of the new Guy's and St Thomas's trust, which will be created on April 1, with Lord Barney Hayhoe, former Conservative Health Minister, as Chair.

4 **The Minister for Health, Dr Brian Mawhinney,** announces the membership of the Primary Health Care Forum, which will act as an advisory body to LIG on the implementation of primary care developments in London. Chaired by Sir Tim Chessells, the chair of LIG, its 14 members come from a wide range of health service backgrounds.

5 **The Public Accounts Committee** publishes a report criticising the Department of Health over the £100 million overspend on the Chelsea and Westminster hospital, and calls on the NHS to seek compensation for some of the cost by taking legal action against those responsible.

5 **Professor Michael Peckham,** head of R&D at the NHS Management Executive, is appointed to carry out a review of the Special Health Authorities (SHAs) in London. The report, due in the Autumn, is intended to guide SHAs towards trust status in 1994.

16 **The Secretary of State** approves the establishment of three new London trusts from April 1 – Guy's and St Thomas's, the Lewisham and King's Healthcare.

23 **Consultation** begins on the closure of Charing Cross hospital's A&E unit.

31 **The Secretary of State,** in response to the Page report, abolishes the London Ambulance Service board and devolves management responsibility for the ambulance service to South West Thames RHA.

April 1993

1 **Consultation** begins on the closure of St Bartholomew's hospital's A&E unit. City business leaders are furious at the proposals contained in an 11-page consultation document.

8 **Sir Tim Chessells,** Chair of LIG, announces new capital projects which are likely to go ahead in London under Government plans to improve primary health care.

28 **The deputy chair of the GP's negotiating committee of the BMA, John Chisholm,** claims that there is no 'new' money for primary care development in London; the programme of improvement in London's primary and community services will be paid for from existing budgets, and not from additional funds.

May 1993

5 **The Department of Health** sets up a clearing house for NHS staff made redundant as the health reforms begin to impact on London's health services. NHS authorities in the London Implementation Zone must notify the clearing house of all suitable vacancies; authorities outside this area are expected to notify of all relevant vacancies which they will be advertising nationally.

18 **Sir Derek Boorman,** currently chair of King's Healthcare trust, is appointed chairman-designate of the new Bart's, Royal London and London Chest shadow trust, and will oversee the proposed merger of these hospitals.

26 **The Secretary of State** dismisses a spate of media speculation, centred around the future of the Harefield hospital, anticipating the recommendations of the six reviews of London's specialty services. The reviews are expected to report in June.

26 **In a speech to the CBI,** the Secretary of State welcomes the opportunity for the private sector to bring new thinking to the delivery of primary care, amidst unconfirmed reports that the Department of Health has approached private health companies with a view to their managing new primary health care teams in London.

26 **St Bartholomew's hospital** announces its aim to shed hundreds of staff in a restructure designed to save £3 million.

June 1993

3 **A BMA survey of London GPs** reveals that less than 30 per cent believe that the Government's plans for London will improve health care.

4 **North East Thames RHA** delays making a decision on plans to merge the management of the Queen Elizabeth Hospital for Children and the Homerton hospital, so that LIG can consider the coordination of proposals across the Thames regions.

10 **South West Thames RHA** is severely criticised by the district auditor over the process of privatising its estates department in 1990.

14 **The local government ombudsman, David Yardley,** rules that Tower Hamlets local authority was guilty of maladministration in failing both to support a mentally-ill man on his discharge from hospital, and to assess his needs. The authority is ordered to pay £550 compensation and assess his care needs in what is the first recorded incident of such a ruling under the Community Care Act.

15 **BUPA** confirms that it is negotiating to build, equip, staff and run health centres for the NHS, as part of the process of improving primary care services in the capital.

16 **Dr Brian Mawhinney,** the Minister of Health, reasserts the Government's commitment to improving primary care in London and rejects claims that new money has not been made available for this purpose.

17 **Gerry Green,** currently South East Thames regional general manager, is appointed as project manager to lead work on the creation of a merged trust combining St Bartholomew's, the Royal London and London Chest hospitals.

17 **The High Court** rules that Riverside health authority and North West Thames RHA acted illegally in failing to carry out proper consultations before allowing the bone marrow transplant unit at the Westminster Children's hospital to close.

18 **Controversy** dogs the specialty reviews as the pressure group, London Health Emergency, leaks a report from LIG on the consequences of the proposed rationalisation of London's specialist services.

23 **The reports of the six independent reviews** into cancer services, cardiac services, neurosciences, plastic surgery, renal services and children's services are published. Their proposals, to concentrate tertiary services for London and the south-east on fewer sites, add fuel to the debate over hospital closures in London.

July 1993

1 **Ruth Carnall,** currently director of performance management, is appointed regional general manager of SE Thames, following the departure of Gerry Green.

6 **North East Thames RHA** recommends to the Secretary of State that the A&E department at St Bartholomew's hospital should close, thereby clearly signalling an intent to move most patient services from this site.

8 **East London and City health authority** draws up proposals for a primary care development agency in east London. Hilary Scott, currently chief executive of Enfield and Haringey FHSA, will be the project director.

12 **The research review of the Special Health Authorities,** led by Sir Michael Thompson, vice-Chancellor of Birmingham University, is published. It concludes that the research of several hospitals which attract special funding is of variable quality, and certainly not of an international standing. The review provides additional evidence to the Secretary of State on which to base broader decisions about the future of London hospitals.

15 **Provisional figures** show that the London Ambulance Service overspent by £2.2 million in 1992/93. LIG has stepped in with some transitional funding following further losses of patient transport contracts.

19 **Charles Marshall,** chief executive of University College London hospitals, which incorporates UCH and the Middlesex, says that the A&E department would have to close, and the hospitals' whole future would be jeopardised by Camden & Islington health authority's plan to stop referring patients there next year.

22 **South East Thames RHA** discusses the devolvement of its £11 million emergency ambulance budget to London purchasers thus increasing speculation about the impact of open competition on London's emergency ambulance services.

22 **Managers at St Mary's hospital, Paddington,** propose to amalgamate St Mary's and the Chelsea & Westminster hospitals into a single trust in order to strengthen their market position in inner London.

26 **Figures released by pressure group, London Health Emergency,** show that over 150,000 people are on waiting lists in London hospitals, an increase of 11 per cent in nine months.

27 **The London Ambulance Service** is restructured with management devolved to four divisional directors responsible for north east, north west, south and central London.

27 **Report from the Select Committee on the Parliamentary Commissioner for Administration** (the Ombudsman) reveals that complaints procedures are not working, with a large volume of unanswered complaints against the London Ambulance Service.

28 **University College hospital** managers call on Camden & Islington health authority to withdraw their plan to move contracts for routine services to other hospitals, as this would make the position of the UCL group financially unviable.

August 1993

5 **North East Thames RHA** goes out to consultation on a proposal to shift care from hospitals to the community by setting up the East London Primary Care Development Agency with the aim, over an 18-month period, of reorganising GP and community services. Covering a large part of east London, it is suggested that the agency takes responsibility for all existing community services. Hilary Scott is appointed chief executive designate of the agency.

5 **John Dennis,** the chief executive of Richmond, Twickenham and Roehampton trust, announces plans to develop a rapid-diagnosis centre on the Queen Mary's hospital site at Roehampton as well as six polyclinics.

10 **The Secretary of State** indicates, in a letter to a local MP, that the Harefield hospital will not close or move to Northwick Park hospital, as was recommended by the Cardiac specialty review.

16 **There is renewed criticism** of the London Ambulance Service as figures show that in the first three months of 1993 only 64 per cent of ambulances reached emergency calls within 14 minutes. The Government's target is 95 per cent.

17 **SELHA's acute services strategy** involving the closure of either St Thomas's or Guy's, and the reduction of the role of King's and the Lewisham to providers of local acute care is criticised by local acute providers and CHCs.

17 **Nurses at University College hospital** strike over a perceived threat to close the hospital arising from Camden & Islington health authority's decision to end patient care contracts with UCH and the Middlesex next year.

19 **King's College hospital** warns staff that it must shed 200 jobs due to a projected fall of £2 million in income next year. It may be necessary to lay staff off if there are not sufficient voluntary redundancies. Chief executive, Derek Smith, also expresses concern at the recently published strategy of its main purchaser, SELHA, which faces a reduction of £8 million in its budget next year.

23 **The dispute intensifies at UCH** as the health authority plans to use private ambulances to move patients out of a ward earmarked for closure.

23 **Proposals from Kent purchasers** for locally-based plastic surgery and cardiothoracic centres conflict with the recommendations of the London specialty reviews. These proposals will be discussed at a meeting with South East Thames RHA in September.

23 **A review of purchasers' plans** in South West London suggests that Queen Mary's hospital, Roehampton may be vulnerable to market pressures.

25 **The Secretary of State** announces the fourth wave of trust applications, to take effect in April 1994, bringing the total to 95 per cent of the NHS. These include all eight SHAs and several reconfigurations of existing London trusts, including the combination of Bart's, the Royal London and the London Chest hospitals, and the UCL hospitals.

26 **The Wellhouse trust** discusses merger on its Barnet site with the Royal National Orthopaedic hospital, Stanmore, as a way of dealing with their mutual financial problems. Martin Havelock, currently director of human resources, is appointed chief executive of the Wellhouse.

26 **University College hospital, the Middlesex and St Bartholomew's** are told to postpone all non-urgent operations on Camden & Islington residents until April 1994 as the purchasing authority's budget is being spent too quickly.

27 **Redbridge & Waltham Forest** health authority asks the Royal National Orthopaedic, the Royal National Throat, Nose and Ear, the Royal London and the Havering hospitals to cut back on non-urgent operations for two months in order to avoid overspending on budgets.

27 **UCH announces plans** to shed up to 30 consultant posts and 40 non-medical staff in order to cut costs.

September 1993

1 **The Wellhouse trust** proposes to transfer in-patient services from Barnet to Edgware hospital, and reduce the 24-hour A&E department at Barnet to a 12-hour minor injuries unit. Estimated savings are £2.1 million but there is local reaction against the proposal.

1 **Sir Bernard Tomlinson** warns, in a talk to the British Association for the Advance of Science, that the effects of the market on London's hospitals has to be modified by management intervention if chaos is not to ensue, and he calls for additional resources for London hospitals during the rationalisation process.

6 **The Secretary of State** approves plans to create a new agency, the City and East London Family and Community Health Services, to manage and develop community and mental health services in east London. In doing so, she accepted proposals to include midwifery services although there had been some pressure to retain these within acute units.

6 **Enfield and Haringey GPs** form a general practice commissioning executive, representing 220 GPs, including fundholders, and responsible for 500,000 patients. Acting in an advisory capacity to New River health authority, their aim is to obtain better performance from providers.

7 **The chief executive of Brent & Harrow commissioning agency, Mary Whitty,** questions the future need for specialist centres such as the Harefield hospital, and calls for more debate about the long-term future of the hospital.

10 **St Bartholomew's hospital** issues a consultation document on a proposal to become part of a trust, effectively accepting merger with the Royal London and London Chest hospitals. No decision has yet been made on the alignment of services across the different sites.

15 **The chief executive of University College hospital, Charles Marshall,** announces the closure of part of the main block of UCH at the end of October, as part of a strategy of bringing the Middlesex hospital and UCH together on one site.

15 **An independent inquiry** commissioned by North West Thames RHA blames weak financial control for the poor financial position at the Wellhouse trust.

20 **North West Thames RHA** provides a £3.2 million subsidy to the Wellhouse trust hospitals, as transitional relief funds, to deal with a 1993/94 deficit. At the same time Brent & Harrow health agency announces the withdrawal of contracts from the Wellhouse in 1994/95.

21 **London waiting lists rise by 14 per cent** in a year to over 151,000 patients, according to analysis of official figures carried out by the pressure group, London Health Emergency.

21 **North East Thames RHA** expresses concern over financial control at St Bartholomew's hospital. An urgent investigation is ordered by external auditors to verify its provisional operating deficit of £2.4 million in 1992/93.

21 **Camden & Islington health authority** presents a detailed proposal – with a three month consultation period – setting out as the preferred option, and a cost-saving measure, the transfer of contracts from UCH and St Bartholomew's hospital to the Royal Free, St Mary's and Whittington hospitals in 1994/95.

28 **The prospective Guy's and St Thomas's trust** announces plan to reduce staff by 30 per cent in the next five years in order to achieve savings of between 25 and 33 per cent.

29 **The LIG working group on mental health services** in London meets for the first time. It is chaired by Judie Yung, the Deputy Director of LIG and Mental Health Project Sponsor.

October 1993

7 **The Secretary of State** defers decisions on a number of London trust applications, including all the SHA hospitals, Riverside hospitals, UCL hospitals, the Royal London/ Bart's/London Chest, Northwick Park and Newham.

12 **Ealing hospital** blames community care assessment procedures for 'bed blocking' which has resulted in patients sleeping in hospital wards as they wait for beds to become vacant. Chief executive, Rosie Faunch, addresses the problem by re-opening a 12-bed ward at a cost of £74,000.

15 **London hospitals** respond to the insistence of purchasers that provider prices are reduced. UCL announces cuts of ten per cent on average but this may not be enough to influence Camden & Islington's decision to withdraw acute contracts in 1994/95. SELHA and New River exert similar pressure on their providers.

18 **The Secretary of State** launches Britain's bid for London as the location of the European Medicines Evaluation Agency, describing the capital as the home of a flourishing pharmaceutical industry and a centre of excellence for medical and scientific research.

21 **A report from South West Thames RHA** favours Queen Mary's hospital, Roehampton and the St Helier losing A&E and in-patient services with a concentration of services instead at St George's and Kingston hospitals.

21 **The Secretary of State** announces a decision to replace the 14 existing RHAs by eight regional offices of the NHSME. It is proposed that north and south London are covered by North Thames and South Thames offices respectively.

23 **A report** by the pressure group, London Health Emergency, alleges that as many as 23 hospitals may close in London.

23 **Mentally ill patients** in London are sent to hospitals in other parts of the country as a result of bed shortages in the capital. The junior health minister, John Bowis, reports that a mismatch of beds has led to this flouting of guidelines on ease of access of family visitors to patients. Chris Heginbotham, chief executive of Riverside Mental Health Trust, claims some seriously mentally disturbed patients are being turned away because of a lack of beds.

28 **UCL hospitals** announce plans to save a further £9 million in 1994/95 by cutting 500 posts, of which 150 are medical, and 25 are consultants.

29 **London wins its bid** to become the location of the new European Medicines Evaluation Agency providing technical and administrative support for licensing procedures which will eventually lead to the creation of a single EC market in pharmaceuticals.

November 1993

3 **Several non-executive members of Camden & Islington FHSA** oppose the option put forward by the local health authority to switch contracts away from the UCL hospitals. A final decision is due on this proposal in January 1994.

4 **Ron Kerr, North West Thames RGM,** denies a claim that there is a purchaser hit list of hospitals for closure. The desire of commissioning agencies to move towards a system where there are a number of 'preferred' providers is welcomed by some hospitals as a way of achieving rationalisation in London, though others are sceptical that it may signal a return to strategic planning.

5 **The board of Guy's and St Thomas's trust** recommends keeping both sites open, with Guy's losing A&E and becoming a smaller specialist hospital. This rationalisation is intended to achieve a 20 per cent reduction in unit costs; 2000 jobs are expected to go over the next five years.

5 **Wandsworth Local Authority** proposes that it should take over the local purchasing function for the NHS. The authority believes that this would make rationing decisions more accountable to local opinion. It is particularly concerned by current proposals which would effectively close Queen Mary's, Roehampton.

15 **The Riverside hospitals group** declares a shortfall of nearly £900,000 for the first half of 1993/94. Cuts in services are planned at Charing Cross and Chelsea and Westminster to achieve a balanced budget by April 1994. A recommendation on the joint fate of Hammersmith and Charing Cross hospitals is expected by the end of 1993.

16 **A London coroner** criticises Greenwich Healthcare Trust following the death of a patient who was left without medical attention for three hours, at Greenwich hospital in September 1993. The trust announces a full inquiry.

18 **The Greater London Association of Community Health Councils** issues a report, *Making London Worse*, which claims that London health care is in a state of crisis, and points to 29 hospitals under threat of closure.

18 **Controversy over the fate of the Royal National Throat, Nose and Ear trust** highlights the clash between strategic planning and market forces. Roger Steer, acting chief executive of the trust rejects LIG's preferred option of moving the RNTNE's services to the UCL site. The RNTNE claims to be a trust success story - 50 per cent increase in patient activity in two years - with widespread support among purchasers and GP fundholders.

24 **The Corporation of London's City Initiative** announces a £10 million plan to develop a private wing at Bart's which would then finance its A&E department. The scheme would also include a private insurance plan for city companies whose employees would be treated at Bart's, guaranteeing an annual income of at least £1.5 million.

24 **A MORI survey** for the National Consumer Council shows a higher level of dissatisfaction with both hospital and GP services in London compared with the national picture.

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2 **The loss of £200 million** by London local authorities in the Revenue Support Grant settlement for 1994/95 is partially cushioned by a special grant of £58 million in 1994/95, but the full effect will be felt in the following years.

7 **Kingston & Richmond health authority** recommends that in-patient and A&E services at Queen Mary's hospital, Roehampton remain open.

7 **Increases in Hospital and Community Health Services** budgets for 1994/95 are below the England average in all of the Thames regions except South East Thames.

8 **Speculation grows** that a decision on the fate of Bart's, Hammersmith, Charing Cross and the UCL group will be announced before Christmas 1993. UCL has been under threat from radical proposals by Camden & Islington health authority to move contracts elsewhere. However this has met with overwhelming opposition.

15 **The Secretary of State,** in a written answer in Parliament, announces decisions in the North East sector of London. These include developments at the Royal London and Homerton hospitals and the closure of Bart's A&E in October 1994, thereby effectively ending most in-patient services on the Smithfield site. She also announces that the Government will intervene to ensure the survival of UCL.

15 **The Secretary of State** announces a £14.8 million investment in the London Ambulance Service in 1994/95.

21 **Sir Anthony Tippett**, general manager of Great Ormond Street children's hospital, criticises a proposal from North East Thames RHA to merge the hospital with UCH on a single site. He stresses the importance of an independent future as being in the best interests of research and treatment at Great Ormond Street.

COMMENTARY

Introduction

Events in London need to be set in the context of the series of reports which have come out over the last 15 months, each in turn providing a partial answer to the future shape of health services in London in the 21st century.

At the same time, the market for health care in the capital has begun to bite. The process of change which this has given rise to has introduced a greater clarity in some areas of decision-making but brought new complications in its wake. The last 12 months might be described as a race between, on the one hand, evolving market forces and, on the other, a more reasoned and planned approach to health care provision in London. Other events in London have been overshadowed by the scale of change taking place. Perhaps the most important of these was the collapse of the London Ambulance Service computer system and the continuing saga surrounding the performance of the service. As all these changes have been taking place, waiting lists in the capital have continued their seemingly inexorable growth implying a continuing failure to meet the demand for acute health care in London.

This commentary attempts to clarify the development of the planning process in London, and relates it to the perennial crises which appear to have been gathering with ever greater speed in the capital. Finally other major events are discussed, and a brief prognosis of the patient is endeavoured.

Plans or markets?

The conundrum facing London is the correct balance between a planned process of change on the one hand, and an unquestioning adherence to the direction dictated by an as yet imperfect market system on the other. There have been three milestones in what might be termed the quasi-planning process in London: the publication of the Tomlinson report (Department of Health, 1992) in October 1992; *Making London Better* (Department of Health, 1993), the response of the Secretary of State for Health in February 1993; and the publication of the specialty reviews in June 1993 (HMSO, 1993).

Regional bodies have carried out more traditional planning exercises, in more, or sometimes less, harmony with the hospitals involved. Since February 1993, the London Implementation Group, created for the purpose by the Secretary of State in *Making London Better*, has played a significant role in monitoring and advising on the future shape of health care services in the capital. However, at the same time, the market for health care has continued to develop, sometimes in ways which may not always anticipate decisions arising from the planning process. The timing of these decisions may yet be critical to their ultimate success, for while the market continues to deliver services, it will develop its own irresistible rationale for the choices which it makes.

The Tomlinson report

The Government signalled a clear intention to deal with health care issues in the capital when, in October 1991, Sir Bernard Tomlinson was appointed as a Special Adviser to the Departments of Health and Education on London's health service, medical education and research, with a specific remit to address the provision of health care in inner London within the context of the reformed NHS. After months of speculation, particularly following the publication of the King's Fund's own report in July 1992 (King's Fund Commission, 1992), which recommended a programme of hospital closures and the transfer of resources into primary and community care over a period of 15 years, the Tomlinson report was eventually published in late October 1992.

Understandably, attention has focused upon the Tomlinson report's recommendations for the rationalisation of the acute sector, and these are addressed in the next section. Yet, one of the key contentions was the need for a transfer of resources from the acute to the primary sector; these issues are also looked at in the following section.

Acute hospitals

The report's conclusion that between 2,000 and 7,000 beds in London would be surplus to requirements by the end of the decade was based on two factors: first, the withdrawal of flows of patients from outside of the area into inner London hospitals, as purchasers of health care begin to secure high quality but cheaper services locally. The market made it clear that these London hospitals were not providing a cheap and efficient service; second, the continuing general increase in the efficiency with which beds are used, so that the needs of the population for health care can be provided within a smaller hospital estate. This has been a major factor in the reduction of bed capacity in much of the post-Second World War period, and is likely to have a growing impact well into the 21st Century. The report assumed that a third factor, reductions in weighted capitation funding to London purchasers, would have a fairly small impact, but it is turning out to be highly significant nonetheless, as we shall see.

Specifically, the report recommended the closure or merger of several hospitals. These included: the merger of the Royal London and St Bartholomew's on to the present Royal London site; the closure of the London Chest hospital with a transfer of services to the Royal London site, subject to a wider review of cardiothoracic services; the merger of the Middlesex and University College hospital (UCH) on to the existing UCH site; the closure of the Charing Cross hospital with the proposed relocation of the Royal Brompton and the Royal Marsden to the Charing Cross site; the closure of the Queen Charlotte hospital with relocation of services to neighbouring maternity hospitals and the Hammersmith; the closure of the Queen Elizabeth Hospital for Children, with a reprovision of its services on the Homerton hospital site; the closure of St Mark's hospital with the relocation of services to Northwick Park hospital; the closure of the Royal National Throat, Nose and Ear and the Hospital for Tropical Diseases, with the relocation of services to the UCH site, and the merger of Guy's and St Thomas's on to one site, with no explicit recommendation as to which site.

Primary care

Such radical recommendations for closure would only work in the context of developing primary care. As Tomlinson put it:

> *Resources need to be diverted from the hospital sector into these services [primary and community] to bring standards up to those found elsewhere, and to enable the rationalisation of hospital services in inner London.*

Thus the report recommended:

- the development of general medical services in London, through improvements in GP premises and more flexible local contracting;
- the enhancement of co-ordination between agencies responsible for the delivery of primary care;
- and the improvement of the level of nursing and residential home provision in London, particularly for elderly people, to help ease the pressure on acute beds.

Finally, Tomlinson agreed with the King's Fund recommendation for five multi-faculty colleges to undertake medical education and research. He also recommended a reduction of around 150 in the intake of medical undergraduates in London, the equivalent of closing a large London medical school.

Managing change

As a number of London hospitals were already in financial difficulty, Tomlinson recommended that work be put in hand immediately in order to plan for a more appropriate level of capacity. Such plans should include the rationalisation of the many dispersed specialist services with some closures and mergers becoming clearly necessary. The hospitals within the control of the Special Health Authorities were identified as a further distorting factor in the London picture, and it was recommended that they should be brought within the NHS market as soon as possible.

The report also recognised the need for transitional funding if change was to take place in a controlled and orderly manner. Thus,

> *It will be essential that adequate transitional funding be provided to ensure that service changes take place in an orderly fashion. The level of such funding will to a large extent dictate the pace of change. Change that is not managed and funded in this way is likely to be chaotic, and will do serious damage to London's health services, and to its medical research and teaching.*

To facilitate these changes, it was recommended that a high-level implementation group should be set up immediately with a remit to follow through with the report's recommendations, and with executive responsibilities to secure effective pan-London co-ordination of the restructured NHS.

Reaction

Criticism has focused on the fact that there was little underlying financial analysis to support Tomlinson's recommendations, and particularly those concerning hospital closures. In considering carefully her response to the report, the Secretary of State recognised the need both for a mechanism whereby the chief recommendations could be followed through in a systematic manner, and for detailed analysis of options across London which took account of the interactions between decisions in different sectors of the capital. Just such a

mechanism for change had been recommended in the Tomlinson report, and so, well before the announcement of the Secretary of State's formal response, the London Implementation Group began to be formed, with the specific remit to manage change, London-wide.

At the same time the other actors on the London stage – the purchasing authorities on the one hand and the hospital units on the other – were playing their parts. The reaction of many of the great hospitals was to steadfastly defend their existence and enlist the support of all and sundry in their cause. St Bartholomew's is a classic example of this phenomenon, with a major campaign against closure being waged in the pages of London's evening newspaper. Purchasers, on the other hand, seized the opportunities, where available, to realign their contracts, and in so doing have made the decisions open to the large London teaching hospitals even more clear. This has left the Government struggling to keep up, with the knowledge that if its efforts are eventually overtaken by events, the result might be chaos in the London health care market.

Making London Better

It was mid-February before the Secretary of State responded to the Tomlinson Report, with *Making London Better* in which she stated her determination to bring about major improvements to the health services of the capital. Though demurring on certain details, she accepted the broad thrust of Tomlinson.

Making London Better did two things: it laid out the options which the Secretary of State favoured for London; and it set out the means and timetable by which change would be invoked. Accordingly, the agenda for change comprised four key elements:

- to provide a better balanced hospital service on fewer sites to meet the needs of London's resident, working and visiting populations more appropriately;
- to rationalise and develop specialist services, reinforce their excellence, the effectiveness of their care and their support for teaching and research, while better meeting patient needs and reducing costs;
- to develop high quality, more accessible, local health services, with primary and community health services provided through family doctors, nurses and other health professionals working in the community;
- to merge free-standing undergraduate medical schools with multi-faculty colleges of the University of London for the benefit of medical teaching and research.

The London Implementation Group

The London Implementation Group (LIG) was formally established in late February 1993, as part of the NHS Management Executive, with a remit to ensure the implementation of the changes necessary for improving London's health services which had been outlined in *Making London Better*. A team was assembled with Sir Tim Chessells, who was chair of North East Thames RHA, as chair, and Bob Nicholls, who was Oxford regional general manager, as chief executive. It had an expected lifespan of at least three years – until March 1996.

LIG was given a monitoring and advisory rather than an executive role. It therefore operates through existing health agencies, working closely with purchasers and providers of health care and other key bodies in order to secure agreement on the detailed way forward and to oversee the implementation of change to a timetable.

LIG's work during the rest of 1993 has been concerned primarily with three areas:

- a reassessment of the provision of specialist services in London;
- the overall realignment of acute hospital provision in London;
- and the implementation of key structural recommendations for improving primary health care in the capital.

Specialty reviews

LIG's first major task was to look at the provision of tertiary services in London. Six key specialties for review were identified – cardiac, neuroscience, cancer, plastic and burns, renal and services for children – chiefly on the basis of the duplication of these services which exists in the capital. All six specialty review teams reported in late June. Although their precise recommendations differed, a common theme was the need to concentrate tertiary services for London and the south-east on fewer sites, in the belief that improved quality would follow from this concentration of resources. Less clear were the implications for those sites which would lose services under the specialty review proposals. The Secretary of State has said that these reviews are just a part of the evidence upon which final decisions will be made.

Reconfiguration of acute services

To ensure the effective realignment of secondary health care, LIG has been monitoring and advising on the work of regions and prospective trusts as they examine options for the reconfiguration of acute services within different geographic sectors of London. A series of appraisals of various options for the siting of services in London have been carried out, under the watchful eye of LIG. Each of

these considered the optimum level and siting of the provision of acute hospital services taking account of access, quality of care and financial viability. The recommendations of the specialty reviews also entered the equation where relevant.

Essentially there are five sectors of London where tough choices were being considered during the year:

East: where the Bart's/Royal London/London Chest shadow trust configuration is the major option for appraisal with some peripheral decisions around the Homerton, Newham, and Queen Elizabeth's Hospital for Children;

South Central: where the Guy's/St Thomas's shadow trust configuration is the major option for appraisal with some peripheral decisions around King's and Dulwich, Lewisham, Greenwich and the Brook;

North West: where the situation is more complex still requiring a major appraisal of the options for Charing Cross, Chelsea and Westminster, St Mary's and the SHA hospitals – the Hammersmith, Royal Brompton and the Royal Marsden;

North Central: where the UCL shadow trust configuration is the major option for appraisal but with the Royal Free and the Whittington entering the equation;

South: where St George's would seem to be the preferred site but with a variety of possibilities around the configuration of services between Atkinson Morley, Queen Mary's Roehampton, the Sutton Marsden, Mayday, Kingston, and St Helier.

Other outer London hospitals may influence these decisions and there may be crossover effects between sectors. For example, St Mary's has an impact on decisions in both the north central and north west sectors.

A statement by the Secretary of State on 15 December 1993 signalled the end of most services at the Bart's site. It also stated the Government's commitment to the future of the UCL hospitals. However, by late December 1993 firm announcements were still awaited in most sectors.

The Primary Health Care Forum

LIG set up the Primary Health Care Forum in March 1993, to oversee the implementation of primary care development. This is the lynchpin of the programme to improve health services in London. An area of London was identified for special attention – the London Initiative Zone (LIZ) – covering those areas thought to have high levels of need, weak existing primary care services and where acute sector rationalisation posed further challenges.

In 1993/94 £15 million was made available from central funds together with £30 million from regional funds for primary health care development in London. On top of this, £170 million has been promised for capital developments in London over a six-year period. Although the Primary Health Care Forum was rather slow into the saddle, relying to a large extent in its first year on plans for work which regions had already drawn up, there has been considerable development throughout the LIZ area. An article in part 3 of the Monitor by Ainna Fawcett-Henesy, LIG's primary care lead, discusses their primary health care programme and future vision for London in more detail.

The Primary Health Care Forum, taking its lead from *Making London Better*, has viewed the nature of projects as being 'innovative/extended', 'primary/secondary interface', or 'getting the basics right', with most funding going into the last one. The Secretary of State announced a range of initiatives in July 1993 which included:

- the development of new primary care centres across several parts of London, providing a range of services including minor surgery, pathology and therapeutic services such as chiropody;
- the improvement of existing premises from which general practitioners operate;
- the development of diabetes resource teams so that patients with diabetes might receive care in the community rather than the hospital;
- the development of 24-hour community nursing services.

Another interesting approach to primary and community care within the LIZ area has been the creation of City and East London Family and Community Health Services (CELFACS). The chief executive of CELFACS, Hilary Scott, provides a more detailed look at the aims and aspirations of this organisation in another article in part 3 of the Monitor. As she says there,

> *[it is essentially] a 'provider-side' agency which would embrace the family practitioner support and development work of the FHSA and the management of the community based services across east London.*

The crises in London's hospitals

While all this attention has focused on the future, there have been times when health care provision in the capital has appeared to lurch from crisis to crisis. For example, in August 1993 residents of Camden and Islington learned that their operations at UCH were postponed because UCH had provided too much care in the first five months of the financial year.

These crises seem to have three sources:

- budget deficits in 1993/94;
- closing off of contracts;
- contracting strategies for 1994/95.

First, budget deficits have arisen, in 1992/93 and the current year, among both provider units and purchasers. Examples range from the closure of wards at Whipps Cross in December 1992 to prevent a projected overspend, to proposals from the Wellhouse trust in September 1993 to transfer in-patient services from Barnet to Edgware and reduce the A&E department to a 12-hour minor injuries unit in an attempt to deal with a deficit in 1993/94. North West Thames RHA, for example, has been unable to fund the extensive demands for transitional relief which it has faced, amounting to twice its available reserves, with the inevitable consequence that units have had to look to alternative ways to finance them. This has usually meant cuts in services and beds closing.

There have been times when projected purchaser deficits have resulted in the second form of crisis where purchasers have insisted that hospitals cease to treat non-emergency patients because of overrun on contracts. There are several cases where this has occurred. We have already referred to the case in August 1993, when Camden and Islington purchasing authority instructed the UCL group and St Bartholomew's to postpone all non-urgent operations on its residents as the authority's budget was being spent too quickly. There was a similar instruction in the same month from Redbridge and Waltham Forest authority to some of the hospitals with which it contracts.

Finally, severe consequences for providers throughout London are predicted in 1994/95 if purchasers go ahead with their proposed contracting plans, and these are affecting decisions being made by providers now. Examples range from King's Healthcare trust where a projected fall in income of £2 million in 1994/5 has resulted in plans to shed 200 jobs, to the Wellhouse trust which is losing £4 million of contracts from Brent and Harrow health agency next year. A striking example is the UCL group of hospitals which, until the Secretary of State's intervention, was in danger of being seriously undermined by Camden and Islington's declared intentions to transfer contracts from UCL to the Royal Free, St Mary's and the Whittington, as a cost-saving measure. Charles Marshall, chief executive of UCL, warned that such moves could make his group of hospitals unviable. The extent of the Government's commitment to UCL remains to be seen.

These crises have occurred as a result of purchasers seeking to achieve better value from existing budgets. This pressure on providers to produce care at a competitive price has been intensified by the downward pressure on the budgets of London purchasers to which we turn next.

Allocating resources to London health care

Almost all London purchasers are facing shrinking budgets, and they will continue to do so in the next two or three years as attempts are made to bring budget allocations in line with what regional formulae suggest a 'fair' distribution would be. In most cases this means moving funds out of London and into the Shires. The situation was not helped by the relatively small increase in allocations which the Thames regions themselves received in 1993/94. Unfortunately reductions in financial allocations to London purchasers have only served to exacerbate the transitional problems which the London health care market has faced.

Purchasers facing reductions in their budgets have had hard decisions to make, and as Martin Roberts indicates in his article in part 3 of the Monitor, they have looked for savings first in acute sector budgets. Recent data produced by the Department of Health (Department of Health, 1993) indicate that London purchasers are overfunded by just £70 million, on the basis of planned allocations in 1993/94. There is an argument for maintaining current allocations while such major upheaval is taking place in the acute sector, but this is not currently the preferred option. Choosing to maintain a second-best solution in the short-term while other issues are sorted out may be more sensible than risking being forced to take urgent action to prevent a total collapse in some sector of the London health care market at a later date.

Purchasers have also been keen to move resources towards primary and community care and so, in a period of shrinking budgets, have chosen to maintain expenditure on primary care at the expense of acute care. To maintain existing levels of acute care they have looked for reductions in prices, and although these have been forthcoming, the recent experience of UCL, which has reduced prices by an average of ten per cent with little apparent response from purchasers, shows the extent of the problems facing some London providers.

In the long-term such substitution between acute and primary care is the Government's preferred option. However, it is unlikely to reduce the demand for hospital services in the short-term, and some have argued it may even increase demand. We have seen that considerable funds are being put into developing primary care in London, but, at least initially, much of that has been devoted to getting the basics right, not to the kind of developments which may eventually result in reduced demands on the acute hospital sector.

An urgent need for decision

The problem posed for any planned realignment of hospital services in London is that the market may determine that a hospital unit is not viable before decisions are made as to its future role. UCL is a good example of just such a worrying phenomenon. It was always likely that some configuration of services on the UCL sites would be a preferred option, and the Secretary of State's recent statement has confirmed this. However, its future may still be uncertain. It remains to be seen if the market will be able to sustain UCL in the long-term. Nevertheless, there is an urgent need for the Secretary of State to declare her intentions for London's hospitals. Equally clear is the need to make sufficient funds available to sustain these choices. Choices are being made within the context of a series of complex and uncertain markets. Mistakes may be made but the biggest mistake would be to allow choice by default.

Other major events

Other events have occurred in London which have not perhaps achieved the prominence they might have if such major changes were not already on the London agenda. The most notable of these is the series of crises in the London Ambulance Service (LAS). The LAS has been consistent in its failure to come even close to meeting ambulance service standards. The breakdown of its new computer-aided dispatch system for ambulances at the end of October 1992, resulted in the resignation of its chief officer. The subsequent inquiry which reported in February 1993 convinced the Government to take the unprecedented step of abolishing the LAS board, and placing the service directly under the control of South West Thames RHA. However, there has been little sign of significant improvement, with response levels still well below nationally recognised standards (ORCON), and a provisional deficit reported for 1992/93 of £2.2 million.

Somewhat ironically this was also the year when a major new hospital was opened in London, the Chelsea and Westminster, amid much controversy, first about the overrun in the cost of building it, which caused adverse comment from the Public Accounts Committee, and perhaps more fundamentally about the need for such a hospital in the first place. It adds just one more factor to the complicated equation in the North West sector of London.

An event which passed with little comment in London but which may have untold significance nationally was the ruling by the local government ombudsman that Tower Hamlets local authority was guilty of maladministration in failing both to support a mentally-ill man on his discharge from hospital, and to assess his needs. This was the first recorded incident of such a ruling under the Community Care Act and the authority was ordered to pay compensation and assess his care needs.

Conclusion

The last 15 months have been a period of incredible change in London: the changes that occur in the next 12 months may leave the London health care scene virtually unrecognisable. However, a measured approach can result in the first steps being taken in the construction of a modern, effective system of health care for the people of London. Unfortunately the odds seem heavily stacked against this.

We have witnessed a period of instability in London as the internal market for health care has started to have a real impact on the management of hospitals in the capital. Significant attempts to reorganise the provision of acute services are underway and LIG has been a major player in this process, if very much in the background.

However, towards the end of 1993, firm decisions were still awaited. In this commentary we have articulated concerns about the planning process chasing the tail of the market. Decisions are not easy and have not been made any simpler by an insistence on simultaneously driving down the budgets of London purchasers. If the process which has been described here is to provide the right structure for health care provision in London, then there must be a definite and stated commitment to transitional funding to enable smooth change to occur. Such funding is a form of risk premium in the sense of reducing the potential for disruption of health services in the capital as the process of change is played out.

The population of London might be forgiven for failing to recognise current changes to London's health care system as an improvement. Indeed neither would many of those working within the health care system. We do not argue that change in itself is wrong and support strongly the need for a body such as LIG taking an overall view of the process. However, a definite lead is now required, and urgently, with sufficient funds to drive change through to a positive outcome. The alternative is to risk the disintegration of the system of health care in London with detrimental consequences for the health of Londoners.

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 to it, and the use which is made of these services.

The availability of compatible data is always a limit on the comprehensiveness of such an enterprise, and this is even more problematic now after major changes in the structure of provision which have taken place since April 1991, with the implementation of the NHS and Community Care Act. Nevertheless we provide a snapshot of some of the main features of the health and health care of Londoners. At the same time this should provide a basis for comparison with previous reports – most recently those published by the King's Fund Commission (Benzeval *et al*, 1992; Boyle and Smaje, 1992; Boyle and Smaje, 1993) – and also with future publications of the London Monitor.

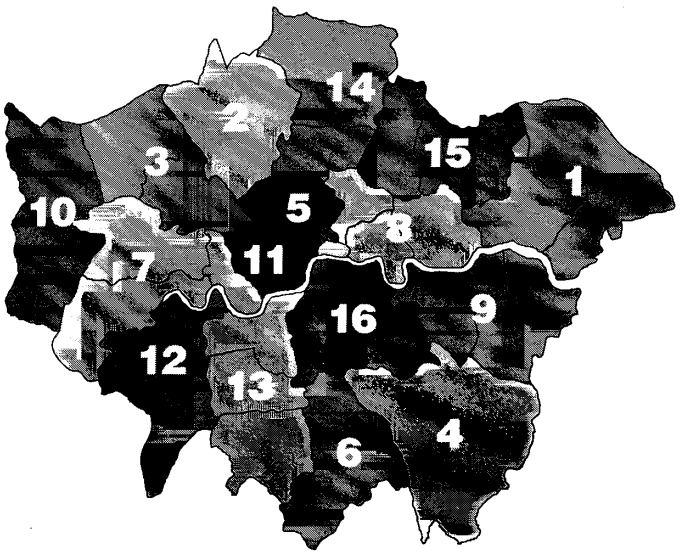
The position in London is compared with that in England as a whole. A purchaser focus has been adopted thereby reflecting the direction of change in the management of the NHS. Information is presented by district purchaser or FHSA according to which services are being discussed. In subsequent years, 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 clearly identified as inner London purchasers – Kensington, Chelsea and Westminster; East London and the City; Camden and Islington; South East London; and Wandsworth. The remaining 13 districts have been grouped as outer London purchasers although some of these cover areas stretching from the outer boundaries of the capital to the inner city. When data is presented in terms of FHSAs, Wandsworth is merged with Merton and Sutton, and so this area is then transferred to the outer London category for the purposes of this analysis.

The first section, using Office of Population Censuses and Surveys (OPCS) estimates and projections for 1992 and 1998, provides information on the structure of the population of London purchasers. This is followed by a section presenting some broad indicators of mortality

Map 1: The new London purchasing authorities

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



based on the Public Health Common Data Set (PHCDS), (Department of Health, 1993), which provides 1992-based data.

The third section considers the amount of funds available to London purchasers. The total revenue expenditure of London districts is presented and a breakdown of expenditure on Family Health Services (FHS) is also given. Section 4 provides information on the amount of HCHS services which are purchased. In both these sections the data refer to 1991/92 and are based on the data underlying the Health Service Indicators (HSIs) (Department of Health, 1993). Section 5 presents some important indicators of Family Health Services activity and staffing levels using a mixture of information from the 1991/92 HSIs and General Medical Services (GMS) Basic Statistics for October 1992.

An important element which is missing from the current analysis is a profile of hospital provision in terms of resource availability. This includes both beds and staffing levels 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.

There are currently approximately 55 acute hospitals in London. Of these, some 35 are in inner London and 20 in outer London; 12 are mainly tertiary referral hospitals, 13 are teaching hospitals and 25 are mainly district general hospitals. There are a few single specialty hospitals although these are all likely to be merged with multi-specialty hospitals as a result of the current reviews of London hospitals.

A map of London is provided which shows the boundaries of the London purchasers as they are likely to be from April 1994. Local authority boundaries within each purchaser area are also indicated.

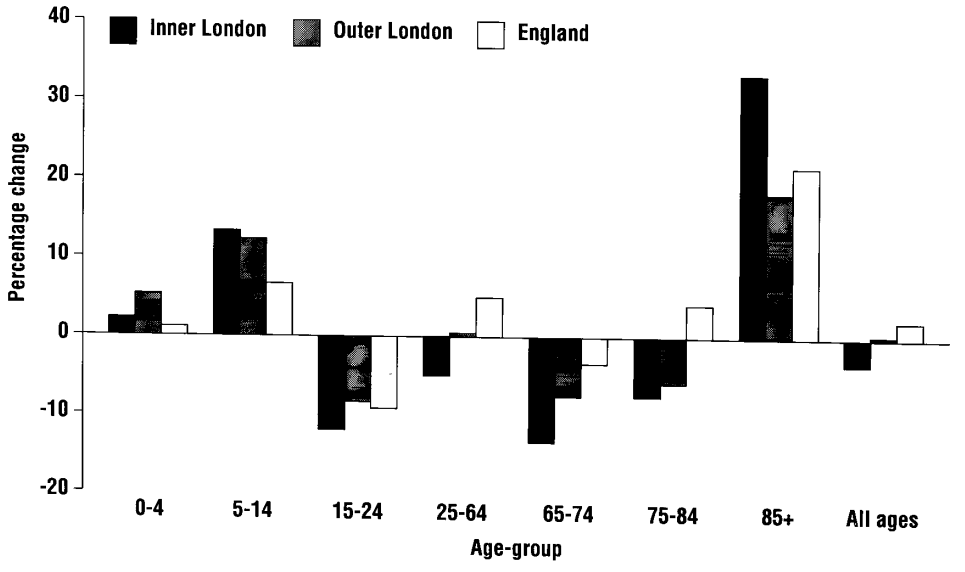
In each section graphical figures are provided which allow a ready comparison between London and England as a whole. Tabulations of more detailed data to support these figures are available on request. Broadly this data refers to the first year of the health service reforms. Subsequent issues of the Monitor will include more detailed data as well as updates of the current tables.

London's population

This section presents information on the current and projected population of London using purchasers as the basic geographic unit. The current breakdown, by age-group, of the population of inner and outer London is quite similar to that in England as a whole, though there are relatively fewer people in the older age-groups. However, clear differences exist across London.

Using population projections to 1998, based on current trends in fertility, mortality and migration, Figure 1 contrasts projected changes in the population of England as a whole with those in inner and outer London. A small overall increase in population is predicted in England but the

Figure 1: Projected changes in population, between 1992 and 1998, by age-group



population of inner London is projected to fall slightly with virtually no change in the outer London suburbs. However, the composition of these changes is very different. There is a projected growth in the 85+ population of inner London – potentially a high-cost age-group in health service terms – of one-third, over 50 per cent greater than that in England as a whole. This is compensated somewhat by the considerable fall projected in the population of inner London, in the 65-74 and 75-84 age groups.

Similarly, the growth in the 0-14 age-group of both inner and outer London is expected to be higher than that nationally with falls projected everywhere in the 15-24 age-group and an expected decrease in the 25-64 group in inner London. It is difficult to be precise about the impact of these changes on the expected demand for health care without more detailed work. The increase in the high-cost 85+ age group in inner London must be balanced against the fall in the numbers of 65-74 and 75-84 which is expected, taking account also of the greater absolute numbers in these latter age-groups. This downward trend in the less elderly age-group suggests that the number of people of 85+ may decline in the following five to ten year period, all other things being equal.

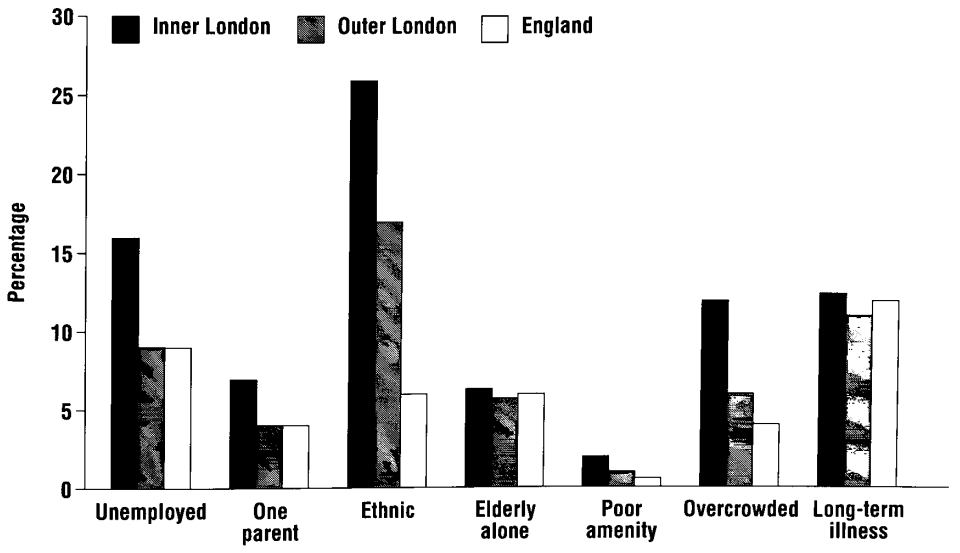
A profile of the current population in London, based on the 1991 Census, is presented in Figure 2. This gives the percentage unemployed, the percentage of one parent families, the percentage of the population belonging to minority ethnic groups, the percentage of elderly people living alone, the percentage of population with poor amenities, the percentage living in overcrowded conditions, and finally the percentage reporting limiting long-term illness.

The first six variables are those composing the DoE social index. There is considerable variation across London and between London and the rest of England. Figure 2 compares inner and outer London with England. There is clearly a very different population structure in inner London, in terms of these variables, when compared with England, though the only marked difference in outer London areas is the ethnic composition of the population and, to a lesser extent, the degree of overcrowding.

Inner London has almost twice the unemployment rate of England as a whole, twice as many one-parent families, and three times as much overcrowding and poor amenities (though this variable now affects only a rather small proportion of the population). Over a quarter of the population belongs to minority ethnic groups compared to just six per cent nationally. However, the response to the self-reported illness question is almost identical to that in England, at 12 per cent. The extent to which this is affected by the age structure of the London population is addressed in more detail in an article in Part 3 of the Monitor, where Roselyn Wilkinson examines age-standardised illness ratios in London.

Even within London there is considerable variation across these variables. Areas such as Bromley or Barking and Havering in fact have lower proportions of people from minority ethnic populations than the national average. However, there is a marked consistency across inner London areas.

Figure 2: A census profile of London districts, 1991



The health of Londoners

This section presents some information on the health of Londoners relative to the rest of England. It is expressed in terms of Standardised Mortality Ratios (SMRs) and so might more accurately be termed the mortality of Londoners. The SMRs reflect the death rate in an area relative to an age-standardised norm, which in this case is derived from English death rates. Figure 3 shows differences between inner and outer London, and London as a whole, for SMRs of four age-groups, 0-14, 15-64, 65-74, and 75+, 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 of differences between inner and outer London and England as a whole is very much dependent on which age-group is considered. The SMR in inner London is at least 10 per cent higher than the national value in three out of the four age-groups considered, and in the case of 15-64 year olds, who make up 65 per cent of the population, by approaching 30 per cent. However, for the 75+ age-group, both inner and outer London exhibit a much lower SMR than is the case nationally. But over 50 per cent of deaths occur in this 75+ age-group, and so when the SMR for all ages is calculated it is just three per cent higher in inner London than is the case elsewhere.

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. 30 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. If this is a good predictor of ill health among this group then it would suggest that the majority of inner London residents suffered more ill health than is the case nationally.

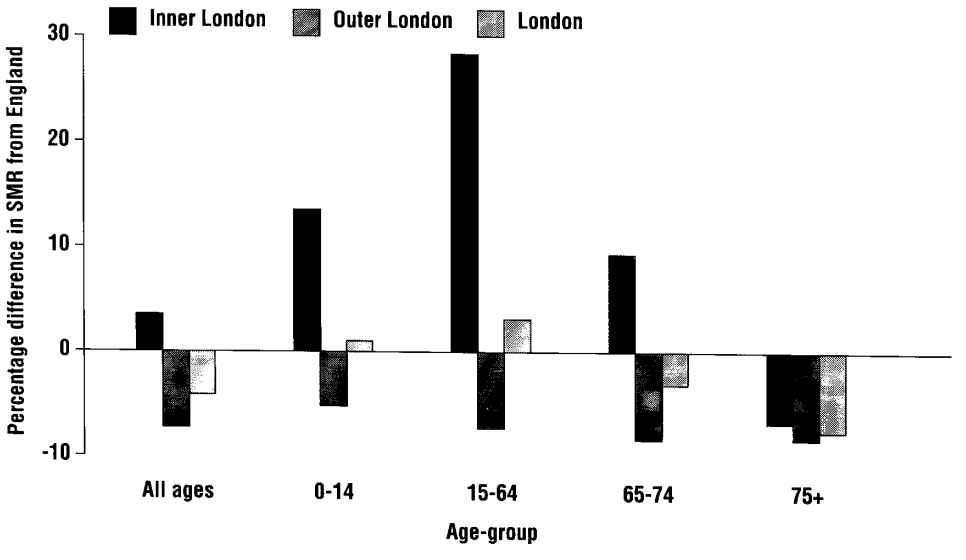
Expenditure on health services in London

We turn now to how much is spent on health services in London. Information is presented on the level of expenditure by purchasers – the Hospital and Community Health Services budget – and also on the main constituents of Family Health Services expenditure.

The level of funds available to inner London purchasers has generally been higher than that nationally. This reflects three factors: the higher costs in inner London which would be expected to account for a nine per cent difference through the special London weighting and market forces allowance; the higher level of need in some London districts; and the historic overfunding of London districts which is gradually being reduced. This overfunding element has recently been estimated at £70 million for 1993/94 (Department of Health, 1993).

Figure 4 is based on the Health Service Indicator data set (Department of Health, 1993) using information on total revenue expenditure by purchasers for 1991/92. It shows that per capita expenditure in inner London districts is over 80 per cent greater than the England average. Most outer London districts, on the other hand, are at or below

Figure 3: Percentage differences in SMR between London and England, 1992



the national average and, in fact, outer London as a whole has slightly less per capita expenditure than England. London overall is some 28 per cent above average, reflecting the substantially greater funding in inner London districts.

Turning to expenditure on Family Health Services, a somewhat different picture emerges. Again using data from the Health Services Indicators package for 1991/92, Figure 5 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 London FHSAs spend over 15 per cent more per capita resident population on GMS than their counterparts in the rest of England. Outer London FHSAs on the other hand spend slightly less and London overall is spending just five per cent more. This is a similar finding to that for HCHS expenditure, although the disparity in inner London is considerably less. A different picture emerges when expenditure on PS is considered. All London districts are spending less than the national average: ten per cent in most cases. This is due to a lower level of prescribing in London, where there are nearly ten 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 London is just four per cent more than the England figure.

Figure 4: Total HCHS revenue expenditure per capita, 1991–92

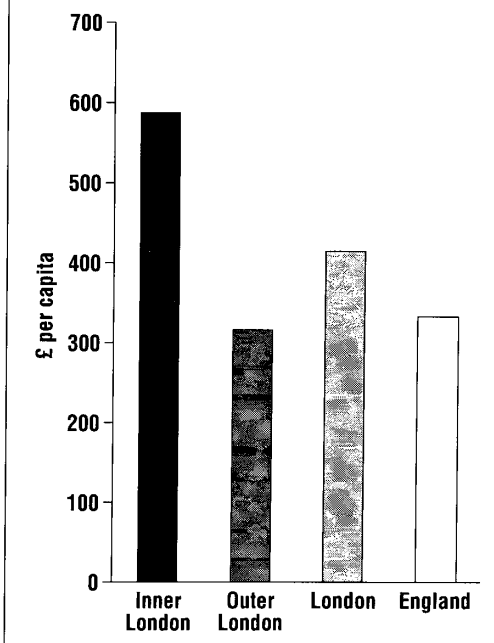
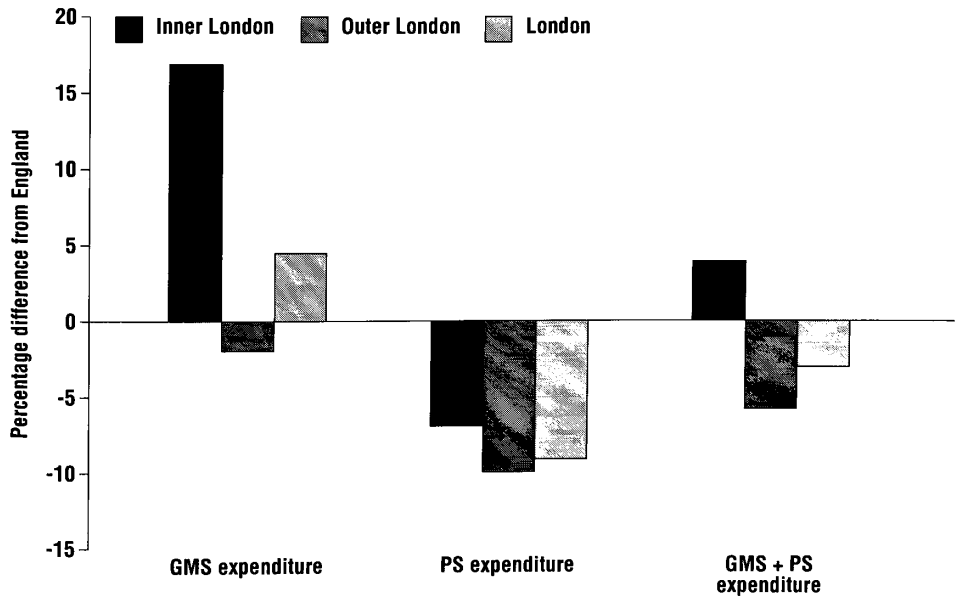


Figure 5: FHS expenditure per capita, 1991-92



The use of health services by Londoners

In this section we look at two aspects of the use of hospital and community services by Londoners: the number of in-patient and daycases in the major specialties, and the use of district nurse services in terms of contacts, in both cases using 1991/92 HSI data.

Hospitalisation

Figure 6 presents standardised hospitalisation rates for inner and outer London compared to England, for seven major specialties plus a total acute figure which is just the sum of these specialties. Although this total does not correspond to the usual definition of total acute services, these specialties account for over 80 per cent of acute activity. Hospitalisation rates are a measure of utilisation of hospital services, expressing the number of in-patient and daycases per capita resident population, and these are standardised by age-group in terms of the English age profile.

Residents of inner London areas have a standardised hospitalisation rate 10 per cent higher overall, but as the figure shows, the General Medicine specialty, where one-third of total activity takes place, accounts for most of this difference. Outer London districts overall have a lower hospitalisation rate than nationally. However, there is considerable variation across London.

Community nursing

Figure 7 compares the number of district nurse contacts in inner and outer London with the national average for two client age-groups, 16-64 and 75+. It is in the latter group that most contacts take place, in some areas ten times as many as in the 16-64 age group. In both cases London overall has less contacts per capita than the England average, although in inner London there are almost as many in the more important 75+ age-group.

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 8, based on data for 1992 from the GMS Basic Statistics (Department of Health, 1993), shows that, on average, there are nearly 10 per cent more GPs per capita in inner London areas than in England as a whole, whereas the outer London figure is close to the national average. However, there are also less practice nurses and other support staff per GP in London, particularly inner London. In fact 31 per cent of practices in inner London are without a practice nurse compared to just 12 per cent in England as a whole.

Figure 9 presents a profile of family doctor services comparing London with England as a whole on a number of indicators, which are derived from the HSI data set for 1991/92. The

Figure 6: Standardised hospitalisation rates, 1991-92

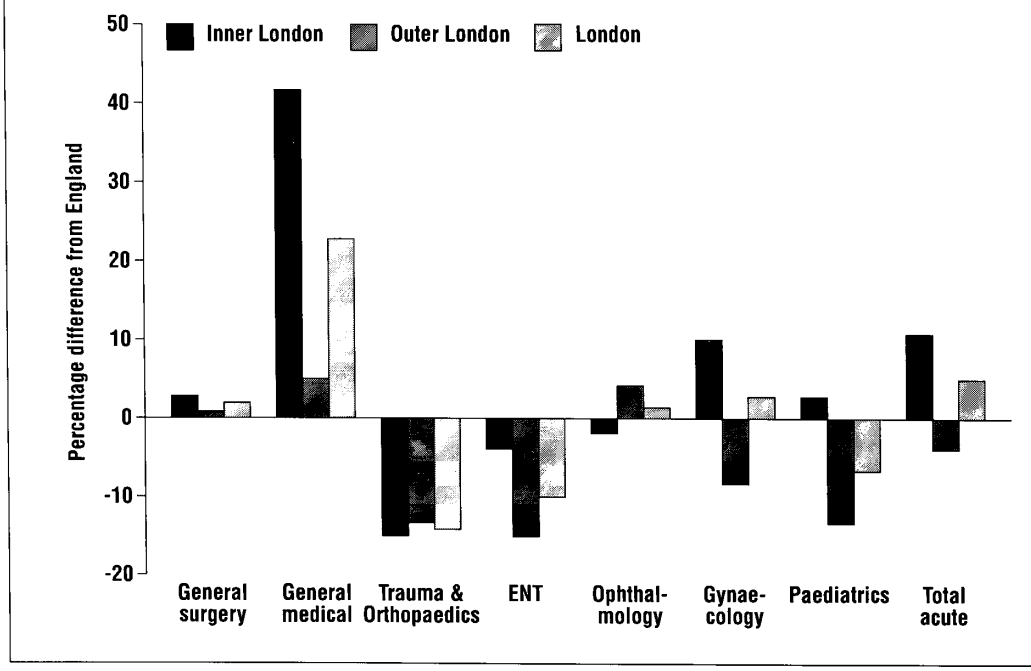


Figure 7: District nurse contacts per capita, 1991-92

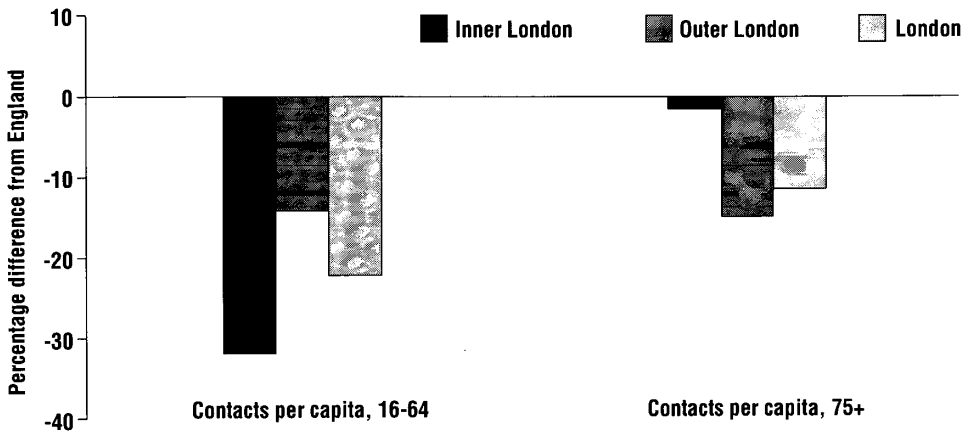
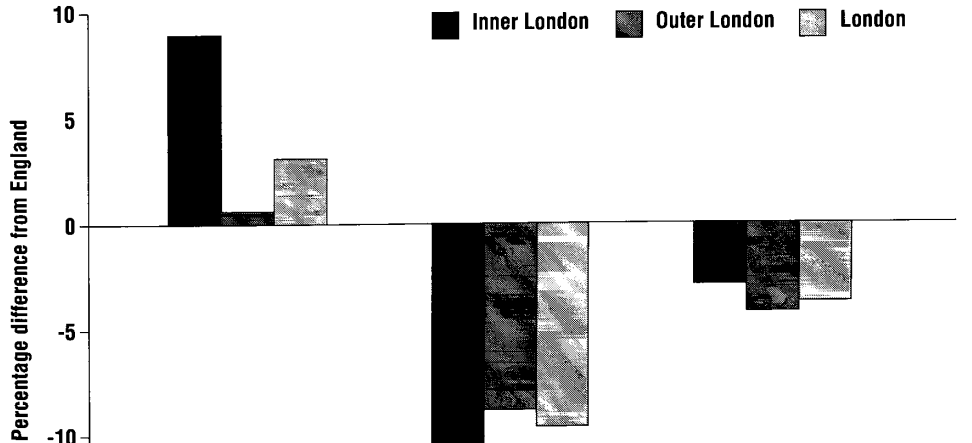


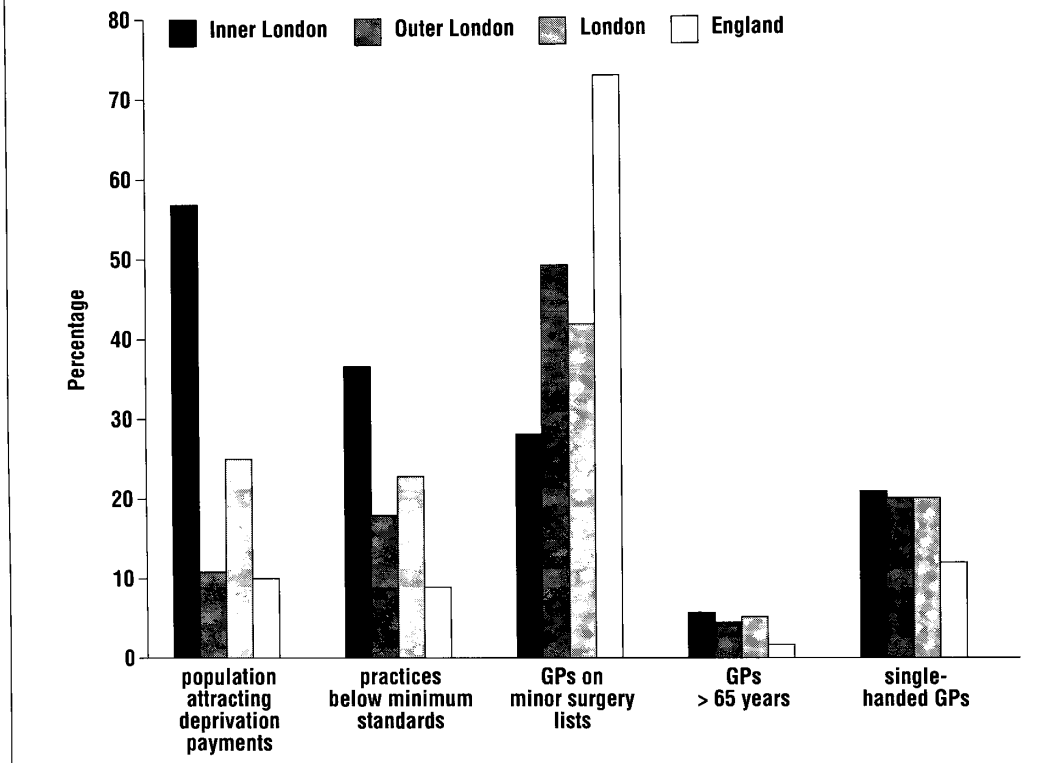
Figure 8: Primary care staffing in London, 1992



situation in London, particularly inner 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).

GPs in inner London receive deprivation payments for over 55 per cent of their lists compared with less than 10 per cent in England as a whole. Over 35 per cent of inner London practices and 15 per cent of outer London are

Figure 9: Primary care profile, 1991-92



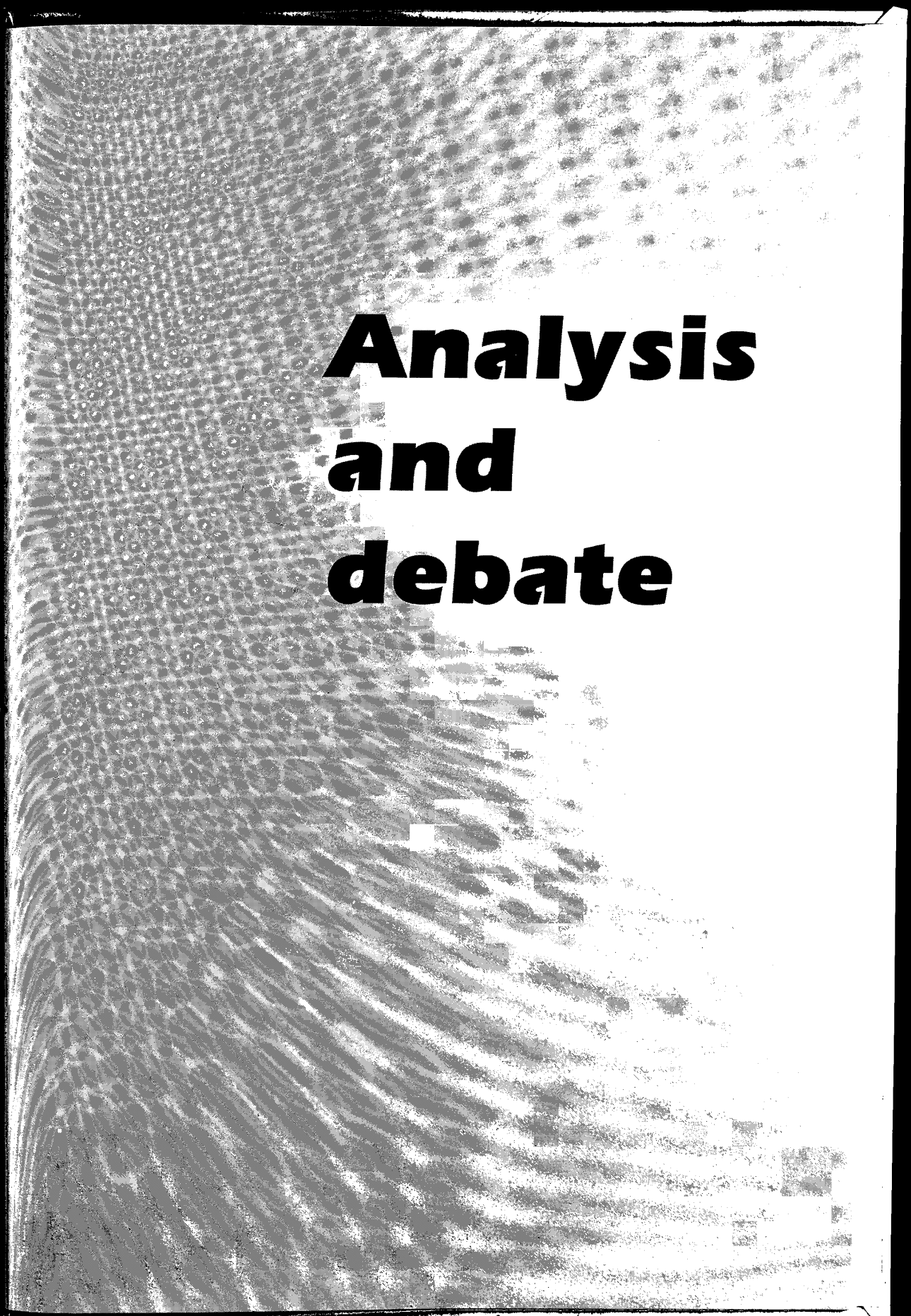
below minimum standards. In England overall just 8 per cent fall below these basic standards required under the rent and rates scheme. Over 70 per cent of GPs nationally are offering minor surgery to their patients, but in inner London the figure is less than 30 per cent, and in outer London less than 50 per cent.

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. The story in 1991/92 remains the same with London having twice as many GPs over 65 years and nearly twice as many single-handed GPs.

Conclusion

The information provided here gives the first insight into the overall pattern of health and health care in London since the NHS reforms took effect in April 1991. As yet, there is little evidence of significant change to the imbalance between primary and acute services in London which has been well-documented in the past. A familiar pattern of underdeveloped primary services and relatively high expenditure in the hospital and community services sector is revealed.

It will be important to monitor developments in the pattern of care over the next five years as the major changes currently taking place in London, which were discussed in detail in the first part of this Monitor, begin to make an impact. Crucial to any attempts to do this is the continued provision of detailed information about all aspects of health and health services in London.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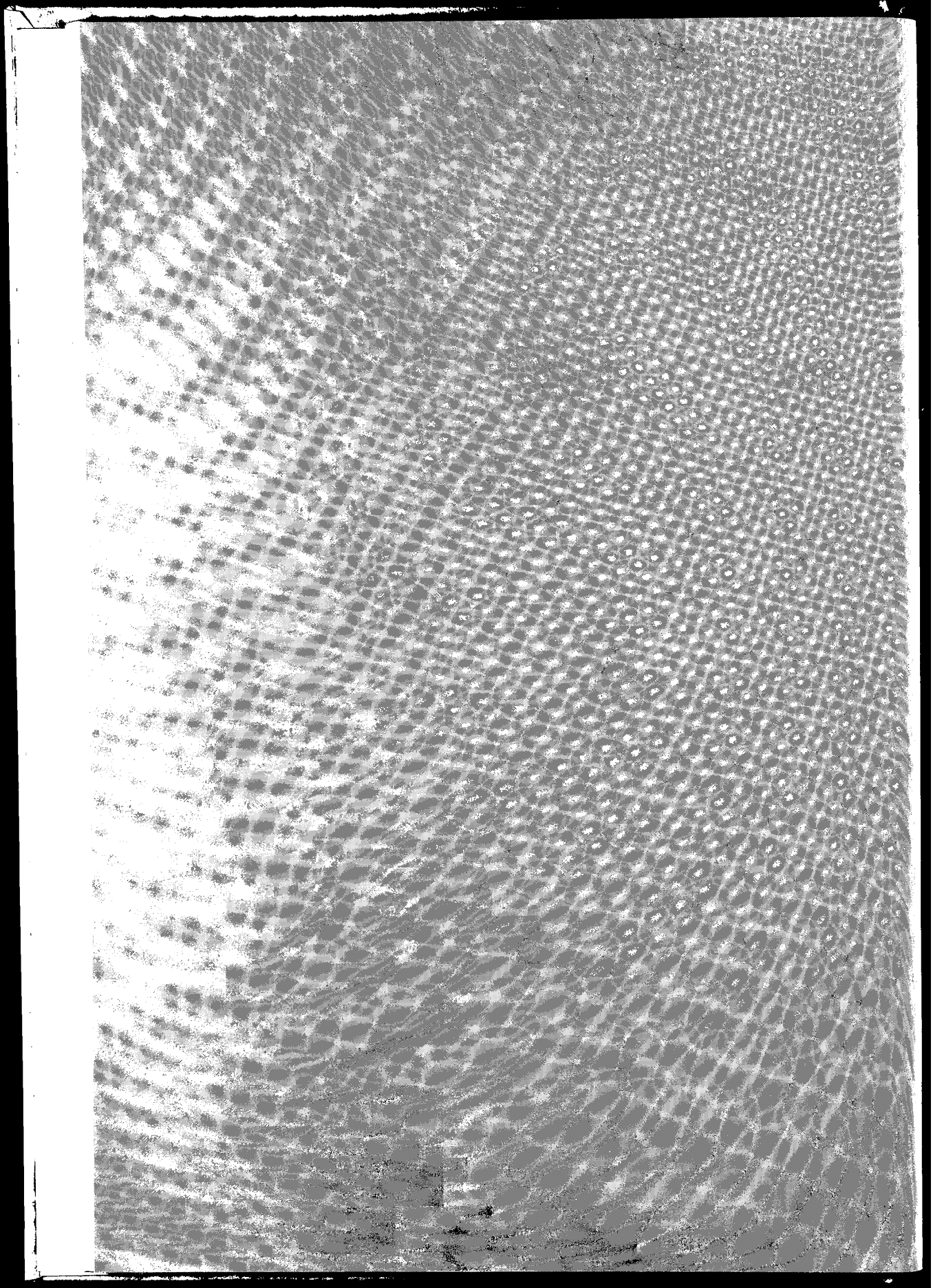

THE FUTURE FOR PRIMARY CARE IN LONDON

Ainna Fawcett-Henesy

Primary Care Lead, London Implementation Group

Introduction

Primary care in London has never before occupied the pre-eminent position that it does today. It is seen as the solution to the current crisis facing London's health care and as the centrepiece to the vision for the future. Each of the reports and policy documents published over the past two years have drawn attention to the problems peculiar to London, and each has identified greater investment in and improvement of primary care as the way forward.

The problems, of course, are well-known. The over-supply of acute hospital beds and the impact of the internal market on the major hospitals, is compounded by expensive, but inadequate, community health and primary care services. Although broadly speaking, the health of London's population is no worse than comparable populations elsewhere in the country – and in some cases better – there are particular sub-groups of the population, such as homeless people, members of ethnic minority groups and travellers, whose health status and access to services are causes of concern.

The reports produced by the King's Fund London Commission (Benzeval *et al*, 1992; Boyle and Smaje, 1993; King's Fund Commission, 1992) set out in detail many of the issues. Similarly, those same issues were the focus for the Tomlinson inquiry, established by the Secretaries of State for Health and Education in October 1991. A similar set of conclusions were reached in relation to primary care. They concluded amongst other things that:

- there should be a transfer of resources from the acute sector to the community health and primary care sectors;
- there should be substantial investment in improving GP premises;
- there should be greater flexibility in how health care professionals, particularly GPs, are contracted to provide services;
- the scope and accessibility of primary care should be extended.

Once the Tomlinson inquiry reported, the Government took stock and responded with its own considered view in the report, *Making London Better*, (Department of Health, 1993) endorsing much of what had been in the Tomlinson Report and in the papers published by the King's Fund London Commission.

Making London Better

The Government broadly accepted the Tomlinson recommendations. It also built many of the King's Fund Commission's conclusions into its strategy for future developments. In particular, the report stressed four central principles:

- accessibility;
- quality and cost-effectiveness;
- application of the internal market;
- quality of medical education and research.

Along with the rationalisation of hospital provision, the development of specialist services and the merging of medical schools with multi-faculty colleges of London University, the development of high quality, innovative and accessible primary care was high on the agenda. Indeed, the enhanced role of primary care was placed at the centre of the plans for the future. And yet, of course, as the King's Fund reports had clearly demonstrated, the under-development of primary care was one of the most handicapping features of health care in London. Briefly, those features can be summarised thus:

- up to 50 per cent of GP premises below standard;
- an older age profile for GPs still practising as compared with other parts of the country;
- more single-handed GPs;
- less use of deputising services;
- greater use of A&E;
- lower prescribing rates than outside London;
- fewer district nurse and health visitor contacts, but at greater cost than in other parts of the country;
- less residential accommodation for elderly people than elsewhere.

Making London Better outlined plans for implementing a strategy for London which foresaw the rationalisation of the acute sector and the substantial development of primary care. In order to accomplish this it proposed the establishment of a London Initiative Zone (LIZ) with an overseeing

body, the London Implementation Group (LIG), which was to operate through existing health agencies in the capital. LIG was to establish a Primary Health Care Forum to be responsible for developing ideas for change, in conjunction with all relevant parties in LIZ.

Implementing better primary care

LIG was established in February 1993. Its first responsibility, through the Primary Health Care Forum, was to agree initial plans for change with the Thames regional health authorities and local agencies by April 1993.

Three specific areas for development were identified in *Making London Better:*

- 'getting the basics right', involving bringing existing services up to standard – improving premises, bringing in young, better-trained staff;
- introducing innovation – supporting initiatives that will bring new forms of primary care to the inner city, to meet its special requirements;
- developing the interface between the primary and secondary care sectors, so that more care takes place in the community.

The Government pledged £40m for the first year, with £170m for capital projects over a period of six years. In addition, it promised £7.5m to stimulate voluntary sector initiatives over three years and planned to establish a London Primary Health Care Challenge Fund – £1m in the first year to encourage innovative and experimental ideas.

LIG has a five year time-frame, and the range and speed of development which is envisaged is substantial. What must be remembered is that the changes and development in primary care have to go hand-in-hand with the rationalisation of the acute sector. As hospitals merge or close, and as the number of available beds diminishes, it is essential that primary care (including community health and social services) is able to handle the increased demands which will be made on it as a direct consequence of scaling down acute sector activity.

FHSA development plans

The Family Health Services Authorities in LIZ submitted development plans to their regional health authorities in March 1993, setting out their proposals for the coming year. The four RHAs reviewed and endorsed the plans before submitting them to LIG.

The timescale for the production and submission of these plans was extremely tight and there was not much opportunity for systematically integrating the plans into a comprehensive framework. In spite of this, each of the FHSAs in LIZ was able to put forward plans which included initiatives of a highly innovative nature and which clearly matched the spirit of the *Making London Better* philosophy. Most of the plans were concerned with getting the basics right, although up to a quarter related to innovative developments which would need to be monitored carefully. One issue to be addressed is the long-term recurrent commitment that the plans entail. It is essential for developments to take place within planned resource frameworks, and where there are long-term commitments, that purchasers have the capacity to meet them.

Many of the plans were concerned with extending primary care into new settings. In South East Thames, for example, Greenwich and Bexley FHSA put forward plans for a network of primary care centres to cover the entire area, while Lambeth, Southwark and Lewisham planned to test the feasibility of polyclinics. In North East Thames, similarly innovative schemes were proposed. Waltham Forest FHSA, for example, planned to link primary care development with housing action projects, while Enfield and Haringey FHSA proposed to open a community centre with primary care input in one of its most disadvantaged housing estates. In other parts of North East Thames emphasis was placed on developing links between university departments of general practice and primary care on the ground in order to strengthen skills and capacity.

A common theme which emerged from all of the regional overviews was the need for careful monitoring and evaluation of the schemes that were set up. It was acknowledged that the vision of the future was radical and that many of the assumptions about the efficiency of primary care were untested. The lack of certainty cannot, however, always be overcome. There are a number of variables which, while they must be taken into account, are unpredictable. These include the impact of weighted capitation over the next five years; the effects on primary care of acute sector rationalisation; and the effect on demand likely to result from the planned improvement of existing primary care services. Likewise, the consequences of the success (or failure) of the 'year one' plans, which are being introduced now, cannot yet be foreseen. These must await evaluation.

As a result, there will continue to be a certain amount of uncertainty surrounding the speed and extent of the development of primary care. This does not mean, however, that the vision for primary care is diminished. It does mean, though, that all developments must be carefully documented and monitored, with year-on-year plans being regularly reviewed in the light of most recent findings.

Voluntary sector initiatives

In March 1993, the voluntary sector was invited to bid for the first tranche of the £7.5m promised as

part of the *Making London Better* package. Part of the Government's intention has been to foster the independent sector in general, seeing it as playing an integral role in the development of primary care across the capital. Until now, its involvement has been patchy. There has been a lack of private sector involvement in the residential sector in London, for example, while the voluntary sector has always been noted for its innovation and imagination in other aspects of primary and community care, in relation to work with ethnic minority communities and with HIV services, for example.

As a result of this invitation, by the end of April 1993 a large number of bids were received. They were judged on two main criteria: that they should contribute to the prevention of admission to hospital, or that they should facilitate early discharge. The Primary Health Care Forum took responsibility for selecting the successful bids.

Of the projects that were successful in bidding for funds, most are aimed at helping people with mental health problems cope better with life in the community, or supporting elderly people and their carers, often on discharge from hospital. Some of the projects are extremely practical – two, for example, are concerned with repairing and improving the homes of elderly people. Others provide activities and support for vulnerable people when statutory services are not available. Projects to assist members of ethnic minority communities are concerned with language issues, offering bilingual advice and counselling services or outreach services to particularly isolated groups such as refugees.

All the projects will be carefully evaluated to identify the contribution they are able to make to maintaining people in the community or helping them once they have left hospital.

The vision

The vision which has informed the thinking of LIG and the Primary Health Care Forum embodies all that is radical and innovative in the field of primary care. Ideas from elsewhere in the country and from abroad have been explored and adopted where it looks as if they could be applied successfully in the capital. As was noted earlier, the demographic profile of London and the pattern of its health care have features which distinguish it from elsewhere. Many of the most innovative ideas are best suited to meeting the needs of some of the groups and situations particular to London.

The principles underlying the vision

A set of principles, derived from the dimensions of quality set out by Maxwell (Maxwell, 1984), govern the thinking behind the plans for London:

Equity

has governed the emphasis on developing primary care services for vulnerable and excluded groups, such as homeless people, drug abusers, members of minority ethnic communities and people with mental health problems.

Accessibility

is the motivation for the development of primary health care services in a whole range of locations, including community health care centres, mobile clinics, sessions in shopping malls and the work place, A&E departments, lodging houses and hostels.

Appropriateness

is matching services to needs in an appropriate manner, which underpins the quest to ascertain what people want from the services through such means as surveys of consumer opinion, focus groups, questionnaire studies and development work projects.

Effectiveness

in terms of successful preventive measures and assessing outcomes of treatment means that rigorous attention is paid to training in new forms and techniques of treatment, evaluation and audit – thus validating the policy shift from the secondary to the primary sector and demonstrating that primary care is as, or more, effective than reliance on acute care.

What the future holds

The three-fold model of development outlined in *Making London Better*, if fully implemented, will achieve a level and range of primary care of the highest quality. Furthermore, it will reach groups in the community who hitherto have had difficulty gaining access to services.

Within a timescale of five years, the conditions in which traditional forms of primary care are delivered will have vastly improved. Substantial investments in improving GP premises will have borne fruit. Basic facilities, such as comfortable waiting rooms, consulting rooms with privacy, toilets, treatment rooms, all with wheelchair access will be commonplace. Surgeries will be geographically accessible, appointments will be easy to make. GPs and their staff will be available when they are needed and a range of services will be offered from the surgery. Quality standards will be widely agreed and publicly adopted.

In addition, there will be a variety of primary care services available, not just those delivered from the traditional surgery. Health centres will become more widespread and have many more services on offer, including complementary therapies, social care services and other social services, as well as a wide range of community health services. Primary care will be taken out to

groups who are not normally part of the general practice clientele. Thus, mobile clinics, sessions in the work place, in hostels for homeless people and in shopping centres may all have become familiar forms of delivery.

The primary health care team will have become a real force for change. It is hoped that organisational disputes between nurse management and the general practice will be a thing of the past. Teams will be composed of doctors, nurses, therapists, social workers, home care workers and others, taking on the assessment and care of the whole range of the needs of the individual patient. Joint training programmes will ensure effective, co-operative working patterns.

In addition, agreement will have been achieved relating to special, flexible arrangements for the employment of GPs within LIZ. Salaried GPs, recruited on the basis of particular expertise and interests will be taken on to develop specific aspects of primary care – for example, working with homeless people or catering for the particular needs of some ethnic communities. Re-training programmes will be developed to offer to some traditionally trained GPs who are felt to have slipped behind; others will be encouraged to retire.

As the range of services delivered by the GP and by the primary health care team in the home and in the community increases, the transfer of care from hospital to community will become a real option. Intermediate care centres, locally based, with beds managed by nurses or GPs, will provide alternatives to acute hospital care. GPs will be undertaking minor surgery on a substantial scale, having received appropriate training and resourcing in order to do so.

Long-term care will be provided in surroundings far more sympathetic and sensitive than the long-stay hospital ward. Nursing homes, respite care, hospital-at-home schemes and hospices will all play their part. The independent sector will be able to take on an active role in this provision. Carers will be better supported as a result of more effective needs assessment and care planning. Relations between all the agencies involved – health, social services, housing, the independent sector – will have improved markedly.

As the benefits of the new structures become apparent, people will begin to regard health care differently. They will no longer look to their local A&E department as their first point of call as they had done in the past because GPs and community health service staff were inaccessible. It will be as important to change the public's attitudes to and expectations of health services as it is to change the services themselves.

The consequences of change

Although ultimately changes will be beneficial to providers and public alike, they will not be achieved without some degree of pain for those providing services.

GPs will have to adjust to possible amendments to their contract, to the introduction of salaried colleagues and to a greater scrutiny of their competence. At the same time, much will be expected of them. They will be seen as the chief vehicle for change, however much they may feel the burden.

Equally, the pressures on community nursing staff will be great. Demand for greater effectiveness will grow; they will be expected to cooperate more closely with other colleagues in the team, especially practice nurses. They will have to become used to working in different and novel settings. Furthermore, many of the nurses will be new to the primary care setting, having transferred from the acute sector as the changes come into effect, and they will have extra adjustments to make.

Purchasing authorities, too, will have had to make major adjustments in their thinking. The transfer of emphasis from acute sector care to the primary care setting will require fundamental changes in the pattern of purchasing. As DHAs and FHSAs merge, the change of focus will be facilitated, but it will require more than that. Productive dialogues between purchasing authorities and GPs themselves will be essential.

Conclusion

By the end of the century, the pattern of health care in London will have changed dramatically. This will not have been achieved without some sacrifice. The acute sector will have been reduced in size with hospital closures and mergers. Staff based in the primary care sector will have had to re-think and extend their roles.

The beneficial consequences, however, will be substantial. More people, on more occasions, will have problem-free, ready access to health care when they need it. For the first time in history, primary care will be tailored to meet the needs of all London's population, regardless of age, gender, socio-economic status and community origin.

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THE EAST LONDON PRIMARY CARE DEVELOPMENT PROJECT

Hilary Scott

Chief Executive, City and East London Family and Community Health Services

Introduction

The Primary Care Development Project was born of a desire, on the part of people working in and with health services, to see something better for people living in east London from those services. This desire was matched by a capacity and determination to do something about it. As a result, it is planned that the family and community-based health services delivered to people living in Newham, Hackney, the City and Tower Hamlets will be commissioned by a unified FHSA and DHA team, and provided by a new organisation, City and East London Family and Community Health Services (CELFACS).

CELFACS will manage the services provided by both family practitioners and community-based health service staff. The project is focused on the unified commissioning and provision of primary care services: this contribution to the London Monitor discusses the service provision aspect of the project.

The genesis of an idea

The project arose in response to familiar problems:

- the difficulty of co-ordinating family and community health services, with cases of the now-you-see-her-now-you-don't attached community nurse, and the possessive GP (**my** health visitor, **my** district nurse);
- the clearly uneven development of primary care team-working, resulting in some local people having access to professionals who worked with each other, and others not;
- the fact that a lot of work had already been done to secure links between hospital and community-based services (including social services), but so much more needed to be done to secure similar co-ordination between family and other community health services.

All these were frustrations which begged for attention, but they were not, of course, exclusive to east London. The difference in east London was, genuinely, the presence of people willing to give a little more time, energy and thought, to risk a little, to find something better.

Joint work on commissioning between City and East London FHSA and East London and the City HA (the newly formed DHA); the FHSA's suggestion that co-ordination of family and community health services might be addressed if it assumed some management responsibility for community health services; the establishment of GP Forums in City and Hackney, Tower Hamlets and Newham (based on the former DHA boundaries) and their engagement in purchasing: these were all components of a strategy designed to find that 'something better' and to create coherent primary care services.

The publication of Sir Bernard Tomlinson's report on health services in London (Department of Health, 1992) and the Government's response, *Making London Better* (Department of Health, 1993), added impetus to the development of the joint DHA/FHSA work. Tomlinson took the view that, where acute and community services were managed together, it was sometimes to the disadvantage of community-based services. As a result, Newham Healthcare's whole district trust application was referred back, and the Royal London Trust was asked to separate out its acute hospital from its community-based services.

East London faced the prospect of having at least nine NHS trusts to provide its health services – three community, three mental health and three acute trusts, the latter based on the Bart's/Royal London/London Chest, the Homerton (both these arrangements fixed upon also in response to Tomlinson) and the Newham acute services trust. Yet the co-ordination of family and community health services was still no nearer.

At this point the Regional Health Authority (RHA), North East Thames, decided to extend some work it had commissioned in east London in pursuit of its primary care strategy and test out the idea of a 'provider-side' agency which would embrace the family practitioner support and development work of the FHSA and the management of community-based services across east London. It would operate as the Primary Care Development Agency (PCDA) during 1994/95 and give way to NHS trusts which were capable of providing the co-ordinated primary care to which everyone aspired, in April 1995.

During the summer of 1993, a series of focus groups (see Box 1) discussed which services might be better managed from a community base and the

views expressed there led the RHA to propose that a range of services transfer to the provider agency as soon as possible. Comments were sought from several sources, including local government, general practitioners and voluntary organisations and while there were many reservations and objections expressed, there was also widespread support for the creation of the PCDA and for the transfer of services. An amended proposal was presented to the Secretary of State in late August and approved, with the exception of the name given to the organisation, which was changed to make its purpose clear. City and East London Family and Community Health Services came into being on 1 September 1993.

The role of CELFACS

CELFACS has three main tasks:

- to manage the services transferred to it;
- to promote and establish new patterns of care;
- to create new NHS trusts to succeed CELFACS.

The first task is already being addressed with work on 1994-95 contracts and mechanisms for specification development falling to CELFACS before the end of 1993. Responsibility for the day-to-day management of those services cannot transfer formally until the end of the financial year, April 1994, but services will come across to CELFACS on management contracts as appropriate. For example, the locality-based FHSA services (the 'provider-side' of the FHSA, to the limited extent that is a suitable description) will be managed through the CELFACS Project Director.

The second task is to promote and establish new patterns of care that more nearly meet the needs for health services of the very diverse community in east London. Creating pictures in people's mind's eye of how an accessible and acceptable service might look, and then of how such a thing might be organised, absorbs much of the time of the small project team assembled to lead this work.

The final task is to create NHS trusts to succeed CELFACS in April 1995 which are capable of delivering those new patterns of care and developing them still further. Widespread discussion of the basic tenets upon which such organisation(s) should be based began in October 1993 and will be concluded in January 1994. This will allow CELFACS to adopt a management structure from April 1994 which assures a smooth transition from the current situation to the new trust(s).

The project team will be supported by a Panel of Advisers drawn from both professional and lay backgrounds which will perform many of the roles identified to non-executive members of Trust Boards. Dr Diane Plamping, as Chair of the Panel, will undertake a role very close to that of a Trust Chair.

Box 1: The Transfer of Services to CELFACS

Focus groups comprising commissioners, providers and users of the services described below convened during May and June 1993 to discuss the strengths and weaknesses of the services and their vision for the development of each of them.

- Services for elderly people.
- Services for people with a mental illness.
- Services for people with a learning difficulty.
- Services for women.
- Services for children.
- Services for people with a physical disability.
- Rehabilitation services.
- Ophthalmic services.

It was proposed that the following services transfer to CELFACS:

- Community health services, including community nursing, clinical nurse specialists, family planning services, breast and cancer screening services.
- Services for people with a mental illness.
- Services for people with a learning difficulty.
- Physiotherapy, occupational therapy, clinical psychology, chiropody, and audiology.
- Midwifery services in Tower Hamlets and Newham.
- The integrated child health service in Newham and community paediatrics in City and Hackney and Tower Hamlets.
- The integrated service for elderly people in Tower Hamlets, and day and continuing care for elderly people in Newham and City and Hackney.
- Medical rehabilitation.

This is a large and complex piece of work. There are two sorts of issue which tax the minds of those involved in the project as a whole: organisational and developmental. The first leads to overarching policy questions such as the nature of organisation which has both GPs and community health services staff as part of it. Sub-contracting through a main or key provider is now an unremarkable

aspect of securing non-NHS community care services but is it acceptable as a way of securing acute hospital services?

The second set are issues concerned with developing and, in some cases, changing the way we do things in the NHS. How do we make primary care teams real? How do we build creative relationships between purchasers and providers and between co-purchasers and co-providers?

The next two sections provide examples which illustrate the type of issues that will need to be resolved if we are to make declarations of the need to shift from secondary to primary care (or, preferably and more accurately, of the need for proper integration of primary and secondary care) any more than a declaration.

What sort of organisation?

The prospect of having general practitioners 'managed' in the same organisation as hospital and community health services staff must have sent a shiver up many a spine. Would this mean the end of independent contractor status? Would community staff become GP employees? What would happen to fundholders: would they be able to exert influence within the new organisation and if not, would they get another chance through the purchase of services from their 'colleagues'? A lot of issues to talk through: some lateral thinking has proved productive.

Perhaps we have to consider changing the definition of an NHS trust before, or at least at the same time as, we start to think of changing independent contractor status. At present, the status of trusts does not allow them to share some roles and responsibilities with FHSAs (or their successor organisations). At the same time, there seems little doubt that legislative structures which have served in family health services since 1948 (and, some would argue, before that) are not up to today's service policy demands and are an obvious target for change. However, the continuing fall-out from the 1990 GP contract changes and the lack of experience, at the most senior levels, of working with family practitioners offer an unpromising foundation for imaginative change on that front. It may be necessary to change the framework for NHS trusts to account for the rather different needs of organisations committed to integrating the provision of family and community-based health care – often thought of, together, as primary care.

If legislative change is not now an option, integrated management of family and community services may be achieved through a sub-contracting mechanism. Instead of a DHA making contracts with individual practices to provide services outside the General Medical Services contract and paying for these from HCHS funds, contracts could be made with an organisation like CELFACS which could manage delivery against specification by general practices as well as other professional groups. This sort of arrangement should make it easier to support and develop general practices which presently offer a limited range of services, and so release pressure on practices which are already overstretched. There is at least now serious discussion of some of the detailed implications these issues have for the way we organise ourselves, locally and at more senior levels.

Developing and changing the way we do things

The work of the CELFACS team is divided between detailed attention to disaggregating services and budgets, and trying to describe to people what services of the future will look and feel like, for both users and providers of those services. There are many local examples of different ways of doing things: for example, mental health locality teams or patch-based occupational therapy services for elderly people. Talking about these helps people (and staff in particular) form a picture of what it is that integrated management of services can achieve.

A discussion paper, *Shaping family and community health services in east London* (CELFACS, 1993), which tries to articulate further what might be achieved, is out on wide circulation for comment (see Box 2). It suggests that family and community health services providers should offer services which are local, simple to use, offer simple access to more complex services for people with more complex needs, and which are focused on individuals and their families. So far, so good. It goes on to describe a number of things CELFACS and its successor organisation(s) must be able to do in order to actually deliver services like that. These include effecting a lasting marriage between general and special care, recognising that generalist care is, in fact, complex itself, and making user involvement a reality: each one a tall order. What emerges is that in order to make life and services much easier for the people we serve, we will probably make things feel more complicated for ourselves, in the short term, at least. Doing things differently will always seem more pressured.

Primary care teams are a good case in point. On the whole they do not operate in large numbers, anywhere, and those which do are the product of focused, difficult and continuing work on the part of all those involved. Yet, on one hand the primary care team, and the general practitioner member in particular, is often referred to as the building block of the future and on the other, investment in education and support for these teams and in an infrastructure for primary care is variable to say the least. Making sure that an individual knows all the professionals caring for him or her is not new (we are all named, now), but making sure that the professionals know and communicate with each other is another matter. Yet it must be so and we

be, unless the community-based trust – CELFACS in this case – and health authorities insist on commissioner support and involvement in making sub-contracts. If we are to get to the commissioning of care from primary care teams, and to care which is focused on individuals and families, we need to learn how to both commission and to provide 'packages of care'.

Is there a danger of confusing purchasing and providing once again, with the provider of services – CELFACS for example – also purchasing services? That confusion will occur if the so far semantic difference between commissioning, purchasing and contracting for services is not made real. Thus, the DHA will commission, but CELFACS will purchase some services and merely contract for others against the DHA's specification. There is a second issue. We know that the internal market has secured improvements in hospital services, the question remains as to whether the same model can secure benefits in community-based services where long-term and developing relationships between commissioners and co-providers of service are needed.

Directions for the future

Improving primary care has been a developing theme embracing the creation of FHSAs in 1990, the involvement of general practice in the implementation of community care legislation and, most recently, the publication of *Making London Better*. The creation of the London Implementation Zone transformed the lives of those working within it, bringing attention, pressure, opportunities for joint work between statutory and with non-statutory agencies, and (some) money, as never before.

Making those improvements happen, however, and particularly in London, has revealed the true dimensions of the task. At the most macro level are questions about the operation and impact of the internal market in primary care and about the legislative framework required. Does improving primary care really challenge the new orthodoxies of commissioning and the internal market, or is it just that the people who tend to work in those services are, well, unorthodox? Policy development often runs ahead of the legislative framework: what can or should be done to bring them closer together? At a time when we seem for evaluation, but against pilots, we seem also to be for improvement, but against legislating for it, or at least, with the same speed.

At the other end of the scale, 'primary care improvers' are wrestling with pressures on several fronts. Teams are difficult, time-consuming and expensive to build when money and time are in short supply. The legacy of poorly co-ordinated services which brought forth CELFACS in the first place remains to be tackled.

Nevertheless, ideas about primary care development in east London first proposed a year and more ago are now being translated into practicalities and, best of all, desire and determination for change is undiminished.

References

CELFACS (1993), *Shaping family and community health services in east London*, CELFACS, London.

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WHAT DO PURCHASERS DO?
A perspective from South East London

Martin Roberts

Chief Executive, South East London Health Agency

The BBC's 'First Sight' documentary, on 21 October 1993, featured the proposals of Camden and Islington and New River health authorities to shift contracts from more expensive to less expensive providers of health care services. This illustrated several aspects of what purchasers do – and some of the dilemmas.

It served as a reminder, if one were needed, of the highly personal nature of health care and the difficulty which people in inner London perceive they may face in travelling slightly longer distances to other hospitals.

In the documentary, prominence was also given to issues of value for money and cost effectiveness and the implications of the changes proposed on the UCH/Middlesex hospitals. A key part of purchasers' responsibilities is to obtain good value for money; failure confounds the purchasers' principle objective – to improve the health of the local population – by reducing the resources available for investment in those services which may most improve health.

It is this concept of improving the health of the population which should underpin the actions of both FHSAs in commissioning services from general practitioners, general dental practitioners and other contractors, within the confines of nationally negotiated contracts, and of DHAs with their theoretically wider discretion on resource allocation.

Purchaser functions

Moving towards this objective of improving health arguably involves six functions:

- assessing the population's health needs, from both epidemiological and other perspectives;
- identifying effective interventions and delivery systems;
- setting priorities;
- developing service strategies;
- developing implementation programmes and implementing them through others;
- monitoring and evaluating performance.

To undertake these functions effectively purchasing organisations have to become good at using intelligence and communicating with many audiences. These activities require them to interact both with the people to whom they are accountable and with the providers and other organisations who deliver or influence the delivery of services.

A simple example makes the point. One problem identified in parts of Lambeth, Southwark and Lewisham is the high level of terminations of pregnancies, particularly in the case of teenagers. In one locality the views of young people were sought and part of this consultation focused on how their access to family planning services could be improved. The young people wanted these services to be provided at the time of day when they were not expected to account for their whereabouts to their parents. This time was identified as being within one hour of the end of school.

This example also highlights another issue. Effective purchasing contains important micro activity elements carried on in partnership with suppliers or providers. It depends on a clear identification of objectives and detailed working with those who deliver and receive the service. The Government is right to emphasise the need to involve clinicians in the contracting process. Purchasers are unlikely to gain commitment to the contract or get into the necessary level of detail of service provision and effectiveness of outcome without them.

London issues

Set against this general approach, the issues facing London purchasers, although not unique, are particularly intense. They may become more so as the work programme established by *Making London Better* gathers pace. For instance, in South East London, the main issues that SELHA faces are:

- many local health measures are worse than the regional and national figures;
- a reduction in recurring revenue expenditure levels due to the move to weighted capitation targets;
- it is assumed that there will not be a fall in hospitalisation rates over the next five years despite the primary care investment programme;

- the prices charged by some local acute providers are significantly above national average prices, and to date not all providers have been able to reduce prices at the speed necessary to cope with market changes.

The FHSA and DHA are committed to improving community and primary care and are using their own funds as well as those made available through the London Implementation Group and South East Thames RHA to invest in primary and community services. Current expenditure levels in primary and community services have therefore been protected, since it would be inappropriate and perverse to remove the funds already spent on those services in the light of the strategic objective to improve them. As a consequence, reductions in revenue expenditure have to be found in the acute services sector.

The acute hospitalisation rate could be afforded from within the projected acute services budget providing prices fall to national average price levels (excluding London market factors). The Authorities are willing to put out to competitive tender those services, particularly those elective services, which are not required to support GP or accident and emergency admissions to hospital.

There has been a preference for working in partnership with providers over the development of business plans, particularly in respect of those services necessary to support A&E departments and emergency admissions.

Conclusion

So, there are several possibilities, some more likely to occur than others, which would ease the burden faced by purchasers in London:

- a fall in hospitalisation rates;
- a reduction in acute services prices to national levels;
- a reduction in expenditure on primary and community services;
- progressive targeting on effective interventions and key health objectives;
- growth funding.

Naturally at this stage in purchasers' development there is substantial scope for improving efficiency and for delivering primary and community services in ways which assist the acute sector to achieve change. However, it has been argued in London that because of higher than average deprivation, morbidity and mortality, the current weighted capitation formula is inconsistent with the aims of the Health of the Nation and should be changed.

In the short-term the key issues remain the need for decisions on the future number of hospitals in London and the provision of sufficient resources to enable those providers with sound business plans to restructure and reduce prices as quickly as possible. Whilst uncertainty lingers on, patients, particularly those with chronic conditions or facing long-term treatment, may become anxious about the future arrangements for their care and get drawn into the debate. Staff, fighting for the survival of their department or hospital, cannot plan as effectively the transfer of their department or the transfer of care to other units. It is in such situations that the ability to listen could be lost – and with that loss goes the chance of effective partnerships which are vital to effective purchasing.

PURCHASING SPECIALIST HEALTH CARE IN LONDON

Seán Boyle King's Fund Institute
Adam Darkins King's Fund Centre

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Introduction

Decisions are expected in early 1994 which will determine the future shape of hospital services in London and thereby decide how £60 billion of public funds will be invested in health care over the next 15 years. Long-term neglect of fundamental problems associated with health care services in London has led to a need for urgent action (King's Fund Commission, 1992). To avoid decision now, or to temporise, will require the NHS internal market to determine these complex isssues by default. A clear vision is needed of what future hospital services London will require and, if the internal market is seen as the vehicle to deliver this, how it will do so must be made explicit. If the required outcome is cost-effective, accessible and high-quality services in the capital with a minimum of short-term disruption, it appears increasingly likely the NHS Management Executive will have to manage the health care market very carefully.

District health authorities, which previously served London's health care needs, have metamorphosed into purchasing agencies that activate the pseudo-market process by contracting for services from providers of health care. These agencies are resourced from budgets which approximate to their old capitation-based budgets, although in many cases these are being scaled down as the criteria for calculating budgets are reassessed. London's unique pattern of hospital services has a higher cost base and includes more specialist services than elsewhere in the UK. A major reorganisation of these services is occurring in a climate of shrinking resources and at a time when demographic changes suggest that the demands made on health care services are set to increase.

A transitional agency, LIG, has been established (Department of Health, 1993) to help direct investment to manage the changes in London's health care services, but, ultimately, it will be the market, and more specifically the quality of purchasing decisions, and how these decisions are resourced and implemented, which will determine the level of services available to Londoners in the future.

The NHS internal market is often referred to as if it is a mature free-standing organism that developed spontaneously. Although it has become more sophisticated in its operation since it was established in 1991, it remains relatively immature and the agents within it reactive rather than pro-active in response to problems which the market poses. For example, the market has difficulty in reconciling a demand for more localised delivery of emergency care with the more pragmatic approach to purchasing elective care which is developing.

There have been several examples of purchasers planning to move substantial contracts in 1994/95, including Camden and Islington from UCL, and Brent and Harrow from the Wellhouse Trust. The consequences for these providers remain uncertain. Emergency and elective care are not one homogeneous service, and a failure to recognise this may be causing current confusion in the market.

The example of emergency services is potentially more than just a glitch in the system, it may indicate a fundamental flaw requiring management action in the short-term, while a longer-term solution is put in place which will support the market process. The situation at the UCL group of hospitals illustrates concerns in this area and has a general relevance to London as a whole. At UCL the market may have to support a complex infrastructure of specialist services, teaching and research which includes Great Ormond Street and the National Hospital for Nervous Diseases. However, even before specialist provision enters the equation, UCL has faced severe problems contracting for its services, with key purchasers indicating that they wished to place contracts elsewhere in 1994/95. This has forced the Secretary of State for Health to intervene directly in the market in this case.

Recent reviews (Department of Health, 1992) have concentrated on options for the reconfiguration of London's hospital services but have failed to address adequately the context within which such options would operate – the internal NHS market. In 1994, as SHA hospitals enter the market for the first time, the added layer of complexity could have disastrous consequences for health care delivery in the capital. We would argue that, at best, the impact of the NHS market upon specialist care providers is uncertain. It is questionable whether the market, as it currently operates, can sustain teaching and research

activity, or even the specialist care, which most tertiary centres undertake and which in turn will be necessary to sustain the NHS in the long term. This paper discusses several models of purchasing and their implications for tertiary care delivery.

The independent review of specialist services

In June 1993 the results of an independent review of specialist services in London were published (HMSO, 1993). This review was undertaken on behalf of the Government and included six specialties: services for children, neurosciences, cardiac, cancer, plastic surgery and renal services. Although different specialties were covered, two common themes emerged: first that specialist services should be provided in large units, although they may be dispersed over a number of physical sites; and second that specialist centres should be multi-specialty, and not on single-specialty sites as sometimes occurs now. However, there was little discussion of how market structures might develop which are capable of sustaining such recommendations.

Several of the reviews suggest that the size of specialty centres should be determined by the need for a certain critical mass, or volume, of work. A size sufficient to service a population of two to three million people is proposed so as to maintain a level of patient throughput which maximises quality and minimises cost. Having large centralised units, of course, leads to a potential conflict with the aim of providing better access for patients to tertiary care. To overcome this, all of the reviews have outlined what has been referred to as a 'hub and spoke' model of specialist care. Essentially the large specialist unit is the hub serving its potential 'catchment population' through a system of spokes radiating into locally-based general hospitals, general practice and directly into the community.

The reviews preferred a model of specialty centres based on mixed multi-specialty/secondary service sites. The major premise behind this proposition is to prevent specialty services from becoming isolated from other related clinical and support services. However, no direct evidence is given to support the notion that single specialty sites are not viable. In fact, there may be a potential conflict between the need to maintain both the secondary care aspect of the site as well as the tertiary. If neither quality nor cost are sufficient incentives to ensure that purchasers refer for secondary services, then services in the tertiary centre may be at risk. The situation at the UCL shadow trust is an example of this, where the withdrawal of secondary contracts by local purchasers may make it non-viable as a tertiary centre. Paradoxically, in some circumstances the market may be more supportive of a single-specialty site.

No clear model of purchasing emerged from the specialty reviews. The Secretary of State for Health has stated that the purchasing agencies are the lead organisations determining the future shape of health care in London. The responsibility for delivering health care is dependent largely on their ingenuity. Purchasers are being asked to make the market for tertiary services work; to deliver routine patient care as well as research and teaching. If the premises of critical mass and multi-specialty centres are accepted as fundamental to the delivery of tertiary care, and the reviews would seem to have been unaminous on this, what purchasing models can make this complex market function and thrive?

Purchasing tertiary care

Three frameworks for the purchase of tertiary care services are discussed. The first is one where tertiary care is purchased by a higher-level agency, responsible for a larger population. This might occur in several ways. Purchasers could form a cartel of purchasing authorities with responsibility for purchasing specialist care. The purchasing function might then be retained within the cartel or devolved to a separate purchasing agency which carries out this function on their behalf.

Alternatively the higher-level agency holds overall responsibility for the purchase of care for this larger population. This could be restricted to tertiary care or the model might be extended to secondary and primary provision so that, essentially, districts are seen as managing localities for these larger, higher-level agencies.

The second model is 'delegated' purchasing where the purchaser buys a package of care from a local provider, with agreed protocols for the transfer between one mode of care and another. Several models of delegated purchasing are possible. Some higher-level models can be viewed as a form of delegated purchasing. Finally, there is a third system, 'non-delegated purchasing', where the purchaser deals directly with the tertiary provider. In Box 1 it is argued that the purchasing of teaching and research at the individual agency level is unrealistic, and the models developed here reflect this assumption.

Higher-level purchasing

The critical mass assumption means that a specialty centre may serve between seven and ten purchasing authorities of approximately 350,000 residents each. For each purchaser, tertiary care represents only a small proportion of its overall budget. The level of investment necessary to develop sophisticated purchasing arrangements to ensure that cost-effectiveness and quality are delivered may be beyond the capacity of any single purchasing authority, even if teaching and research are ignored.

Box 1: Teaching and Research

It is worth considering whether there is any model of purchasing teaching and research from tertiary centres which allows responsibilty to devolve to the level of individual purchasing authorities. Although the reviews have placed considerable emphasis on tertiary centres acting as the focus for teaching and research, it is not clear how these outputs will fit within a market framework. Tertiary centres have a joint product in terms of care, training and research, and indeed, some non-tertiary centres may have an equal claim to be joint-product sites.

Funding for training and research has tended to be top-sliced and allocated to designated centres. If this were to remain the case, then it is difficult to see how purchasers would have an input into how and where these funds are allocated. On the other hand, if a market solution is to be attained then it is necessary to identify who are the potential agents in the market for these joint outputs. There are significant additional costs associated with both teaching and research which purchasers would need to support financially.

In the most unrestricted market model, purchasers would buy teaching and research from their budgets, which would include an element for these, though this would not be 'ring-fenced'. This would tend to create a disincentive, in the short term, for investment in these areas when faced with supporting the more immediate demands of acute patient care.

On the other hand, if an element of individual purchaser budgets is 'ring-fenced' for teaching and research then there are two immediate problems: firstly that the size of the budget may not justify the disproportionate amount of time required to perform this task adequately; secondly it is unrealistic that tertiary centres have to develop teaching and research programmes from contracts negotiated with several purchasing agencies, some, or all, of which may have differing agendas in these areas. There will be an inevitable need for purchasing agencies to form cartels to liaise and collaborate over teaching and research activity in tertiary centres.

These cartels of purchasing agencies will effectively re-create an organisational tier similar to that of the new regional offices to oversee research and teaching activity in the specialist centres. The Government could allow the present structures to disaggregate, with the attendant disruption and cost associated with this, merely to see the structures re-form, requiring further investment.

An alternative is to accept that a market for teaching and research is beyond the capacity of current purchasing agencies to deliver. Budgets for teaching and research could continue to be top-sliced from purchasing budgets and a pseudo-market for teaching and research operate at a level approximating to the new regional tier within the NHS ME. Specialty centres could then tender for funding to support research and teaching from these organisations, which would also be able to define strategic aims for these activities, sensitive to national and local perspectives.

Some of the specialty reviews in fact proposed that centres with a high standing in the area of international research, such as the National Hospital for Nervous Diseases or Great Ormond Street Hospital should be supported despite the fact that the market for health care alone might not support them. The question of how to manage the market in a way that supports a decision such as this was left unanswered.

Instead, purchasing authorities could delegate contracting for tertiary patient care services to a higher-level agency. An obvious candidate would be the agency that purchases teaching and research. Whether this agency is recreated by cartels of purchasing authorities or whether this function is retained within some existing regional framework is a decision about managing the market. The latter case could be a situation where the higher-level agency exists as an entity with overall responsibility for the health care needs of the larger population, and districts then function as locality purchasers. In the former case such cartels could divide responsibility for purchasing between them, on a specialty basis for example; form a coordinated tertiary purchasing function; or contract with an external agency to purchase on their behalf.

A large higher-level purchasing agency coordinating the purchase of teaching, research and patient care at the tertiary level has many advantages. Its purchasing power will allow it the resources to monitor cost and quality effectively. It will also be in a position to monitor the joint production of care, training and research more easily.

On the other hand, there may be a conflict between the provision of secondary and tertiary care services on a multi-specialty site. The single-speciality site may in fact be easier to manage. The large tertiary care purchasing agency may still not be able to guarantee sufficient contracts for tertiary provider units to survive without contracts from the more volatile secondary care market.

The higher-level agency may have difficulty in reacting to the needs of the cartel of local purchasers to which it corresponds. Equally, in the decentralised model, local purchasers would still need to put in place some means of monitoring outcomes for their populations which included this tertiary care sector. The survival of the tertiary care sector relies on differentiating its product from secondary care. There would have to be review procedures in place which would allow the transfer of some forms of care out of the tertiary sector as these became more commonplace in the secondary sector. This would help to prevent the current situation where, in some instances, purchasers see no difference between an episode of care offered in a tertiary centre and that available locally, except price.

Delegated purchasing

The reviews stressed the need to develop integrated services with the 'seamless' transition of patient care between general practice, community care, and secondary and tertiary care services. Specialist care has to be integrated with secondary and community care. The purchaser may find it difficult and costly to develop the expertise for negotiating contracts with tertiary providers, and so delegating the purchasing of the tertiary care package to a community or secondary care provider may be the preferred option. If the individual purchasers still retain ultimate responsibility for their respective populations, then the higher-level model discussed above could be thought of as a form of delegated purchasing. The difference lies in that the higher-level model generally refers to a situation where there is a well-defined larger population base.

If the contract for a seamless package of care were placed with the community unit, then this unit would negotiate a contract with secondary and tertiary care providers. This model would emphasize the current trend towards care in the community as opposed to hospital-based care by breaking down many of the illusory barriers which exist between community, secondary and tertiary care. It would also allow a method of purchasing tertiary services which was closer in form to locality purchasing.

However, there are disadvantages to this system. The purchaser would still need to develop sophisticated methods of monitoring quality to ensure secondary and tertiary aspects of care are adequate. This system will require communication, and support of community services from secondary and tertiary care services. The joint products of tertiary care become even more complex, and the opportunity costs associated with the different tiers of care more obvious. It will be even more difficult to maintain the product differentiation essential to the survival of the tertiary sector. It will require standards to be legislated and enforced which, in turn, will require liaison with the teaching and research agency.

Similarly, the purchasing of tertiary care could be delegated to the secondary care provider. The secondary care unit then acts as the agent of the purchaser in negotiating a package of care that includes tertiary care. There are several advantages to this model: the process of secondary and tertiary care is well-integrated; the purchasing process is simplified and there is an incentive for the secondary care unit to refer patients on to tertiary care only where necessary.

On the other hand, there are disadvantages. Clinicians in the 'hub and spoke' model working as both secondary and tertiary care providers, would face a potential conflict of interest. Similarly, in a multi-specialty centre, a conflict might exist between the interests of the secondary care unit and the tertiary centre which could be providing competing secondary care services. The purchaser would again have to develop sophisticated measures of quality to assess both the performance of the tertiary centre, and how well the overall package of care was being managed. Again if the joint products of tertiary services that presently exist are to be preserved it will require standards to be legislated and enforced which will require liaison with the teaching and research agency.

A third alternative of delegation to a larger purchasing agency, either formed by a cartel of several purchasers, or an agency independent of the constituent purchasers, has been considered in the discussion of higher-level purchasing above.

Non-delegated purchasing

This model assumes that each purchasing agency will develop contracts itself with tertiary centres for specialist services. It approximates to the present model of purchasing for secondary care services. Purchasing agencies may negotiate block contracts with some provider units, but the relatively small number of referrals in some conditions may mean a lot of the care will be negotiated as extra-contractual referrals.

The purchaser negotiates directly with the tertiary centre on the quality and the cost of the services provided, and so has a direct input into service specification and can ensure quality. The purchaser is free to negotiate with adjacent tertiary centres and this will introduce an element of competition. For example, a purchaser in Buckinghamshire could negotiate with provider units in Oxford, west London or north west London. On the other hand, this element of competition may have a potentially destabilising influence.

This model, with seven to ten purchasing agencies with regular contracts with the tertiary care centre, may also lead to a problem with equity. Different purchasing agencies may define packages of care differently such that patients in

adjacent beds, with the same condition requiring similar treatment, receive a differing quality of care depending on the lottery draw of from which locality they came.

If the individual purchasing agency is truly freed from a direct need to consider teaching and research in the tertiary care centre, then the tertiary care product is no longer seen as a joint product. The purchasing authority may then purchase care from a hospital which provides some similar services to a tertiary centre, but without the teaching and research, and hence at a cheaper price. The existence of such unfair advantage may undermine the tertiary care centre. Again, if this style of market is to work it may be necessary to legislate so as to ensure that sufficient contracts are placed in tertiary centres. The process of reviewing and defining what constitutes a joint product will require a permanent need to manage the market in this way.

General purchasing lessons from London

The problems facing hospital services in London are complex and long-standing. Destabilising pressures are already being exerted by the market. The review process itself may be blighting some centres as contracts are removed by purchasers in the expectation of closure. Other contracts are switching in response to cheaper contract prices elsewhere.

Building, salary and other costs are higher in London than outside and have traditionally entered the equation in terms of larger budgets for London DHAs. However, the market framework presents the choice of meeting legitimate excess costs in London by a direct subsidy to the provider or by a capitation supplement passed on to the purchaser. In a free market, the purchaser is not constrained to use this supplement to sustain existing services within London. Equally, the provider may go out of business regardless of the subsidy, if it is still unable to obtain sufficient contracts.

How the purchasing of tertiary services is resolved in London will have a crucial impact on the provision of tertiary care services in the rest of the country. Whatever model or models of purchasing are adopted it is difficult to see how the Government can avoid managing the market for tertiary care services to some extent. While teaching and research remain outside the market system, and it is unlikely that they can be brought into a completely free market, then some protection will have to be offered to the tertiary care centres which have been selected for survival. It seems clear that the Government will have to manage this market until it develops the sophisticated structure required. This commitment may be indefinite.

Such a structure would eventually embrace primary health care services and community services. Changes in hospital services require strategic thinking including a careful consideration of how to manage change. Individual purchasers, already facing the challenge of maintaining existing secondary services and developing new ones for the whole range of health care provision, will be hard pressed to develop adequate models of purchasing for the tertiary sector. There is a clear case here for central direction if the trinity of quality, cost-effectiveness and access are to be protected.

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STANDARDISED ILLNESS RATIOS FOR LONDON

Roselyn Wilkinson

Census Research Officer, King's Fund Institute

Introduction

For the first time in a British population census, the 1991 Census included a question on the health status of enumerated persons. Whereas in previous decennial censuses it was possible to identify adults (of 16 years and older) who are permanently unable to work because of sickness or disability, the 1991 Census Health Question provides information on the health status of the whole population, regardless of age or economic position.

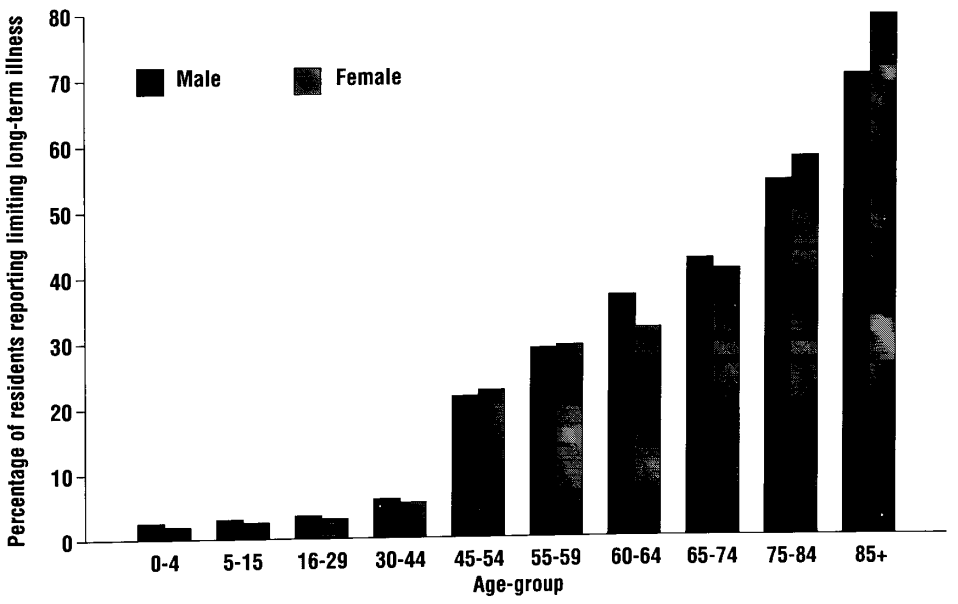
Using this data, in this article we look at the health status of the populations of London health purchasers. The two Census questions relating to illness are age and gender standardised for each London purchaser to provide a clearer picture of the reported health status of Londoners. A pattern emerges which suggests a marked difference between inner and outer London.

The impact of age and gender

Preliminary analysis by the London Research Centre (LRC) of the Census Health Question on limiting long-term illness (LTI) has shown considerable differences in self-reported illness rates between different population groups (Jones, 1993). In particular the LRC found that whereas 13.1 per cent of the population in Great Britain as a whole reported a limiting long-term illness, this proportion falls to 11.8 per cent in London. There is considerable variation within the capital with the boroughs of Kingston-upon-Thames and Kensington & Chelsea recording the lowest incidence at ten per cent and Hackney the highest reported rate at 14.4 per cent.

On this basis the population of London would

Figure 1: Limiting long-term illness in Greater London, 1991



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seem to report less illness than is the case in the rest of Britain. However, as Figure 1 shows, the incidence of limiting long-term illness is strongly correlated with age. In London, over half of all residents aged 75+ reported long-term illness, compared to a reported rate of just 2.5 per cent for 0-15 year olds. The pattern of gender differences, though less straightforward, may also be important.

To explore differences in self-reported illness between areas, it is clearly necessary to standardise for both age and gender. For comparison purposes, we have also provided standardised ratios for adults who reported that they were 'unable to work because of long term sickness or disability' in response to the 1991 Census question on economic activity. These two questions were separate on the Census form and are not necessarily the same measures of morbidity, although almost all adults who were permanently sick also reported long term illness. Figure 2 shows the different pattern of reporting of permanent sickness.

Standardised illness ratios

The pre-tabulated layout of the 1991 Census statistics determined the analysis options to some extent. Census data are available for two population bases – 'all residents' and 'residents in households'. The latter includes all those persons who usually live at a local address, even if they were temporarily absent on Census night.

'All residents' includes household residents and persons present in communal establishments if this was recorded as being their 'usual address'. As a general rule, a stay of six months or more in the same home or hospital classified an individual as being a resident there. This was the base chosen for this study as it is the more inclusive.

Local area populations were age-standardised using the age bandings found in the Local Base Statistics LTI tables. The data for 16-17 year olds have been combined with the 18-29 age grouping and the standard population base is England.

The health purchaser boundaries reflect the reorganisation of administrative areas for the purchase of health care which resulted in a considerable reduction in the number of old District Health Authorities (DHAs). For the purposes of this study these boundaries are co-terminous with the April 1991 Local Authority boundaries, except for six Putney wards of Wandsworth LA which are part of Kingston & Richmond health purchasing agency. Esher in Surrey is also part of the Kingston and Richmond agency.

Table 1 shows the calculated standardised ratios for both Census health questions – what we have termed the standardised illness ratios (SIRs) and standardised permanent sickness – alongside the standardised all-age mortality ratios (SMRs) for 1992 taken from the Public Health Common Data

Figure 2: Permanently sick in Greater London, 1991

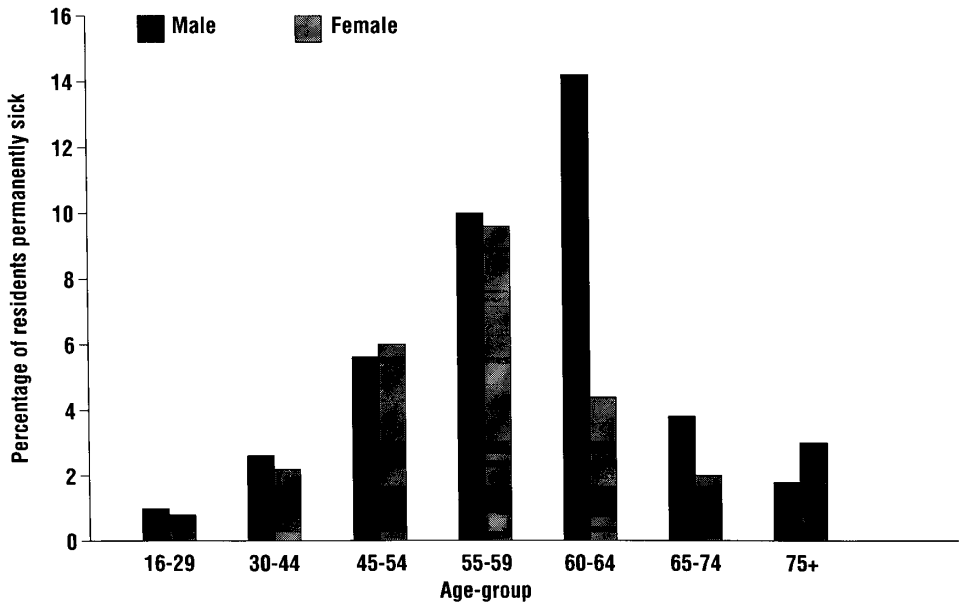

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Table 1: Standardised Ratios for London Health Purchasers

HEALTH PURCHASERS	SIRs	STANDARDISED PERMANENTLY SICK	SMRs
East London & the City	127	144	108
SELHA	113	119	105
Camden & Islington	112	123	101
Wandsworth	103	108	110
Kensington, Chelsea & Westminster	89	89	93
Inner London	112	120	103
Ealing, Hounslow & Hammersmith	100	99	98
Redbridge & Waltham Forest	99	93	93
New River	99	94	94
Barking & Havering	96	86	97
Bexley & Greenwich	96	84	95
Brent & Harrow	94	87	88
Croydon	89	76	98
Hillingdon	85	67	91
Merton & Sutton	85	68	88
Barnet	84	70	92
Bromley	82	62	87
Kingston & Richmond	80	65	88
Outer London	92	82	93
Greater London	98	94	96

Source: OPCS Crown Copyright

Set (1993). There is a striking dichotomy between the figures in inner and outer London for all three variables, although in the case of the SMRs the difference is less, both between inner and outer London, and London and the rest of the country. A notable exception in inner London is Kensington, Chelsea and Westminster, which is well below the national average on all three measures, and on this basis alone fits better the outer London pattern, where no district is higher than the national average.

Using a different population base, the School for Advanced Urban Studies (Forrest and Gordon, 1993) has produced standardised limiting long-term illness ratios for each local authority district in England. They found that the principal cities – Manchester, Liverpool, Newcastle-upon-Tyne, Sheffield, Birmingham and Leeds – all have above average illness ratios, ranging from 105 in Leeds to 140 in Manchester. This is not, however, an exclusively large, inner city phenomenon. The greatest concentrations of high SIRs occur in the North, North East and East Midlands, typically the industrial areas of the Pennines, Tyne & Wear and Nottinghamshire. The inner London districts certainly stand out as the exception in the South of England.

Conclusion

Figure 3 shows a distinct difference between inner and outer London for all three measures of ill health considered here. The inner London SIR is over ten per cent above the national average, whilst the outer London SIR is almost ten per cent below. The Permanently Sick variable shows an even greater difference between inner and outer London: 20 per cent above the national average compared to 20 per cent below. The SMR exhibits a much smaller differential between inner and outer London, and indeed between London districts and the rest of the country, suggesting that the Census health questions are picking up differences which

Figure 3: Standardised ratios for inner and outer London

Source: OPCS Crown Copyright

are not reflected in the SMRs.

Looking at the picture in London overall, Table 1 reveals that the Greater London SIR, at 98, is close to the national average, rather a different picture from that shown earlier when a comparison of crude illness rates showed London some ten per cent below the national figure – 11.8 per cent compared to 13.1. This clearly illustrates the importance of looking beyond crude rates of morbidity or mortality when making comparisons between one population and another.

The two Census health questions, in conjunction with other Census data provide a new and unique opportunity to explore the geographic and socio-economic dimensions of the health status of Londoners.

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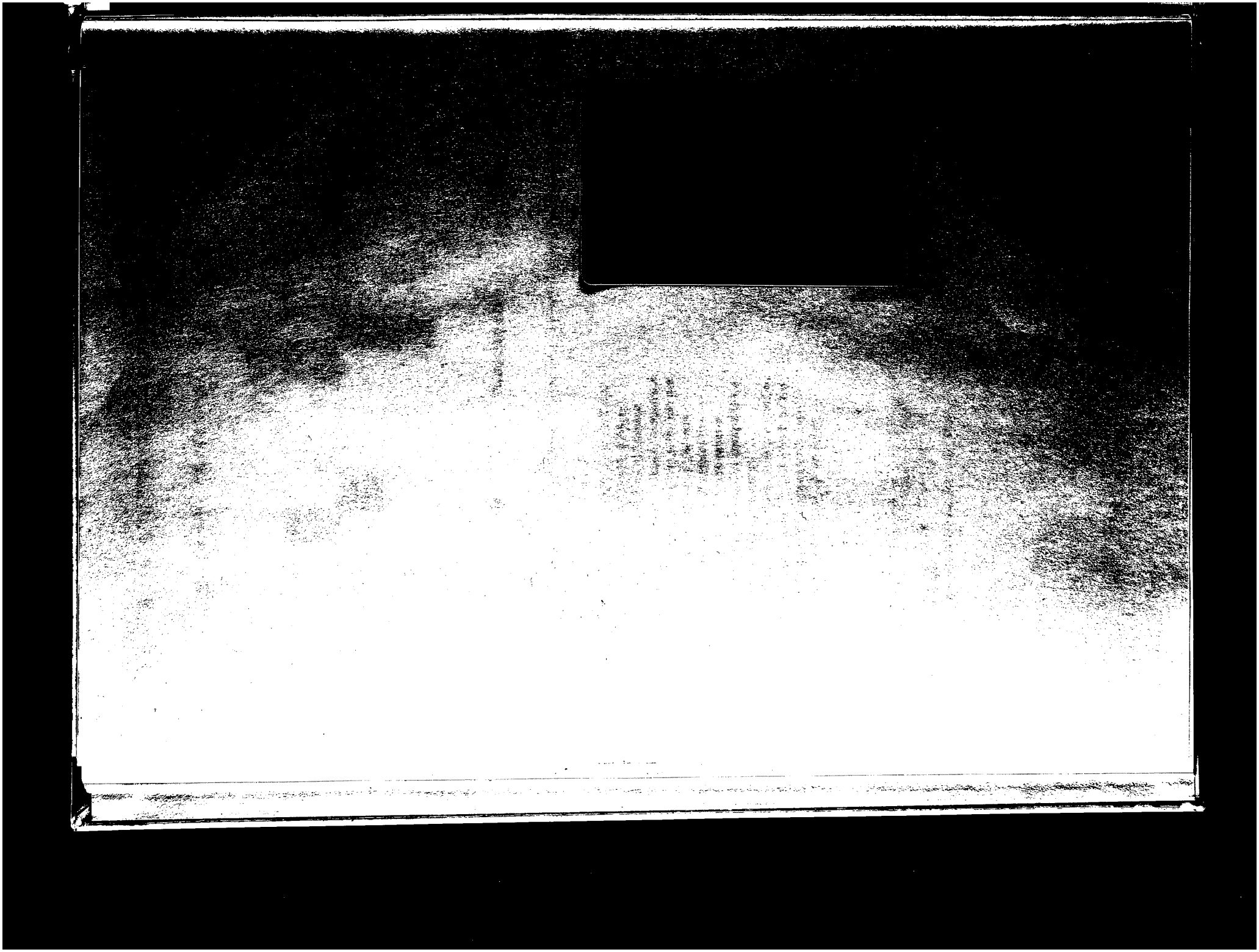

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