

LONDON STRATEGIC REVIEW

INDEPENDENT ADVISORY PANEL

*Richmond House
79 Whitehall
London
SW1A 2NS*

Rt Hon Frank Dobson MP
Secretary of State for Health

18 November 1997

Dear Secretary of State

I enclose our report of the Strategic Review into London's health services. The attached Executive Summary sets out our detailed recommendations. We have drawn on existing extensive sources of information and sought advice widely from those responsible for using, planning and delivering health services in London.

We found a health service under pressure. Services across the whole spectrum of care, from those in the community and primary care to those in the hospitals, were sorely stretched. Although the impact of these pressures were most keenly felt in the care of elderly people and those with mental illness, others were not immune from failures to meet an acceptable standard of service. Furthermore, there is evidence to suggest that the pressures are increasing. Despite all this, health care workers are doing the best they can and we found examples of good practice, even in circumstances of severe pressure.

Here, we make proposals about how London's health services can be planned equitably and rationally across the whole of London and how the organisation required for their delivery at the local level can be best achieved. At all levels we press particularly for improvements in the ways in which the various parts of the health service can work more closely together and in which the NHS can plan and deliver services jointly with local authorities.

We make proposals aimed at improving the standards of primary care which lags behind the remainder of the country in a number of ways. We also point to the need to provide more intermediate and other types of community care. We pay special attention to recommendations about mental health services. In the hospitals we draw attention to the fact that London as a whole does not have more beds than elsewhere in the country and that rationalisations being proposed should not result in losses of beds overall.

We have spent much time assessing a number of specific plans for rationalisation of hospital services and have made what we hope will be helpful proposals. We realise that such difficult and usually controversial issues evoke strong reactions. We believe however that our proposals are realistic and rational given the circumstances which we discovered.

I hope you will find the report helpful in your efforts to improve London's health services.

LESLIE TURNBERG

CONTENTS

Page

Summary of Recommendations	1
Terms of Reference: Panel members: acknowledgements	7
1. Introduction	9
2. Factors influencing health needs in London	11
3. Recent changes in London’s health services	17
4. Planning and providing services; breaking barriers to effective joint working	23
5. Involving Londoners in London’s health services	29
6. Primary Care	33
7. Intermediate and Community services	41
8. Mental Health services	49
9. Hospital Care	55
10. Queen Mary’s Hospital Roehampton	65
11. Harold Wood & Oldchurch Hospitals	69
12. Proposals to rationalise services in The Royal Hospitals NHS Trust	73
List of contributors: Appendix	79

SUMMARY OF RECOMMENDATIONS

CHAPTER 4: PLANNING AND PROVIDING SERVICES: BREAKING BARRIERS TO JOINT WORKING

1. Here we focus on ways in which a pan-London oversight of London's health needs can be developed, and in which plans can be effectively delivered locally.
 - 1.1 The two Thames Regional Offices should enhance their working relationships now to ensure coherent strategic planning across London with a single London Regional Office as a longer term aim. Greater powers should be accorded them by Government, so that they can ensure that agreed-plans are implemented.
 - 1.2 Services of a specialised nature should be commissioned at the level of the five sectors into which London can be divided, each relating to the new University of London medical school groupings and covering populations of about 1.5 million. Health authorities should work together at the sectoral level to achieve these ends, and to monitor local commissioners and providers. Local commissioners should be required to develop and review plans in each sector with 5 and 10 year targets for specialist services and for training and research.
 - 1.3 There are several possible models for commissioning services at the local level. While not being prescriptive, we can commend the pilot locality commissioning projects in which about 60–70 GPs provide and commission services for populations of about 100,000. Other models of locality grouping of primary care teams may also prove effective.
 - 1.4 At all levels, especially at locality level, close working with local authorities is essential. Joint working with agreed plans, supported by agreed funding, should be required of health authorities and local authorities. Co-terminosity 'between locality commissioning groups with local authorities, probably three locality commissions per local authority, will facilitate joint work.
 - 1.5 A number of supporting recommendations are made:–
 - a) Primary care, mental health and community health services should be priorities for the pan-London strategic planners until such time that these services have improved to the levels available in other parts of the country.
 - b) Public health strategies should be included on the planning agenda, with relevant representation at joint planning levels.
 - c) Developments should be monitored and evaluated before being generalised.
 - d) We recommend further work on mechanisms to spread good practice and the institution of accurate information systems. Competition within the NHS should not impede communication. Methods of achieving this should be explored with positive incentives to improve and reward good collaborative work within and outside the NHS.

- e) We welcome the Government’s creation of a working party to review the resource allocation formula and its study of the implications of its findings for London. We recommend that the possibility of using GP lists (with anti-inflation measures) be investigated as the population basis for resource allocation. We also recommend rapid implementation of the working party’s review. This review should link with the parallel review of the funding formula for London local authorities.
- f) We recommend that the NHS Executive be given the task of analysing the substance of the evidence submitted to the Panel, and incorporating the findings in their work on setting planning and priority guidelines for the NHS.

CHAPTER 5: INVOLVING LONDONERS IN LONDON’S HEALTH SERVICES

- 2. Here we explore ways in which greater public involvement in health services can be facilitated,
 - 2.1 Health authorities and NHS Trusts should draw up improved local strategies for public consultation and involvement. Focus groups, surveys and citizens’ juries are examples of feedback mechanisms which are helpful and we recommend that the expertise of local authority social services and other departments in effective local consultation should be drawn upon. Closer working with local authorities in these efforts is encouraged.
 - 2.2 Existing NHS Executive guidance on public consultation should be urgently reviewed.
 - 2.3 A positive communications strategy to facilitate debate on London’s health services should be developed at the pan-London level.
 - 2.4 Two other recommendations are worthy of note:
 - a) Health authorities and NHS Trusts should be encouraged to make full use of the opportunity provided by the NHS 50th anniversary to communicate and engage with the local communities they serve.
 - b) Health authorities and NHS Trusts need to ensure that local services meet the needs of people from diverse ethnic minority communities, and further efforts should be made in recruiting staff from ethnic minority backgrounds. This should be monitored annually.

CHAPTER 6: PRIMARY CARE

- 3. Here we make recommendations to improve the overall standard of primary care and to increase recruitment into general practice.
 - 3.1 The number of general practitioners practicing in London should be increased proportionally to match the rest of the country. Levels of deprivation should be taken into account, and action to achieve this

should reflect the recent recommendations of the Medical Practices Committee for introducing adjusted lists for “really equitable distribution”.

- 3.2 Flexibilities in employing and rewarding general practitioners should be explored further to improve recruitment and retention rates. This should include options such as the extension of opportunities for salaried employment and reward systems for GP principals.
- 3.3 Further consideration should be given to ways in which the support for single handed GPs can be maximised through other employers such as community services or acute services NHS Trusts.
- 3.4 The role of nurse specialists working with a number of primary health care teams in defined areas in London should be further developed and expanded.
- 3.5 Options for improving recruitment and retention within the primary health care team should be developed as a priority. This should include exploration of ways of improving opportunities for further training and career development for non-medical professional staff. Workforce flexibilities should not be limited to single and two-handed partnerships, in order to encourage the development of primary care teams.
- 3.6 London’s health authorities should be required to ensure that the proportion of practice premises which are below minimum standards should be reduced from the current 50% by 10% annually. Funding for cash-limited GP premises nationally should be related to the proportion of practice premises which are below minimum standards. The Regional Offices should ensure that there is co-ordinated advice and support for general practitioners on all aspects of premises provision for London.
- 3.7 Formal and informal arrangements to bring together general practitioners within localities should be promoted (see Chapter 4).
- 3.8 Current LIZEI projects should remain in place until their evaluation is complete.
- 3.9 Action should be taken to introduce compatible general practice computer systems.

CHAPTER 7: INTERMEDIATE AND COMMUNITY SERVICES

- 4. A range of ways in which care in the community setting might be enhanced is detailed in this chapter.
 - 4.1 We recommend that health authorities should explore further provision of intermediate care facilities, with beds, for rehabilitation, recuperation and respite care. This should provide more appropriate care for patients not requiring hospital services. Health authorities and NHS Trusts should examine ways of making good use of existing NHS estate to provide local and easily accessible care. Research will also be needed into the costs and effectiveness of intermediate care and we so recommend.
 - 4.2 Action should be taken to ensure the rational planning and delivery of a range of community and acute services (see Chapter 4) and we commend the approach suggested in the Audit Commission report *The Coming of Age* to stimulate work in achieving improved co-ordination in services for elderly people.

- 4.3 Action should be taken to develop further the strategy for child health services.
- 4.4 Community services NHS Trusts are not all achieving their potential and we recommend that further work is done to review how they will fulfil their roles and to encourage close working with primary care and hospital services.
- 4.5 Supporting recommendations include:-
- a) Nursing staff provide a key link in the smooth transition between different types of care. Efforts should be made to maximise their role in this activity.
 - b) Ambulance services should be encouraged in their efforts to provide a more flexible service to support emergency and other care in the community.
 - c) Ways of supporting team working and overcoming barriers which arise from strict role demarcations should be sought.

CHAPTER 8: MENTAL HEALTH SERVICES

5. Here we make recommendations to try to improve serious deficiencies in mental health services.
- 5.1 Central direction to secure improved co-ordination of NHS, local government and other services, including health, social services, housing and the criminal justice system should be provided by Government.
- 5.2 The development of a mental health strategy for London should be a key task for the NHS Executive across London. The two Regional Offices should work together in generating a pan-London strategy pending the institution of a single Office.
- 5.3 There is a need for greater investment in a range of community services for patients with mental illness. Joint planning and funding, as recommended in Chapter 4, should help ensure that mental illness receives the greater attention it deserves.
- 5.4 Minimum standards of services applicable across London should be developed. These should include maximum waits for appropriate residential care, speed of response of community teams, and availability of 24 hour support services.
- 5.5 Hospital acute psychiatric services should be enhanced pending more investment in and development of community services.
- 5.6 Further work is recommended:-
- a) to assess whether the current weighted cavitation formula reflects the burden of mental health need in London.

- b) on more innovative approaches to resolving skills and staff shortages with the aim of maximizing support for staff caring for violent patients; helping to overcome the isolation of some staff working within psychiatric units: and freeing up highly qualified staff to develop services.
- c) mental health databases and information management systems should be harmonised and information management systems developed taking account of current initiatives in this area.

CHAPTER 9: HOSPITAL CARE

6. Here we take account of the fact that there is not an excess of beds in London in making recommendations about directions of change in general and about some specific hospital plans.
- 6.1 Health authorities and NHS Trusts should plan services for the local, sectoral and pan-London populations in a co-ordinated way. Our recommendations on planning at sectoral and pan-London level are designed to address this issue. The University of London Colleges have provided a valuable model for rationalizing activities across several sites which could be emulated.
- 6.2 There should be greater clarity about funding for tertiary services so that potential conflicts with funding for local communities are avoided.
- 6.3 Hospitals in the “outer ring”, away from the centre of London, should be supported and services planned in relation to the local needs of the communities they serve and the need to work closely with tertiary centres, largely in their own sector.
- 6.4 Accident and emergency departments should not close unless the conditions described in Chapter 9 are met. Facilities, such as Minor Injuries Units, should only be introduced with properly developed and managed communication plans locally to ensure that these are well publicised.
- 6.5 **Guy ’s/St Thomas’ proposals:**
- (a) the closure of Guy’s Hospital A&E department should be carefully re-evaluated to ensure that services are able to cope.
 - (b) Before proceeding with major capital development on the St Thomas’ site, the Guy’s and St Thomas’ NHS Trust needs to demonstrate the validity of its plans.
- 6.6 **Hammersmith Hospital**
- A long term plan should be developed for the Hammersmith Hospital, to ensure that its role in national and international research is fostered. Rational plans for service distribution across the sector should be encouraged to help achieve this aim.

6.7 The plans for development of the Queen Elizabeth Hospital, Greenwich, and for UCLH are supported by the Panel. We also believe the Whittington and Newham Hospitals are in urgent need of capital investment.

6.8 London’s hospitals need more effective ways to address problems in recruiting and retaining nursing and other professional non–medical staff. This should include action to support the changes introduced in nurse training and education, improvements in the physical environment in which many staff work, and innovative recruitment initiatives that attract staff into the health service.

7. CHAPTER 10: QUEEN MARY’S UNIVERSITY HOSPITAL, ROEHAMPTON

7.1 We consider that the option preferred by the local Steering Group provides a reasonable solution. However, we expect local views to be fully considered in the consultation process, which should be followed with a commitment to deliver the eventual outcome.

7.2 There is a need for a clear, unambiguous commitment to fulfil a credible plan which sets out where patients will be cared for, both immediately and in the longer term. The solutions for these two timescales may not necessarily be the same.

8. CHAPTER 11: HAROLD WOOD AND OLDCHURCH HOSPITALS

8.1 We endorse the single site Oldchurch area proposal as optimal on the grounds of access to a large proportion of the most deprived population and the strong support from the local authorities and GPs. Further work is necessary to develop this solution to show it is based on a sound financial footing in the local health economy.

9. CHAPTER 12: PROPOSALS TO RATIONALISE SERVICES IN THE ROYAL HOSPITALS NHS TRUST

9.1 We recommend a package of services to meet the needs of the deprived local population, and also to ensure that tertiary services and teaching and research responsibilities are supported. These proposals will need to be kept under review as health care needs, and ways of meeting them, change over the years.

9.2 Investment in intermediate care beds and community services should be made now and advantage taken of the recent Government initiatives on community services for elderly people.

9.3 Capacity at Homerton and Newham General hospitals should be fully utilised.

9.4 A new hospital at Whitechapel is sorely needed and should include about 900 beds for secondary and tertiary care.

9.5 Some tertiary services should be maintained on the Smithfield site with a particular focus on cardiac and cancer services.

TERMS OF REFERENCE

On 20 June 1997 the Secretary of State for Health announced a review of London's health services to be undertaken by an independent advisory Panel. The Panel was asked to ensure a coherent approach to planning health services in London. It was to advise the Minister for Health on the development of health services in London which are effective, efficient and fair and also to advise on how best to maintain the pre-eminent role of medical education and research in the capital.

The Panel consisted of

Professor Sir Leslie Turnberg (Chairman)
Past President,
Royal College of Physicians

Miss Francine Bates
Assistant Director,
Carers National Association

Professor Ian Cameron
Provost and Vice Chancellor,
University of Wales College of Medicine

Professor Brian Jarman
GP and Professor of Primary Healthcare,
Imperial College School of Medicine

Miss Denise Platt -
Head of Social Services and Health,
Local Government Association

The Panel were supported in their work by the NHS Executive Regional Directors in North and South Thames and a small secretariat based in the Department of Health, led by Ann Stephenson, and assisted by Mary Grafton, Carol Heard and Rebecca Webb.

The Review's terms of reference were:

- ◆ to undertake an independent review of health services in London based on the available data and published literature, and commission further work as necessary;
- ◆ to advise in particular on the future of St Bartholomew's Hospital and of Queen Mary's Hospital, Roehampton, and on the changes proposed in relation to Harold Wood and Oldchurch hospitals;
- ◆ to ensure coherence in health authority and NHS Trust plans - including proposals for capital investment:

- ◆ to review health authority plans for 1998/99, ensuring that the Government's priorities are being effectively pursued and that people living in every part of London have ready access to healthcare facilities that meet the Government's vision for London's health services;
- ◆ to work in partnership with the NHS Executive to establish the financial implications of any proposed service changes, including their impact on other services, within the framework of the resources available to the NHS in London.

Over 200 organisations including NHS Trusts, London Boroughs, Health Authorities, Community Health Councils, Members of Parliament, Royal Colleges and Voluntary Bodies were invited to submit written evidence. A programme of meetings and visits were also undertaken to provide the opportunity to listen to a wide range of views and concerns about the future of health services in London. Over 1,500 letters were received from the public expressing their views and concerns.

We are grateful to all the individuals and organisations who submitted written and oral evidence and participated in the meetings and visits which enabled us to build up the detailed picture of London's health services necessary to write this report.

1: INTRODUCTION

1. Our highest priority has been to address the question of equitable access by Londoners to services which they should be able to expect from the NHS. We recognised the need to re-establish public confidence in its health service. With this in mind, we have tried to analyse health and related social care provided by each of the separately funded and managed parts of the NHS, by local authorities and by other organisations.
2. In focusing on the health requirements of Londoners, we were conscious of the need to ensure that our recommendations would not damage the ability of London's medical schools to fulfil their nationally, and internationally, important teaching and research roles. We were aware, too, that there has been considerable progress in the reorganisation of London's medical schools and that the overall direction of change seemed both necessary and appropriate.
3. In the light of these findings, we paid particular attention to the need for more and better community-based care, including care for those with mental health problems, the availability of beds to cope with the rising trend in hospital admissions and the severe pressure on in-patient facilities in many parts of London.
4. We invited a wide range of individuals and groups to contribute written evidence: all London's health authorities and NHS Trusts, local government bodies, Members of Parliament, and a range of voluntary, professional, and academic groups were approached. We also embarked on a series of visits and discussions to form an impression of services on the ground and we met representatives of patients and service users as well as staff in contact with patients, senior clinicians and managers.

Agreed principles

5. We have developed a number of principles as guides to our task:
 - ◆ Patients need and deserve high quality care in all parts of the health service, recognizing that their views should be at the heart of decision-making.
 - ◆ We should focus on health services for Londoners, not simply health services that happen to be provided in London.
 - ◆ Boundaries between services should not be allowed to create barriers to care.
 - ◆ We should aim to encourage experiment, innovation, and good practice, not to try to impose a single model.
 - ◆ We acknowledge that there is a tension between encouraging local diversity and ensuring equity in a national health service.
 - ◆ It is critical that health services interact effectively with the public health agenda.

2: FACTORS INFLUENCING HEALTH NEEDS IN LONDON

1. London is the largest city in Europe and home to 12% of the British population. Although London's health problems have similarities with those of major conurbations elsewhere in England, the extent of these poses particular difficulties and exerts high demands on health services. These have been well rehearsed in previous publications but some key issues are summarised here.

Demography

2. The population of London has some very specific characteristics. There are areas of great affluence in close proximity to those of extreme deprivation – see Figure 1. Of the 564 most deprived electoral wards in England and Wales, 39% are to be found in London¹ – 1170 are in the East London and the City Health District. This includes the most deprived population in the country, within the London Borough of Tower Hamlets (the next most deprived being Hackney, Southwark, Newham, Manchester, Islington and Lambeth – in that order). There is evidence to suggest that rates of emergency admissions to hospital are linked to levels of deprivation – see Figure 2.
3. Almost 45% of Great Britain's ethnic minority population lives in London². Within that population, there is significant diversity of ethnic origin, culture and language. Around 100,000 people in London are refugees or are awaiting confirmation of refugee status. Some 85% of people who have been granted refugee status have settled in London, the majority in inner London.
4. Up to 79,000 individuals are estimated to be homeless in London³. This figure does not include thousands of unofficially homeless people, the majority of whom are single people living in hostels, temporary accommodation, with friends or sleeping rough. Estimates are that this population is over 109,000 – the largest group being the “hidden homeless”.⁴
5. The 1991 Household Condition Survey showed that 13.5% of all housing in inner London was unfit for human habitation. The effects of unfit and poor quality housing on health are well documented. London has a preponderance of one person households (31.9%). This factor is associated with a higher prevalence of mental illness and the need for greater individual support. There is also a need for increased support for elderly people living alone.

¹Underprivileged Area Scores

²1991 Census data

³Shelter

⁴London Research Centre

FIGURE

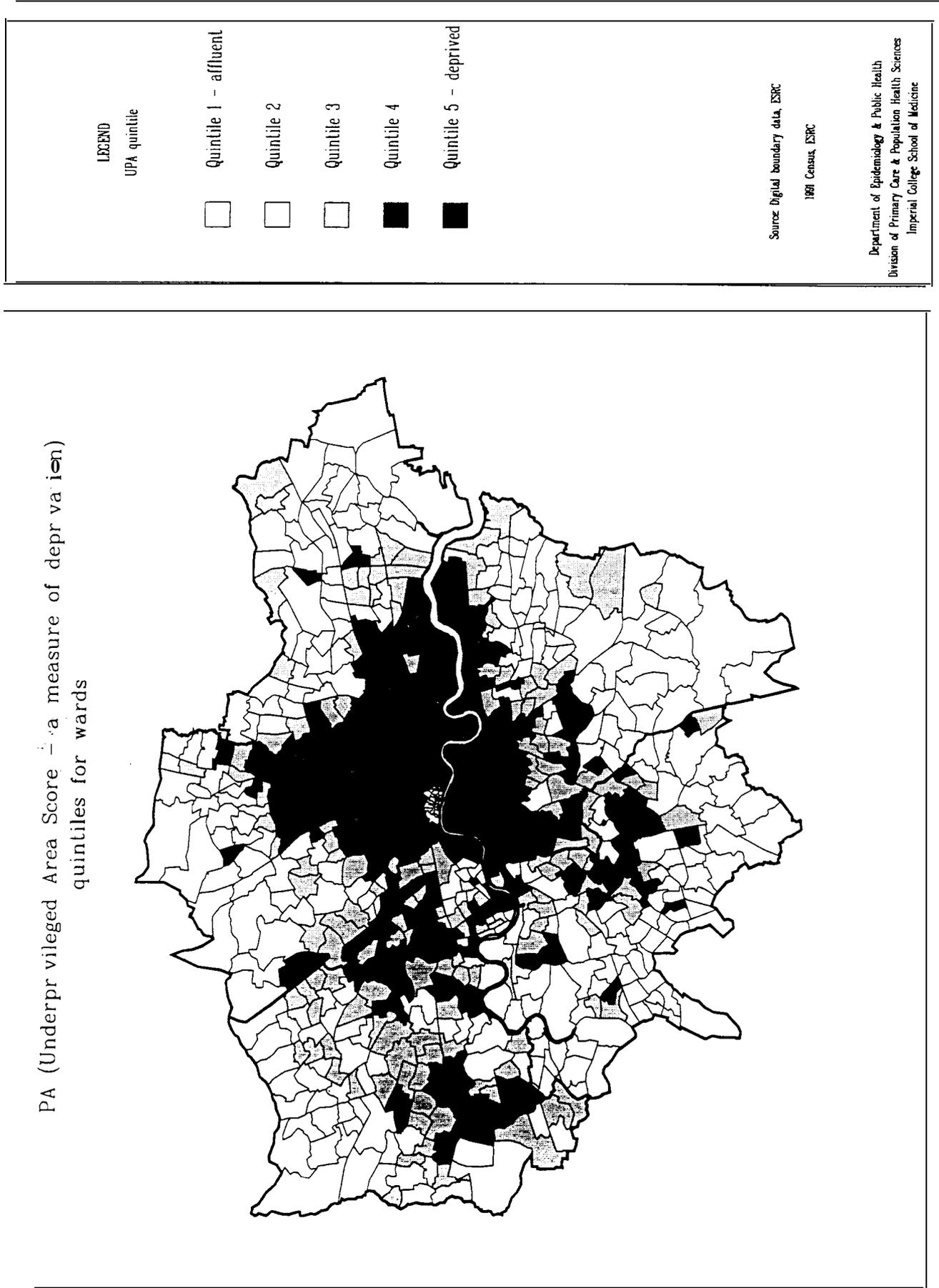
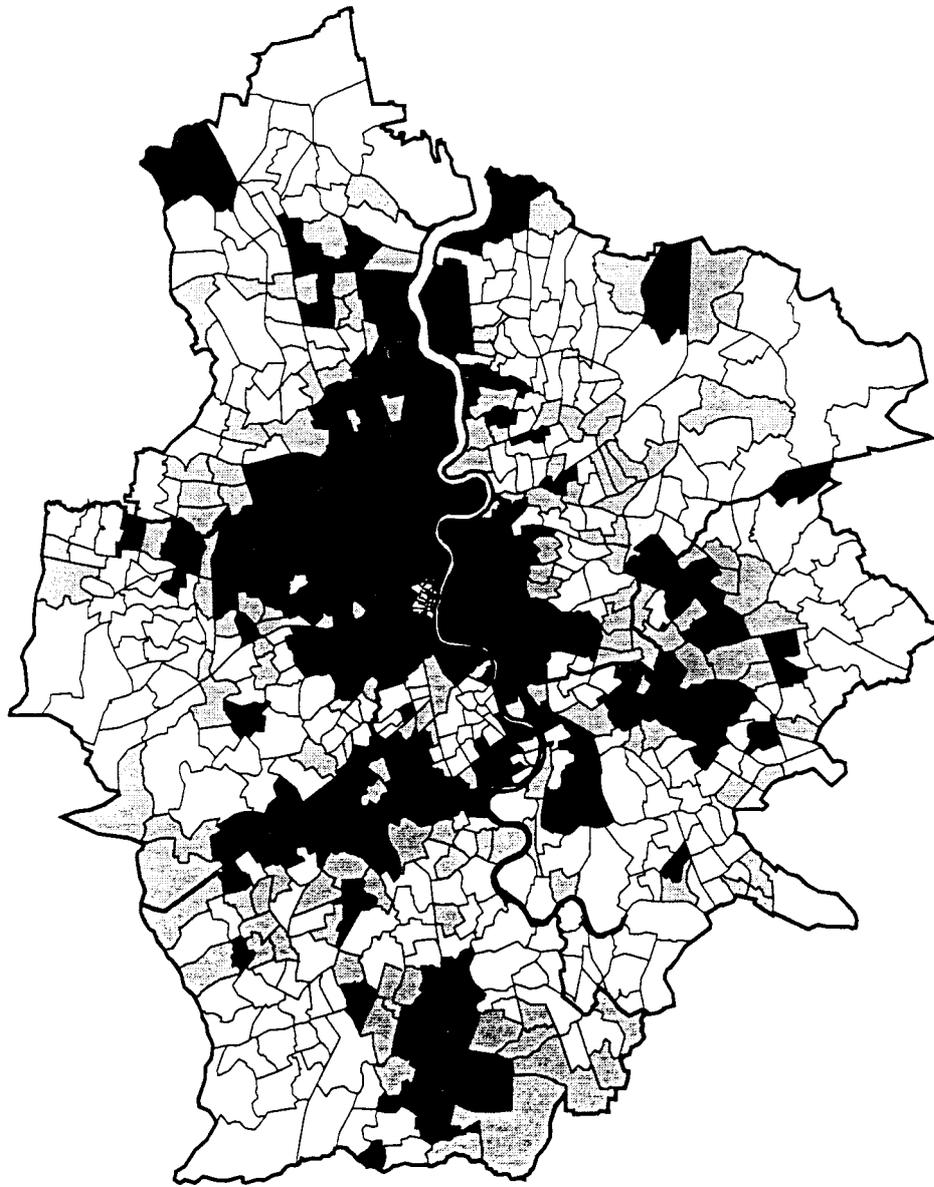


FIGURE 2

All emergency hospital admissions (1992 to 1994)
 (Standardised rates adjusted by age and sex)



LEGEND

Standardised all emergency admission rates (1992-1994)

	< 0.83
	0.83 - 0.93
	0.94 - 1.04
	1.05 - 1.17
	>= 1.18

Source: Digital boundary data, ESRC
 Hospital Episode Statistics, Dept. of Health
 Department of Epidemiology & Public Health
 Division of Primary Care & Population Health Sciences
 Imperial College School of Medicine

6. London has a large daytime population with an influx of just under 1 million commuters a day⁵ and it is the most popular destination for tourists in Britain with 24 million overnight visitors (1995). Both groups add to the need to provide emergency health care unaccounted for in the resource allocation formula.
7. The public health agenda is discussed elsewhere in this report. Two of the health problems which affect London's population disproportionately – mental illness and HIV/AIDS – merit particular mention because of their resource implications for health services. Expenditure on both needs to be considered in setting resources if Londoners' other health needs are to be met adequately.
8. There are a number of other health issues which are particularly important for London. Some of these can be attributed to the characteristics of the population described above – for example the increased prevalence of diabetes amongst some ethnic minority populations, the high incidence of TB and mental illness amongst people living rough, and the risk of tropical infectious diseases amongst a population with so many global travelers. Multiple factors in individual mentally ill patients complicate management of their care. Psychotic patients who also misuse drugs and alcohol and offend against the law are particularly problematic.

Complexity of administrative boundaries

9. London is unique in the UK in the juxtaposition of so many local authorities, health authorities, NHS Trusts, medical schools, and research centres. These are more concentrated the closer one gets to the heart of London but there are few bodies with any over-arching responsibilities. Even within small geographical areas, there are few common boundaries. For example, twelve of London's sixteen health authorities cover two or more London Boroughs, each with different population characteristics and different priorities in meeting local needs.
10. Co-terminosity is not the only boundary issue for Londoners. Even where the NHS and local government share boundaries, these are drawn through densely populated areas and do not always match community patterns of behaviour.
11. Within the health service, users and carers may experience a multiplicity of organisational boundaries between general practice, community and secondary service providers and health authorities. This, again, is felt strongly in London where a transfer of residence may involve a complete change in health and social service personnel (apart from the GP) and possibly even the loss of access to the very services which enable an individual to remain stable within the community.

Competition v collaboration

12. It is in London, where so many hospitals are in close proximity, that many of the sharpest effects of the NHS internal market have been felt. Acute NHS Trusts, in particular, have attempted to maintain clinical and financial viability by competing for contracts. We observed the relative weakness of health authorities in this environment when faced with the negotiating power of the London teaching hospitals. This has the potential for speculative investment which can lead to waste and inefficient

⁵Focus in London 1997

working when decisions ultimately pointed to the need to invest elsewhere. It has been alleged that health authorities and GP fundholders have also sought to gain short term benefit from buying services at marginal capacity, thus risking long term problems of failing to invest in services when and where these are needed.

Financial issues

13. The financial position in London reflects general pressures in the NHS, although there are a number of special features that gave rise to the changes recommended in the Tomlinson Report. Despite the fact that, over the last three years, approximately £600 million of transitional support funds have been allocated to London over and above main allocations to support these changes, the financial position gives rise to continuing concern. There is a gap between realisation and requirements. . .

Teaching Hospitals and Medical Schools

14. London receives 70% of all the research and development funds allocated by the NHS Executive. Its medical schools train 42% of all medical undergraduates in England. This concentration of academic activity can appear to conflict with the provision of health services that meet local needs. There is a need to examine how these responsibilities can be properly balanced.

Primary care

15. London continues to lag behind the rest of England in the standards of primary care. For example, the number of GP principals in London has reduced in recent years, adding to the strains of dealing with a complex workload.

Transport issues

- 1 6 London's public transport and road systems assist movement in and out of the centre, not across and around the capital. This affects the ability to travel relatively small circumferential distances, in addition to the pressure of traffic and poor access to public transport for frail or disabled people.

Workforce issues

17. Injections of funds have only limited effects if suitably trained staff are unavailable to increase levels of service. We have received evidence from health service providers throughout the capital, and from professional bodies, which confirm the critical shortages that exist. Some of these are discussed elsewhere in this report, in the chapters on service delivery.
18. Nurses are the single largest group of staff and are key to providing direct patient care. The recent changes in nurse training, which" have reduced the numbers trained in London, have caused concern . for many of those who submitted evidence to us. Many young people come to London for a period of training, remain in their early careers, and then choose to move out as they settle down. Failure to take this behaviour pattern into account in planning training numbers has left London with a critical shortage of nurses – with vacancy rates of 20% in many places. Other professions, too, have experienced similar difficulties. The high cost of housing is an important factor. The close proximity of so many health service employers also adds to the competition for staff.

19. In summary, London's population is vulnerable to a range of social and health problems, yet the services provided are patchy and often less satisfactory than elsewhere. Complex organisational structures and boundaries confound the ability to plan and deliver services, which show wide variation in standards. Providing care in London is more expensive than elsewhere. There is a high concentration of research and teaching activity which fulfils national as well as London responsibilities. Transport arrangements in London facilitate centripetal and centrifugal travel. Our further work has concentrated on efforts to deal with these issues in the most effective and efficient way possible.

3: RECENT CHANGES IN LONDON'S HEALTH SERVICES

1. The 1992 Tomlinson Report and *Making London Better*, the 1993 Government response, are key documents in setting the direction for London's health services over the last five years. This section examines the changes which have resulted from the recommendations and comments on possible reasons where changes have not been achieved.

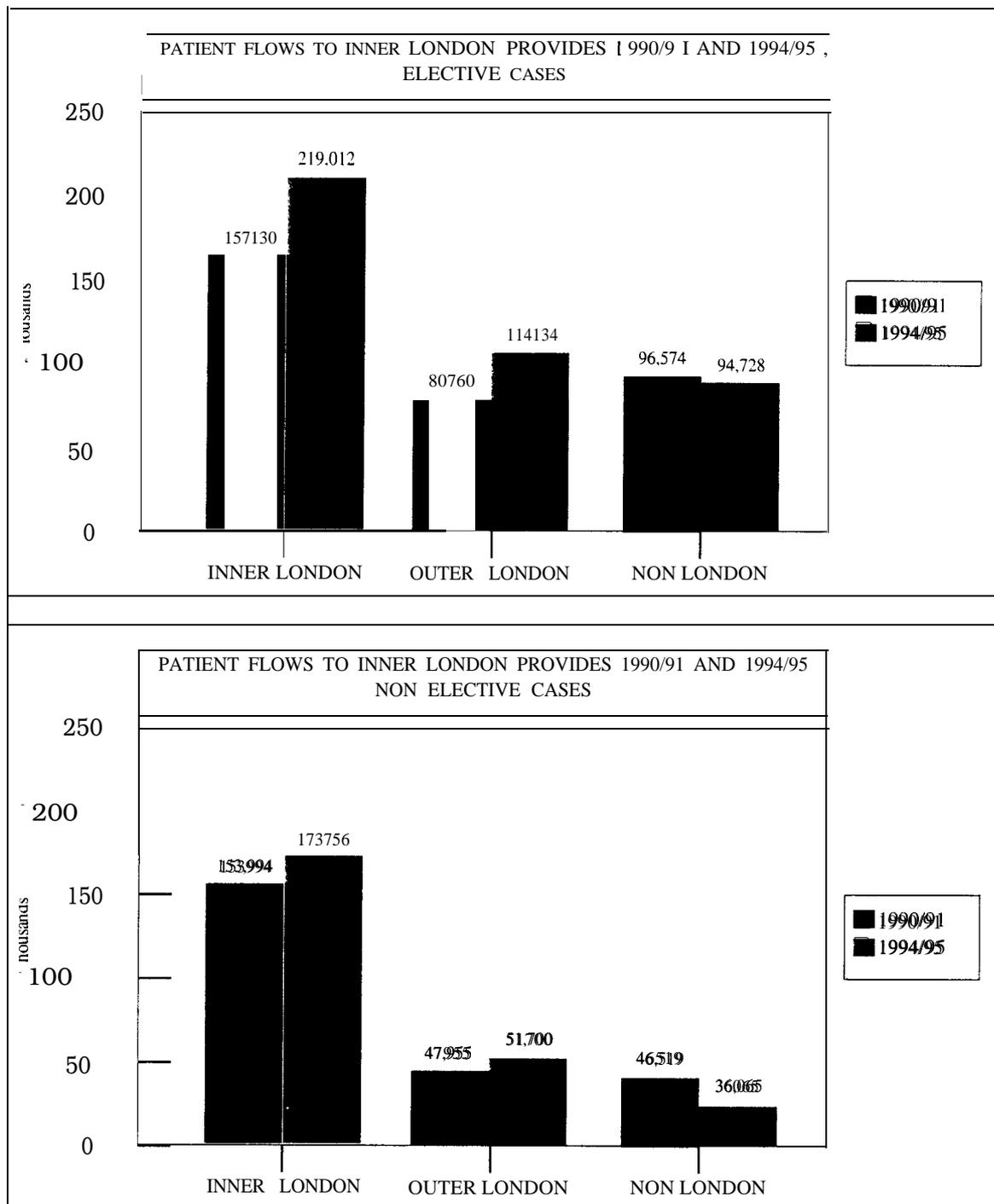
REPORT OF THE INQUIRY INTO LONDON'S HEALTH SERVICE, MEDICAL EDUCATION AND RESEARCH (THE TOMLINSON REPORT)

2. The Tomlinson Report stated that there was under-provision of primary and community health services and an over-provision of acute care in inner London. To correct this imbalance, it recommended changes in the resourcing and organisation of health services in London to rationalise acute services, so that provision matched demand, and to develop community-based services.
3. The Tomlinson Report assumed a fall in the requirement for in-patient beds in London hospitals due to continuing trends in the efficiency with which beds were used and a reduction in patient flows towards London hospitals, as purchasers secured high quality, and cheaper, services locally. These factors, together with high overhead costs and a mismatch in the scale and nature of London's acute services to meet demand, suggested a need to address the competitiveness of London's hospitals in the reformed NHS. A slimming down of bed provision within individual hospitals would not fully address the impact of competitiveness and financial pressures on London's hospitals, as the problems of excessive fixed costs and under-used buildings remained. Therefore, the Tomlinson Report recommended that whole hospital sites be taken out of service with essential services relocated, staff redeployed and capital stock sold or turned to alternative-use. It also recommended NHS Trust mergers to help bring this change about.
4. It was recognised that a programme to rationalise acute services and develop primary care and community services would require transitional funding support and capital investment, to ensure that patient care was maintained and services were built up in the community before acute hospitals were closed. As more efficient and cost effective services were matched more closely to need, it was considered that in the medium to long term change should at least be cost-neutral.

Demand for in-patient beds in London

5. At the time of the Tomlinson Report, the data available on use of beds were not as reliable as now. We have had the benefit of more accurate information provided through the Hospital Episode Statistics (HES) data to examine the situation.
6. Between 1990/91 and 1995/96, the number of inpatient acute beds fell in inner London by 1130 (compared with the 1365 predicted by the Tomlinson Report) largely as a result of greater efficiency (as the Tomlinson Report predicted). During this period acute beds in London as a whole reduced by 2761 and, more alarmingly, the total number of beds in London (ie including geriatric, psychiatric and maternity) reduced by 9271. The number of beds per 1000 episodes of acute care has fallen, from 18.4 in 1990/91 to 13.4 in 1995/96. Comparative figures for England nationally are 18.0 and 12.5, respectively.

FIGURE 3



SOURCE: NHS EXECUTIVE

7. Data on changes in patient flows in London are difficult to summarise accurately, but Figure 3 shows that between 1990/91 and 1994/95 elective caseload in inner London increased by 30% (which is consistent with the trends nationally). Whilst referrals from outside London have reduced by 2%, the elective and non-elective caseload referrals from outer London have increased by 41% and 8%, respectively.
8. It appears that changes predicted in the Tomlinson Report on referrals from the rest of the country have been borne out only to a modest extent. Changes in referral patterns from outer London to inner London providers are not as predicted but are in the opposite direction. The reasons for this require further analysis. The Tomlinson Report maintained that the high overhead costs of the inner London providers would make them uncompetitive in price terms. Referral patterns may be determined by other factors, such as access and quality, as well as price. Slippage in the acute rationalisation programme has affected the need for outer London purchasers to change referral patterns. Transitional revenue funding has also helped protect the prices of the inner London providers.

Bed availability in London

9. In the limited time available, we have undertaken initial analyses comparing the number of beds available to London residents with the England average. These analyses have considered the most up to date published data available which extends to 1995.
10. Achieving meaningful comparisons of bed numbers with averages for other parts of the country is complex. Adjustment must be made for beds which are in London but not used by Londoners, and for the characteristics of the London population compared to the rest of the country. It is also necessary to take account of complementary services, such as the availability of intermediate, residential and nursing home care.
11. In terms of global bed numbers, London has approximately 17400 acute beds. A significant proportion of these provide care for non-Londoners. The focus of our analysis to date has been to understand the usage of beds by non-Londoners, which we assess to be in the order of 2500-2800 beds. This is the most material factor in terms of understanding the number of beds available to London. Further structured analysis is needed to account for the other demographic, socio-economic and service factors. We have carried out preliminary analyses showing the approximate effect of these factors.
12. Overall, our conclusion from these preliminary analyses is that there is no evidence that there are more acute beds available to Londoners than the England average. Using a number of methodologies, the results of analyses has suggested that bed numbers in London range from broadly equivalent to materially fewer than the England average. Our interpretation, having reviewed these methodologies, is that London probably has fewer beds available to its population than the average and that further bed closures should not be planned.
13. Our analyses also demonstrated that bed availability varies across the sectors. We recommend that further analysis should be undertaken to understand the position in each sector and the nature of bed usage by non-Londoners. We recommend that commissioning this analysis should be an early task for any pan-London body, in conjunction with expert stakeholders.

Income and Expenditure position

14. To date, three of the main assumptions underlying the Tomlinson Report and *Making London Better* have not occurred:
- ◆ the predicted reduction in purchasing power of the London health authorities by a reduction in their over-target cavitation positions has not taken place.
 - ◆ the predicted reduction in the income of the inner London providers as a result of a reversal of elective inflows from outer London health authorities has not taken place.
 - ◆ improvements in primary care have not been able to substitute for reductions in secondary care.
15. Nevertheless, the financial position of both the London health authorities and NHS Trusts remains of concern. Their planned income and expenditure deficit, after taking account of transitional relief, is projected to be £35 million (less than 1%) by the end of 1997/98.

Weighted cavitation

16. The weighted cavitation position of London's health authorities has been affected by several factors; such as changes in the funding of the Postgraduate SHAS, teaching and the distribution of NHS research and development money, the allocation of funds through assessments of socio-economic and health indicators and the costs of providing services. A focus on "continuity and stability" rather than "strategic shift" has also reduced the pace at which health authorities have moved towards cavitation targets. As a result, London's health authorities are currently £81 million over-target (some 2% of London's annual income).

Central funding

17. *Making London Better (MLB)* confirmed the Government's intention to provide early investment in primary care and community services and transitional funding for acute services to support the need for change. The London Implementation Group (LIG) was charged with driving this forward through existing health agencies and advising the Government on progress. Some £331 million transitional relief was provided in the period 1993/94 to 1997/98 to support predominantly inner London NHS Trusts while they reduced fixed costs and overheads as part of the rationalisation process. Additional revenue support was also provided for some London health authorities to pump-prime strategic change (such as the rationalisation of single specialty and other hospitals and the re-generation and development of primary care and mental health services) through a variety of mechanisms (special assistance, challenge funds and London Initiative Zone (LIZ) funding). This totals some £362 million over the period 1993/94 to 1997/98. In addition, over the same period, capital funding totalling £141 million was made available to support the acute services rationalisation programme. Table 1 analyses the central monies allocated to London over the period 1993/94 to 1997/98:

TABLE 1: Central funding for London since 1993/94

	93/94 £'m	94/95 £'m	95/96 £'m	96/97 £'m	97/98 £'m	TOTAL £'m
Revenue						
Transitional Funds	68	62	67	73	61	331
Revenue support to PGSHAS entering the internal market	0	47	33	17	0	97
Challenge Funds ¹	0	0	0	3	19	22
LIZ (inc capital)	16	48	63	70	46	243
Sub-Total	84	157	163	163	126	693
MLB Capital	5	13	36	46	41	141
Total	89	170	199			834

¹.Challenge Funds were granted to support the development of mental health services nationally. This now represents London's share of the funds.

Capital Investment

- In recent years, at a national level, there has been a reduction in Exchequer funding for capital. Instead, NHS Trusts have been encouraged to develop solutions under the Private Finance Initiative. PFI has, however, been slow in taking off. Financial pressures have also caused NHS Trusts to transfer resources from capital to revenue. The combined effect of the reduction in Exchequer funds and financial pressures has squeezed capital expenditure. Top slicing of capital for certain priorities (such as the LIG acute capital programme) has provided London with extra funding to support change in the acute sector and in the medical schools.

Reports of the Independent Review of Specialist Services in London

- The Tomlinson Report recommended the rationalisation of specialist services in London with the establishment of working parties to look at the provision of cancer, cardiac, plastic surgery and burns, renal and neuroscience services. The LIG commissioned these reviews of specialist services, adding a review of children's services. The review teams published their reports in July 1993. Not all of their recommendations were accepted or implemented. The Thames Regional Offices provided us with an analysis of progress to date.

Cancer:

About half of London's 15 hospitals with specialist cancer facilities are now working as joint centres, but none have completely withdrawn from this specialty. Five centres are in the

process of developing capital schemes to enable consolidation. The Calman–Hine Report recommendations will also have had an influence here.

Cardiac:

It was recommended that the 14 adult tertiary centres be consolidated into 9 but only the Brook Hospital centre has closed. Progress is subject to further review and/or capital developments.

Children:

Plans have been agreed to concentrate on two or three tertiary centres in South East England for each specialty. These are also subject to awaited capital development.

Plastic surgery and burns:

Services should be organised on a “hub and spoke” principle. Capital developments are still awaited on three sites. Decisions on services at Queen Mary’s Hospital, Roehampton are awaited.

Renal:

Five tertiary centres in London were planned with 5 specialist centres in the Thames Regions. This has been achieved in the North Thames Region and in South East London. Consolidation of services at St George’s Hospital and the St Helier Hospital has yet to be agreed.

Neuroscience:

11 centres to be reduced to 6. Capital developments are awaited in East London and South West London.

20. . . . On this evidence, health authorities and NHS Trusts are working together in the right direction to develop specialist centres of sufficient size, not necessarily single sites, for the best standards of clinical care.
21. The University of London has proved to be a significant influence in driving moves to rationalise specialist services. In the past five years, there has been major progress in merging undergraduate medical schools and postgraduate institutes within multi-faculty colleges. Where similar rationalisation has been recommended in the health service, progress has not occurred at the same pace. There appear to be a number of reasons for this. The changes are often complex and, where these involve the closure of a local hospital, attract greater public interest than the merger of academic institutions. Difficulties in securing capital investment have also affected progress in the health service, where local agreement on principles has been achieved.
22. All these influences have inhibited increased efficiency in the acute sector. As a result, health authorities have been unable to invest money in primary or community services at the required pace, as the following chapters describe.

4: PLANNING AND PROVIDING SERVICES: BREAKING BARRIERS TO JOINT WORKING

1. This chapter focuses on ways in which the disparate organisations within and outside the NHS can work together to provide a service. We concentrate on:
 - ◆ effective joint working at locality level
 - ◆ effective health authority roles for planning and commissioning specialist services and to set priorities and monitor local care.
 - ◆ ways of achieving pan-London strategic planning.
2. Recommendations which encourage joint working between the NHS and local authorities have been made repeatedly over many years, yet effective implementation has been patchy in London. Complexity of boundaries is an important contributing factor. London has 32 boroughs, plus the City of London, and 16 health authorities. In many places, collaboration within the NHS has not been as close as it should be for efficient and equitable provision of care. Competition between NHS Trusts and the purchaser/provider split has prevented close co-operation, both within the NHS and external to it.
3. There are difficulties inherent in joint working between separately funded organisations with different geographic boundaries and lines of accountability. Policy perspectives also differ, with local authorities having local democratic accountability and the NHS responsibilities for a nationally equitable service. There is also a tension between universal health services free at the point of delivery and targeted means-tested social care. There are a number of examples of good collaborative joint working in London. These are effective, despite the barriers, and are largely dependent on the dedication and effort of the people involved.
4. We recognise that there will always be boundaries between organisations and we were anxious to avoid wholesale administrative re-organisation, which might distract attention from efforts to joint and more effective work which can be accommodated within existing structures.

Working in localities

5. Our vision is that planning be carried out at the level that is closest to the individual, whilst remaining consistent with rational decision-making. For many services (eg many of those provided for elderly people, children, or people with mental health problems) this suggests there should be a body at a local level to plan services for a population size rather smaller than those served by the existing health authorities, probably about 100,000 people. This body or agency may, indeed, be a locality commission.
6. There is more than one model for such commissioners and providers of care in localities. We see a vital role being played by primary care in their development. In these localities, plans need to incorporate input from patients, users and community groups. Consideration needs to be given to appropriate collaborative structures for local authorities to liaise with primary care locality commissions.

7. We have been impressed with the increasing success in involving general practitioners in commissioning care at a local level, whether through multifunds, total purchasing projects or more direct engagement with health authorities. We describe this in greater detail in Chapter 6. The local authority experience of directly involving users could also be extended to give health users a more direct voice in the commissioning of health care. Locality agencies could commission a wide range of community services and standard acute services, including emergency admissions. Enough management capacity will need to be provided to carry out the role effectively.
8. We see it as critical that locality agencies match local authority boundaries if seamless packages of care are to be achieved. It is likely that there will be more than one of these within a given London Borough but, with the exception of the City of London, none will cater for more than one local authority. This work has the potential to link closely with local authorities, to develop a rounded system for setting priorities and considering services including housing.
9. Locality commissioning would operate within the framework of the health authority. It needs appropriate managerial support, and will only work with top level support on all sides. Looking outside the health service, we have learnt of positive results from the Home Office requirement for “leadership groups” where the police and local authorities get together on crime prevention. Their role is planning and not delivery. They are required to develop joint plans, coming together as problem-solvers rather than involving each other only when required to consult on solutions. This approach implies a duty of partnership between health service bodies, and more broadly with their local authority partners.

The health authority roles

10. The health authority would be responsible for monitoring the performance of the locality agencies or commissions and ensuring that nationally set priorities are pursued. We see the existing health authority as a source of funding for localities, delegating much of its purchasing to each locality. It will provide support to the process, for example with public health advice, and continue to carry out statutory functions. Health authorities would also have an important role in managing the tension between local demands and national priorities. Mechanisms for improving collaboration could be developed from the existing structures supporting Joint Consultative Committees and local service liaison committees.
11. We recommend that health authorities should combine to purchase more specialist services, such as those traditionally designated as regional specialties. Health authorities of the current size have encountered problems in planning rationally for these services and the experience of recent years has provided examples of duplicated and irrational development of services. There is a need for broader planning at sectoral level, matching the five sectors set out in Chapter 9. These sectors would each serve a population of about 1.4, million people. In due course, it is likely that health authorities will merge to serve sectoral populations. Meanwhile, they should develop a well defined mechanism for joint sectoral planning for specialty services and for ensuring coherence of plans for all services across the sector.
12. The public health agenda needs to be incorporated more effectively into planning of health services. Finance, health care and development of the public health agenda are proceeding in three different streams even within the health service. Beyond it, the development of key public health strategies – housing, traffic, pollution control – are areas with potential for much closer sharing of interests

between health and local authorities. We recommend that these aspects should be recognised by a requirement for inclusion on the agenda, with relevant representation at a joint planning level. Health Action Zones may play an important part in developing models for effective collaboration in this area.

13. At this sectoral level, links with medical teaching and research and development have obvious advantages. We have been impressed by the existing effectiveness of sectoral relationships with academic interests and see this as having potential for an effective forum for planning for the future. At this level, too, it will be important for commissioners and providers to work closely together in planning services.
14. We recommend therefore that health and local authority commissioners and providers should be required to develop joint plans for each sector annually, with 5 and 10 year targets for specialist services, public health targets and development of teaching and research.

Pan-London issues

15. We see the need for a clear strategic planning role combined with a requirement to ensure practical operational collaboration and coherence across the whole of London. One method of achieving this would be a single London body to develop coherent plans, liaise with any proposed Greater London Authority, and have powers to ensure that resources are focused on need.
16. We considered whether this would be best achieved by creating a single Regional Office of the NHS Executive for London. This would remove the boundary between North and South Thames, but create new boundaries between the London Regional Office and the home counties currently incorporated into the Thames regions. These boundaries could impair the collaboration necessary with those parts of the Thames regions outside London for planning the specialist tertiary services and teaching and education which London provides to a much wider area. On balance, we are of the view that effective planning across London is highly important and a single London Regional Office should be able to 'work effectively with extra-London offices.
17. We recommend that while this should be a longer term aim, the two Thames Regional Offices should enhance their close working relationships so that they can ensure coherent strategic planning, particularly for the development of hospital services, primary care and mental health services. A pan-London body should be set the task of considering the last two as a matter of urgency until such time that these have improved to the levels of service available in other parts of the country. Whether as a single office or a closely working pair, it is important that adequate levers are available at the Regional level to ensure that improvements in services are delivered. This will necessitate the acquisition of greater powers than at present. The Government and the NHS Executive should consider how this might be best achieved.
18. The recent accent on public health provides an opportunity to consider the public health aspects of infectious diseases. These pose an often unappreciated public health hazard and, in London, have a particularly deleterious impact on deprived populations. High incidence in London of food poisoning, tuberculosis, sexually transmitted diseases and hospital acquired infections point to the need for an effective means of prevention and control. The Public Health Laboratory Service (PHLS) has a key responsibility here with others in this field. The PHLS has recently developed an imaginative scheme to unify the service on a London-wide basis with a pair of hospital based laboratories as the focus of a network of collaborating centres based in laboratories around the

metropolis. This integrated system will provide an improved surveillance system and, together with its new single site food, water and environmental laboratory, has the potential for rapid detection and reduction of common communicable diseases. This unified London-wide service fits well with the idea of a London-wide planning body for other aspects of public health and planning of the service.

Reviewing the cavitation formula

19. We note elsewhere in this report the large sums which London has received in transitional and special funding support. This cannot be perpetuated. It must be demonstrated that London's health service is performing as efficiently as other parts of the country. The situation will always be particularly complex for London, and standard formulae cater poorly for the situations endemic in the capital with its extremes of deprivation, the presence of so many homeless people, individuals with severe mental illness, and refugees with complex needs. Under-enumeration is inevitable in a population with these characteristics, providing a double jeopardy by not counting those whose needs are the greatest. GP list sizes are larger than the official Census figures. Even if there is some discrepancy in these they do suggest that under-counting of the population is likely. Account should be taken of GP list sizes in assessing populations, as the lists become more accurate.
20. Charging by health service providers in London is affected significantly by high capital charges. We understand that the real effects on prices of siting services in central London should not be ignored, as it would be perverse to continue to send patients into high cost services when they could be treated effectively and more cheaply close to their homes. The consequence of capital charges for inner London is distorting the ability to purchase care for local residents. This effect needs to be recognised and examined to ensure that Londoners are not put at a disadvantage in obtaining health care.
21. We welcome the Government's creation of a working party to review the resource allocation formula, and welcome its study of the implications of its findings for London.

Progress through monitoring and evaluation

22. We are concerned that developments should be monitored and evaluated before being generalised. We recommend that this be a key factor in re-building public confidence in health service changes.

Systems for sharing good practice

23. In references to services for individual client groups, we touch on good practice that should be examined for its potential to generalise elsewhere. Mechanisms need to be developed to promote good practice which has been notoriously hard to achieve in the health service.

Information systems

24. The sheer quantity of information available is overwhelming and information management systems are urgently required. We recommend further work on the institution of accurate information systems which will provide relevant data about problems and needs and ways in which these are being met locally and for Londoners as a whole. Any good planning system will be dependent on reliable information. We see this as an issue which goes beyond London's health services, but also one which has direct local impact.

Incentives for collaboration

25. In parallel with greater coherence in planning, there need to be effective incentives to collaborate. It has been our experience that collaboration in the health service is highly dependent on individuals and to some extent goes against the cultural grain. As a result when an individual leaves a post valuable collaborative mechanisms may wither rapidly. System incentives to reward and promote collaboration between organisations should support activity regardless of the personalities in leadership positions. We recommend that positive incentives should be provided by rewarding good collaborative work and methods of achieving this should be explored.

Making use of the evidence

26. In the timescale for this report, the Panel has not been able to exploit the full potential of the evidence submitted which provides a compelling picture of the concerns about the health service in London. We have been able to do no more than draw some strategic threads from this valuable documentation. We recommend that the NHS Executive be given the task of analysing the substance of this evidence and incorporating the findings in their work on setting planning and priority guidelines for the NHS.

Recommendations

27. Here we focus on ways in which a pan-London oversight of London's health needs can be developed, and in which plans can be effectively delivered locally.
- 27.1 The two Thames Regional Offices should enhance their working relationships now to ensure coherent strategic planning across London with a single London Regional Office as a longer term aim. Greater powers should be accorded them by Government, so that they can ensure that agreed plans are implemented.
- 27.2 Services of a specialised nature should be commissioned at the level of the five sectors into which London can be divided, each relating to the new University of London medical school groupings and covering populations of about 1.5 million. Health authorities should work together at the sectoral level to achieve these ends, and to monitor local commissioners and providers. Local commissioners should be required to develop and review plans in each sector with 5 and 10 year targets for specialist services and for training and research.
- 27.3 There are several possible models for commissioning services at the local level. While not being prescriptive, we can commend the pilot locality commissioning projects in which about 60-70 GPs provide and commission services for populations of about 100,000. Other models of locality grouping of primary care teams may also prove effective.
- 27.4 At all levels, especially at locality level close working with local authorities is essential. Joint working with agreed plans, supported by agreed funding should be required of health authorities and local authorities. Co-terminosity between locality commissioning groups with local authorities will facilitate joint work.

27.5 A number of supporting recommendations are made:-

- a) Primary care, mental health and community health services should be priorities for the pan-London strategic planners until such time that these services have improved to the levels available in other parts of the country.
- b) Public health strategies should be included on the planning agenda, with relevant representation at joint planning levels.
- c) Developments should be monitored and evaluated before being generalised.
- d) We recommend further work on mechanisms to spread good practice and the institution of accurate information systems. Competition within the NHS should not impede communication. Methods of achieving this should be explored with positive incentives to improve and reward good collaborative work within and outside the NHS.
- e) We welcome the Government's creation of a working party to review the resource allocation formula and its study of the implications of its findings for London. We recommend that the possibility of using GP lists (with anti-inflation measures) be investigated as the population basis for resource allocation. We also recommend rapid implementation of the working party's review. This review should link with the parallel review of the funding formula for London local authorities.
- f) We recommend that the NHS Executive be given the task of analysing the substance of the evidence submitted to the Panel, and incorporating the findings in their work on setting planning and priority guidelines for the NHS.

5: INVOLVING LONDONERS IN LONDON'S HEALTH SERVICES

1. We received evidence from a wide variety of London based voluntary organisations and groups representing patients' and carers' interests. We were greatly struck by the high degree of expertise and understanding that many of these groups, particularly Community Health Councils (CHCs), exhibited with respect to both local issues and the wider debate.
2. It is a matter of concern to us that many of these groups reported that they felt that their views were often ignored by health authorities and NHS Trusts and that decisions were taken with little reference to the local community.
3. The statutory requirement to consult seems often to be earned out in a perfunctory manner. Outmoded and blanket approaches, such as public meetings and advertisements in the local newspapers, are still used as the main vehicles for consultation. It was also brought to our attention that, whilst health authorities are under a statutory duty to consult, NHS Trusts do not have a similar obligation. This often makes NHS Trusts, particularly those providing acute care, seem distant and removed from the community they serve.
4. A recent King's Fund report¹ looked at public satisfaction with the NHS, on a regional basis, between 1992 and 1997, The results for London are the worst. showing a 28.6% increase in dissatisfaction over five years.
5. It is possible to involve the community in a far-reaching debate on local strategies and service configurations against a backdrop of financial difficulties. We were particularly impressed with the communication strategy of the East London and the City Health Authority (ELCHA), which has gone to considerable lengths to consult and communicate on its strategic plans. As well as working with local CHCs, ELCHA has developed relationships with other voluntary organisations such as The East London Communities Organisation (TELCO) which includes a number of communities from a wide variety of cultural, religious and ethnic backgrounds.
6. Elsewhere we were impressed by some NHS Trusts which have developed a programme of "Open Days" at local hospitals. This undoubtedly helps to break down barriers and build up understanding.
7. Steps need to be taken to address adverse and sometimes mis-informed media coverage. This calls for greater emphasis on community involvement within planning and decision-making processes and a more coherent and consistent communications strategy across London.

Consultation

8. Whilst health authorities and NHS Trusts considered that they were genuinely trying to engage with local people, they were often at a loss about how to do it better. Existing NHS guidance on consultation is out of date and should be urgently reviewed. This should be carried out in conjunction with the NHS Research and Development Advisory Group, which is looking at harnessing consumer

¹Health Care UK 1996/97; The King's Fund annual review of health policy

views for the delivery of health care, and the work of the Patient Partnership Strategy. In reconsidering guidance, thought should be given to whether NHS Trusts, which are in direct contact with patients, should have a more prominent role to play in engaging with the wider community.

9. In the short term, health authorities and NHS Trusts should draw up local strategies that include different models of consultation and user involvement. These might, for example, include citizens' juries, surveys, focus groups and other feedback mechanisms. We would support closer working with social services and housing departments, many of which have developed effective and new ways of consulting and involving tenants, users and carers in planning and service delivery.

Communication

10. We recommend that developing a coherent communications strategy should be one of the earliest tasks of any pan-London body. We have gone to considerable lengths to discuss and listen to the views of local communities and the outcome of our review should be widely and swiftly communicated to Londoners.
11. The NHS 50th Anniversary celebrations are an ideal opportunity for London's health authorities and NHS Trusts to re-engage with their local communities. In doing so it will be important to convey that local health services include primary health care, community, intermediate care and public health as well as acute hospital care.
12. At local level, health authorities and NHS Trusts (particularly acute hospitals) should review their communication functions and strategies to ensure that messages are clearly directed and understood by the community, particularly those from ethnic minorities and different cultural and religious backgrounds. All should incorporate feedback on how this has influenced service planning and delivery.

Meeting patients' cultural expectations

13. We have been particularly struck by the distance between patients' and carers' expectations and health service understanding of the services to be delivered in some areas – most forcefully in the expectations of people from ethnic minority groups. By 2011, one third of Londoners will come from an ethnic minority background. There is an urgent need to ensure that their requirements are understood and expectation of diversity is built into mainstream care.
14. There is a need for considerable community involvement in recruitment initiatives and increased representation of staff from black and ethnic minority backgrounds to address the wider representation of ethnic communities in the workforce. This point has been made to us specifically about nurses, whose role in direct patient care requires close awareness of different cultural expectations.

Recommendations:

15. Here we explore ways in which greater public involvement in health services can be facilitated.
- 15.1 Health authorities and NHS Trusts should draw up improved local strategies for public consultation and involvement. Focus groups, surveys and citizens' juries are examples of feedback mechanisms which are helpful and we recommend that the expertise of local authority social services and other

departments in effective local consultation should be drawn upon. Closer working with local authorities in these efforts is encouraged.

15.2 Existing NHS Executive guidance on public consultation should be urgently reviewed.

15.3 A positive communications strategy to facilitate debate on London's health services should be developed at the pan-London level.

15.4 Two other recommendations are worthy of note:

- a) Health authorities and NHS Trusts should be encouraged to make full use of the opportunity provided by the NHS 50th anniversary to communicate and engage with the local communities they serve.
- b) Health authorities and NHS Trusts need to ensure that local services meet the needs of people from diverse ethnic minority communities, and further efforts should be made in recruiting staff from ethnic minority backgrounds. This should be monitored annually.

6: PRIMARY CARE

1. Despite considerable investment in primary care services in the last few years, services lag woefully behind those in the remainder of the country. The number of practices below recommended standards remains high, too many premises remain poor, single handed practices represent a larger proportion than elsewhere, recruitment is difficult and the total number of GPs has fallen slightly in the face of a rise across England.

The London Initiative Zone

2. Following the Tomlinson Report the London Initiative Zone (LIZ) programme was established to facilitate improvements in standards of primary care in London. LIZ investment had three components:
 - ◆ The main LIZ investment programme in service development.
 - ◆ Medical education incentives to encourage the recruitment and retention of GPs and to refresh and add to the skills of London GPs.
 - ◆ The introduction of flexibilities in workforce regulations to support small practices, in particular single-handed and two-handed practices, in service and practice development. These allow for the employment of GP assistants. Some practices are now very dependent on the funding to support these staff.
3. To date, LIZ investment amounts to some £265 million, with a projected total of £402.9 million by the end of the programme in 1998/99. Of this, over £ 100 million has been invested in primary care premises. Some £50 million has also been invested in other basic primary care provision, including £20 million on increasing the numbers of GP practice staff.

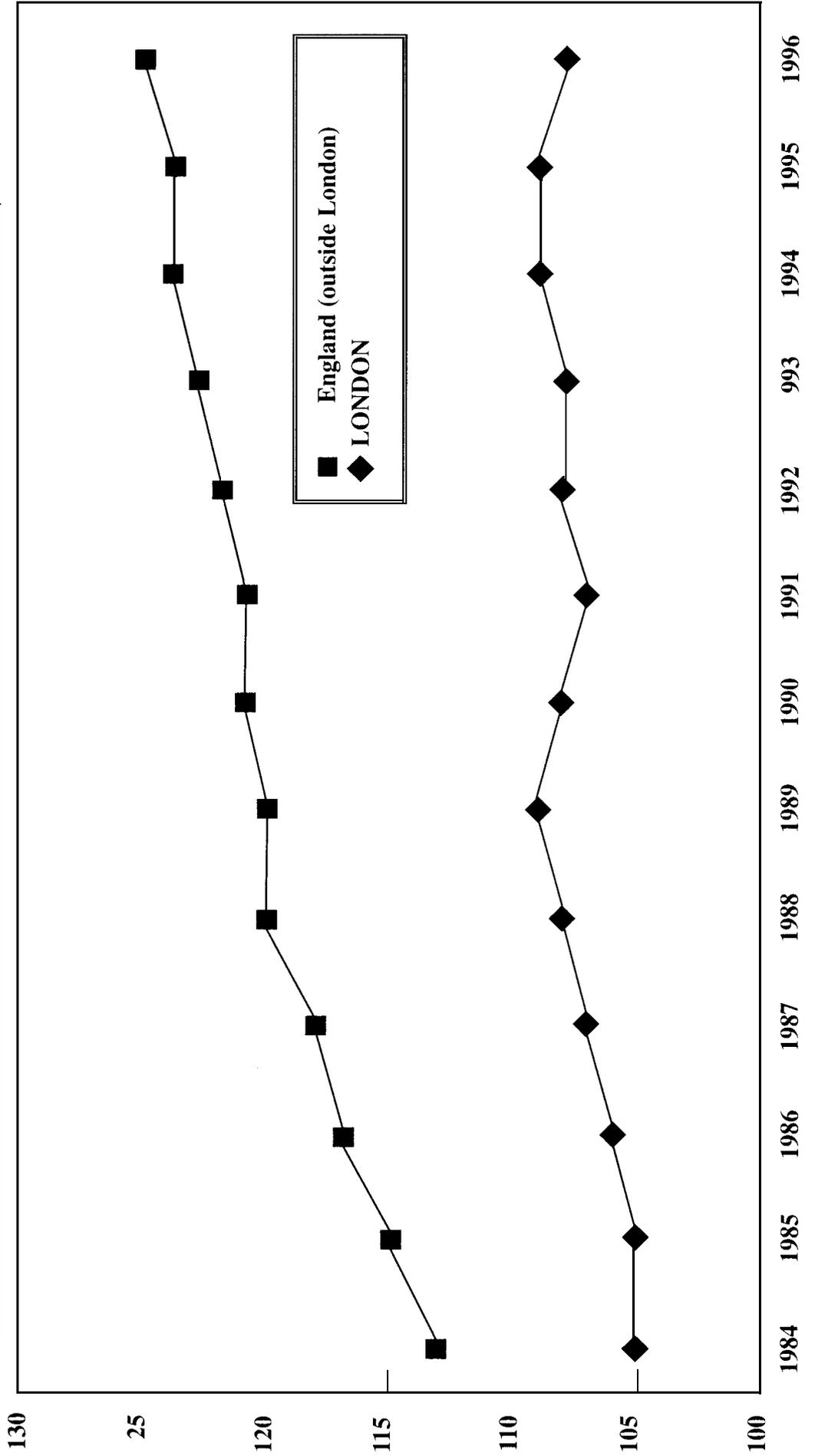
General practitioner recruitment, employment and incomes

4. As Figure 4 illustrates, the availability of GPs in London has failed to match that of the rest of the country. A greater cause for concern is that the number of GPs in London has actually fallen by 1% since the introduction of the new general practitioners' contract in 1990, during the time when the population in London has increased by 1%.¹ The number of GPs in England outside London increased by 6%.
5. From 1977/78 to 1995/96 the proportion of single-handed general practitioners in London decreased from 30.6% to 20% but in England outside London the decrease was from 13.3% to 8.67%. During these 18 years the proportion of general practitioners in London aged 65 or more and the proportion with patient list sizes of 2,500 patients or more was persistently greater in London than in England.

¹ DH data

FIGURE 4

TRENDS IN AVAILABILITY OF GPs (unrestricted principals)



6. Reasons for these differences have been well documented over the years, notably in the 1981 Acheson Report on primary health care in London, the Tomlinson Report and in a series of reports issued by the King's Fund and others.
7. We are concerned to note that, even allowing for considerable LIZ investment, general practice still lags behind the rest of the country and, in some ways, appears to be getting worse rather than better. These conditions are not uniform across London. In some parts of outer London, patterns of general practice are much closer to the rest of the country than to those in inner London. There are, in contrast, many parts of London where the workload and pressures on services, the consultation rates, and the health and social conditions of patients are more stressful than elsewhere. We have been given evidence by the BMA that this leads to longer consultations per patient. Despite these pressures and the higher costs of living and practicing in London, London GPs' incomes (including those from pharmaceutical services) are lower than the national average. It was also noted that there is still a significant minority of GPs in London who provide a limited range of services and yet achieve a reasonable income from higher than average list sizes and deprivation payments.
8. In London, the GP contract acts as a constraint on some doctors who may be interested in general practice but do not wish to take on the responsibilities of a partnership, either single-handed or in a group. This suggests that there is a continuing need for the GMS flexibilities introduced in the LIZ to support the employment of staff and to develop other models of GP care (eg salaried GPs). There are a number of advantages, including the improvement in the number of GPs in London, which have already been provided through the LIZEI projects. We noted the concern of some East London GPs that changes should ensure that care for the poorest patients is not fragmented where young doctors only spend the early years of their career in deprived areas. We felt, however, that the advantages gained by bringing in new recruits were sufficient for this approach to be encouraged.
9. An increase in the number of general practitioners practicing in London is needed to help close the gap between London and the rest of the country. This might be achieved by expanding the LIZ workforce flexibilities scheme. This should no longer be limited to single handed or two partner practices, to provide a broader basis for practice development. The deprived populations of some parts of London make greater demands on GPs and attention should be paid to the current formula which determines the number of GPs in each MPC area as unrestricted principals and as assistants in London.
10. The incomes of general practitioners in London should be commensurate with their workload and the pressure on their services and should make allowance for the above average costs of living and working in London.
11. Action to help reduce the administrative workload on practices is greatly needed. For example, well designed practice computing systems can be of great benefit if these take account of the need for compatibility.
12. Single handed practitioners can also be greatly assisted by practice support staff. The LIZ programme has helped increase the number of practice managers, practice nurses and other professional staff. Further consideration should be given to ways in which this support for single handed GPs can be maximised through other employers such as community services or acute services NHS Trusts. Shortages in the availability of skilled staff remain and these shortages are compounded by the unsuitability of the majority of practice premises in inner London as locations to support the coming

together of primary care teams. Such teams play an important role in meeting health care needs and ensuring links across into education, housing and other environmental needs of the local community. That role needs further support and strengthening if these responsibilities are to be fulfilled.

Primary health care premises

13. The high proportion of single-handed general practitioners is one measure of the lack of progress in developing primary care teams in London; another is the low number of practice premises which provide accommodation above minimum standards. This problem is particularly acute in East London (see table below). The definition of acceptable premises standards varies across health authorities but, by their own local definitions, fewer than 50% of premises in London meet acceptable minimum standards – compared with nearly all practice premises being above minimum standards in the rest of England. It is also disappointing to note that progress in non-LIZ areas seems to have been a little slower, from a base that was generally higher than the LIZ area (mainly inner London).

GP premises in London above minimum standards in 1992 and 1997				
Health Authority	Number of premises		% above minimum standards	
	1992	1997	1992	1997
Bamet	72	75	69%	85%
Camden & Islington	104	04	18%	37%
Enfield & Haringey	122	27	3070	45%
Bexley & Greenwich	113	14	41%	51%
Bromley	55	57	9670	98%
Lambeth, Southwark & Lewisham	179	163	2170	47%
Croydon	66	69	80%	10070
Kingston & Richmond		75		61%
Merton, Sutton & Wandsworth		148		55%
Barking & Havering	124	124		8%
East London and the City	191	196	24%	3270
Redbridge & Waltham Forest		138		14%
Brent & Harrow		118		63%
Ealing, Hammersmith and Hounslow	183	204	31%	52%
Hillingdon		56		647c
Kensington, & Chelsea and Westminster	105	105		4170
North sector	298	306	36%	52%
South East sector	347	334	39%	5770
South West sector		292		6770
East sector		458		20%
West sector		483		5470
London		1873		48%

14. This lack of progress is a serious impediment to the improvement of primary health care in London, particularly in offering a wider range of services to patients and in supporting the development of effective team work. It is recommended that the premises development programme is continued, as a matter of urgency, to bring all premises up to standard. As part of moves towards more collaborative working, health authorities should pool available expertise to support those GPs who wish to develop premises.
15. Much of this chapter has focused on general practitioners. Chapter 7 also discusses the part played by other members of the primary health care team. Community nurses, working in collaboration with general practitioners, have the potential to manage the care of patient groups, to manage appropriate illness and, if necessary, to provide a triage service. Nurses can undertake follow-up work and supervise the care of those patients who may previously have attended outpatients' clinics in acute hospitals. Community nurses working with vulnerable populations such as homeless people, refugees and some ethnic minority communities can also help improve the knowledge of individuals and their access to health services.
16. The re-definition of the roles and responsibilities of district nurses and health visitors as nurses specifically addressing public health provides an opportunity for teams to become a focus within the community which they serve, linking across into education, housing and other environmental services. This key worker approach is commonly used in caring for patients with mental health problems and has the potential to be applied to other specialties.
17. Nurse specialists also have the potential to bridge the boundaries between different types of care, enabling patients to be treated within or close to their own homes. We recommend that consideration be given to expanding the role of nurse specialists working within primary health care teams in defined areas in London.
18. More generally, good team working is still relatively uncommon in primary care and does not happen without effort. There is a need to explore different models that help change cultures towards team working and which help different professionals to share their skills for the local good. This need will be highlighted further as locality initiatives such as research, locality planning and locality education develop.

Workforce Skills and Availability

19. To work as an effective team, there needs to be a balance of skills and expertise. As in other workforce areas, there are recruitment problems. We have already mentioned problems in recruiting and retaining GPs in London, but there are also persistent and high levels of shortages in nursing and therapist staff. This may well jeopardise progress in improving primary and community health care standards in London and moves to improve prevention and public health. Our attention has been drawn to two major independent surveys of recruitment and retention in the NHS – the Income Data Services (IDS) survey in 1996 and the Audit Commission's report *Finders Keepers: The Management of Staff Turnover in NHS Trusts* published in February 1997. These reports highlighted shortages in key professional staff groups, with the Audit Commission indicating that NHS Trusts need to do more to manage staff turnover. As suggested elsewhere in this report, the higher cost of living in London is a factor. Further attention should also be paid to ways in which staff can increase their professional skills through training and career development opportunities. Employers must also give greater

recognition to the important role that non-medical professional staff can play in health care planning and delivery of services. Options for improving recruitment and retention within the primary health care team need to be considered to ensure that staffing needs are met in the longer term.

Reducing the isolation of General Practitioners

20. In chapters 4 and 7, we indicate that we were impressed with the increasingly successful involvement of GPs in commissioning care at a local level, and have proposed in chapter 4 a model for developing that involvement. The emergence of various models of collaborative/co-operative arrangements have brought GPs together to achieve a more effective influence on care provided both in the community and in hospitals. We visited the Kingston and Richmond, Central London and Newham Multifunds and heard how these models have helped reduce the isolation of GPs – particularly single-handed practitioners – and improve access to greater levels of support offered, for example, in GP out of hours co-operatives.
21. These arrangements can help to improve communications between local GPs. There is also evidence to suggest that coming together in this way enables peer group pressure to raise average standards up towards those of the best practices. Where groups cover the whole population in a defined area, the practices may be held responsible for accepting all patients in that area wishing to join one of their lists. In deprived inner city areas, this can improve access to services for groups such as homeless people, drug misusers and asylum seekers who may find it difficult to register with a GP. They can also assist in implementing quality standards in primary and secondary care eg prescribing protocols and disease management in primary care.
22. Flexibilities in the GMS regulations on workforce issues have allowed the creation of approximately 400 new posts for those general practitioners in practices with one or two partners. As a result, significant numbers of GPs have been freed up to take part in a range of professional schemes (for example training in teaching clinical skills, support for spending an extra 6 or 12 months of training in general practices rather than in hospitals and time out to participate in research). There is evidence to suggest that the LIZ Educational Initiatives (LIZEI) are making a positive contribution to developing general practice in London. The LIZEI projects are subject to a three year external evaluation. Although LIZ funding ends on 31 March 1998, we recommend that the current projects remain in place until this evaluation is completed.

Recommendations

23. Here we make recommendations to improve the overall standard of primary care and to increase recruitment into general practice.
- 23.1 The number of general practitioners practicing in London should be increased proportionally to match the rest of the country. Levels of deprivation should be taken into account, and action to achieve this should reflect the recent recommendations of the Medical Practices Committee for introducing adjusted lists for “really equitable distribution”.
- 23.2 Flexibilities in employing and rewarding general practitioners should be explored further to improve recruitment and retention rates. This should include options such as the extension of opportunities for salaried employment, and reward systems for GP principals.

- 23.3 Further consideration should be given to ways in which the support for single handed GPs can be maximised through other employers such as community services or acute services NHS Trusts.
- 23.4 The role of nurse specialists working with a number of primary health care teams in defined areas in London should be further developed and expanded.
- 23.5 Options for improving recruitment and retention within the primary health care team should be developed as a priority. This should include exploration of ways of improving opportunities for further training and career development for non-medical professional staff. Workforce flexibilities should not be limited to single and two-handed partnerships, in order to encourage the development of primary care teams.
- 23.6 London's health authorities should be required to ensure that the proportion of practice premises which are below minimum standards should be reduced from the current 50% by 10% annually. Funding for cash-limited GP premises nationally should be related to the proportion of practice premises which are below minimum standards. The Regional Offices should ensure that there is co-ordinated advice and support for general practitioners on all aspects of premises provision for London.
- 23.7 Formal and informal arrangements to bring together general practitioners within localities should be promoted (see chapter 4).
- 23.8 Current LIZEI projects should remain in place until their evaluation is complete.
- 23.9 Action should be taken to introduce compatible general practice computer systems.

7: INTERMEDIATE AND COMMUNITY SERVICES

1. There is currently a gap in services to support patients at home or in the community which will offer care and support appropriate to their needs, reduce their need for hospital admission and support them in the transition between hospital and home. We make recommendations aimed at filling that gap. Using examples of good practice, we recommend that a range of intermediate and community care options be developed in each locality through collaboration between the NHS, local authorities and the voluntary and private sectors.

Intermediate care services

2. We have taken intermediate care to include all measures which can support patients between hospital and home. We recognise, however, that there is an interdependence between such intermediate care and support which can and should be provided at home.
3. The key priorities in providing these services must be the delivery of appropriate care in the most appropriate settings and accessibility for both patients and their carers. Facilities at this interface can be particularly valuable where these focus on rehabilitation and recuperation. These are needed following severe illnesses requiring hospital admission and where patients are not quite fit enough to be discharged home due to social circumstances (poor housing, living alone) or the nature of their illness means they cannot be discharged earlier. Others, given a period of respite for patient and carer, may not need admission to hospital. The old style convalescent home provided some of this support. The pressure felt on hospital beds may also be relieved. Despite the advantage to individuals and in managing levels of admissions for acute care, levels of intermediate care in London are very variable.
4. We have seen a number of positive examples of good practice in intermediate care services based in the community and in patients' own homes. The following show how effective services can be provided in a variety of settings:

nurse-led day care, rehabilitation services, respite care, palliative care and other inpatient services are provided at the purpose built Lambeth Community Care Centre in south London. Some 76 local GPs support and use the Centre which also provides a range of therapy services and consultant outpatient clinics. This facility has helped improve communication between GP users and is a factor in the recruitment and retention of GPs in that area of London. The Centre is also a focus for social care services and provides facilities to support a number of local community groups. As a response to the success of this Centre, a similar facility is being developed in Brixton.

the Havering Hospitals NHS Trust has demonstrated success with a hospital based nurse-led model which facilitates slow-stream rehabilitation and discharge from hospital. This NHS Trust works closely with the local authority to support rehabilitative care that focuses on the ability to cope at home rather than admission to residential or nursing home care.

St Charles' Hospital in west London provides a range of community based services, including outpatients' clinics and a 15 bed GP unit with links to St Mary's Hospital, social services and voluntary sector organisations. St Charles' Hospital works closely with the 15 bed Patients' Hotel at St Mary's Hospital which is supported by a team of 8 carers whose patients stay on average around 3 days in the "hotel". Two patient surveys have given an overwhelmingly positive response to this facility.

5. Such good practice does not always achieve savings for health authorities or NHS Trusts. Some have appeared as expensive solutions to providing care. The costs of these services need to be set against the quality and appropriateness of care and the ways in which this can offset the need for long term hospital and nursing home care.¹ This may well provide a useful basis for a more systematic evaluation of these services to demonstrate the benefits of this approach. We are convinced that the improved quality of care is a worthwhile aim.
6. It should be possible to convert some existing small hospitals (which may be due for closure) for this purpose. We recommend that health authorities and NHS Trusts should consider this fully in planning strategies.

Residential and Nursing Home Care

7. Nursing home care and residential care are important resources, particularly for older people. There is a wide variation in the provision of nursing homes within London and within individual health districts. Nursing homes and residential care can provide intermediate care to facilitate a patient's return home as well as alternative long term care. Just as it is important that acute hospital facilities are not used inappropriately, it is equally important that nursing home and residential care services are not misused. The lack of rehabilitation and recuperative services can also result in people being placed prematurely in long term care.
8. The decline in the availability of NHS long stay or continuing care beds has meant increasing reliance on the private and voluntary sectors and the availability of local authority funding to purchase such care. The NHS Executive issued guidance to health authorities to clarify the health service's role in funding these services and to require them to determine eligibility criteria for access to services in consultation with the relevant local authority. The guidance also required re-investment in long term care, rehabilitation services and respite care.
9. Such definitions have not always been jointly agreed, although all parts of London have working arrangements. There is still tension between some NHS Trusts and local authorities about these definitions. NHS Trusts, for instance, are not always aware of the amount of care that a local authority has agreed to provide. One NHS Trust visited by the Panel considered that the local NHS definitions had been too tightly drawn, which might result in unsafe placement with inadequate medical supervision for some people. A number of local authorities have not been given information by their local health authority of the budget which has been set aside for long term care services.

¹Intermediate Care – A Conceptual Framework and Review of the Literature, the King's Fund

10. All local authorities have a joint mechanism with their health authorities to review hospital discharge arrangements and to review cases where there are problems. There was little evidence to suggest that information from these arrangements was being used to determine a range of alternative service developments for the long term.
11. Whilst we welcome evidence that there is increasing co-operation and collaboration between the health service and local authorities to resolve these difficulties, there is clearly still some way to go.

Caring for People at Home

12. Many people with complex needs remain at home, often supported by services arranged by both health and local authorities, by carers and a range of private and voluntary sector services. The community care arrangements introduced in 1993 have clearly improved the level of assessment of very frail and vulnerable people living in the community. The King's Fund review work shows that London has a high level of provision of domiciliary care which provides the opportunity for people to remain in their own homes.
13. The ability to remain at home depends on the the quality and suitability of a person's home. The involvement of housing services – both statutory and voluntary – is critical to the process of planning effective services. We received evidence that a number of people remained inappropriately in hospital because of their poor housing conditions, or were placed in residential care because of inadequate accommodation. Local authorities need to work in a more systematic way with their health authorities to identify the range of housing services necessary for the needs of the local population in line with the guidance issued by the Department of the Environment, Transport and the Regions and the Department of Health. We saw a number of positive examples of good co-operation, and commend the East London and the City Health Authority's project to improve local housing conditions in conjunction with the London Borough of Hackney and local home improvement agencies.
14. Skilled outreach nursing staff also train carers to undertake tasks once considered to be part of specialised skills (eg paediatric nurse outreach teams). Where patients and carers want an active role in managing care, this is a welcome development. This must be supported with effective training and good communications between patients, carers and medical and nursing teams. A good practice example was seen at the St George's Hospital Breast Cancer Centre. Effective services were also provided elsewhere:

the Wandsworth Community Health NHS Trust provides 24 hour intensive district nursing support for patients with long-term needs. At any time, patients can access this service which provides continuity of care and helps to avoid unnecessary pressures on the emergency ambulance services, A&E departments and often inappropriate admission to a hospital bed.

the London Borough of Bexley has developed a system of packages of social care available via GPs to avoid multiple approaches to a range of different services.

15. Despite good examples, intermediate care services are sorely stretched and are often unavailable when needed. We recommend that more efficient and effective use of resources for care at home can be achieved by better joint planning and a reduction in professional boundaries. This should be a priority for locality commissioners, health authorities and local authorities.

Care for elderly people

16. Elderly people are the largest age group requiring acute and intermediate health care. The recent King's Fund report² confirmed that the demographics of older people in London are similar to those elsewhere in the United Kingdom and that, unsurprisingly, the poorest health in older people is to be found in inner-city deprived areas and amongst the more recently established minority ethnic groups. The King's Fund London Commission noted that there was a striking difference in the use of hospital beds by elderly people in London compared with those in similarly deprived areas outside London (up to 15% lower in London in some age groups). This reflects their shorter lengths of stay and more day case treatment in London.
17. The recommendations of the recent Audit Commission report³ reinforce our general recommendations on the need to break down barriers between services. Both the NHS and local authorities need to obtain a fuller picture of public and private provision of community care for elderly people in order to develop strategies for delivering more effective care. Elderly people, in particular, need seamless links between service provision.
18. We welcome the Government's proposals to promote greater collaborative working. Some health and local authorities have already begun to pool resources in an innovative way to develop jointly provided services – the London Borough of Bexley, for example, is working with Bexley & Greenwich Health Authority on the reprovision of services for elderly mentally ill people as part of plans to facilitate the closure of Bexley Hospital.
19. Whilst we have seen good examples of the co-location and management of services for mentally ill people or people with learning disabilities, such schemes are not consistently available for older people.
20. It is in dealing with older people that the conflict between universality of the NHS and the targeted nature of social services can have most impact. Whilst many older people may need a small amount of domiciliary care to sustain them in the community, such services are now targeted by most local authorities on those with complex needs. The Social Services Inspectorate Chief Inspector's annual report demonstrates this – there are fewer households receiving domiciliary care than in recent years but the amount of care received in each household has increased. Before services can be described as "seamless", there needs to be a clearer agreement about the characteristics of the group of frail, older people who will receive help from the public funds of local authorities, and how the needs of those who do not meet these criteria will be met. This is not just an issue for London and we hope that this policy question will be addressed by the proposed Royal Commission inquiring into long term care funding and jointly managed and provided services.

² The Health and Care of Older People in London. July 1997

³ The Coming of Age, Audit Commission, 1997

Caring for Children

21. The treatment of children has, more than any other group, moved away from hospital based care. We have seen examples of community and acute health services working together effectively to plan and integrate the delivery of health care for sick children and for those children with special needs. We also received evidence of gaps in services and pressures due to overstretched facilities and shortages in key groups of staff such as nurses and therapists. Problems highlighted in child health services included the availability of services for children with special needs, child and adolescent mental health services, respite care and services which are responsive to problems of housing, language and culture. There was also concern that better arrangements should be in place to support the smooth transfer of children in their late teens from child health to adult services, particularly those children with special needs. The Health of Londoners Project on child health services is due to report in December 1997. We expect this to provide an important contribution to the development of a strategic overview of child health services. Within local government, social services, education and leisure departments all have key responsibilities which help determine the health of children and their future health status.
22. In inner London, the number of children on child protection registers in 1995 was almost twice the England average (58 compared to 32 per 10,000 children under 18). Area Child Protection Committees report an increasing workload and a continuing problem in engaging GPs in child protection work. There is evidence to suggest that pressures on community care budgets have also contributed to difficulties in supporting the child protection system and family support services. We understand that a number of initiatives are in hand to deal with these pressures, led by the London Branch of the Association of Directors of Social Services and the London Senior Child Care Managers' Network.
23. We recommend the approach suggested by the Audit Commission. We recommend that further encouragement be given to the "single service" concept for pediatrics (acute/community) funded and managed by one agency – for example a community services or acute services NHS Trust. Commissioners and providers of services should develop the joint planning of services at a locality and sectoral level so that children's services are included as an important part of the agenda. The health service should take note of ongoing reviews to improve children's services.

The Role of Community Services NHS Trusts

24. We found that the standards of services provided by community services NHS Trusts were variable. Often, these were perceived as "invisible" to those who did not access them. We also found that these NHS Trusts provided excellent services that could be perceived as the "glue" which linked hospitals with the community and supported patients in their own homes. Care at home, in particular, needs to be planned by agencies working together. Community Services NHS Trusts have an important part to play in agreeing effective approaches with GPs, local authorities and the voluntary and private sectors, as well as with carers. Their services are particularly important for elderly people, children and other dependent and vulnerable groups and their carers; these can help balance the demands on community, intermediate care and acute services.
25. We found that some NHS Trusts were hampered by the configuration of services drawn up as part of their application for NHS Trust status. Whilst we recognise the arguments for separating combined acute and community services NHS Trusts, there can be instances where this might be the best model

to provide integrated services to local people and to support joint working with other care providers. Evidence has suggested that some Community Services NHS Trusts which provide both community and mental health services may also find it difficult to balance service provision where there is great demand on both services. We recommend that further thought be given to maximizing the role of Community Services NHS Trusts, particularly where there are gaps in intermediate care services and where there are pressures on local general practitioner services.

26. People express a strong preference for treatment at home wherever possible. When working in households, it is important that demarcation lines between different professions and agencies are handled flexibly, for the sake of the patient and to ensure effective use of resources.
27. We were struck by the role which nursing staff can and do play, whether based in the community or in hospitals, in ensuring the transition between different types of care. We recommend that greater use is made of their networking skills in helping overcome barriers and in achieving coherent packages of care for individual patients and their carers. Nurses should be encouraged to take a greater degree of involvement in this responsibility and the resources needed to **support** this should be examined.
28. Elsewhere in this report, we express concern about the impact of manpower and skills shortages in London which will affect progress in developing services and improving the health of local communities. In the community, these shortages can have the starkest impact because of the range of skills required and the need to provide services across a wide area. The current poor quality of many premises, disparate locations and the pressures of working within very deprived areas of London are important factors in recruiting and retaining staff. There are also shortages of qualified, motivated staff to supervise and train others. Some of these problems can be addressed by improving the physical environment and integration between the different care sectors. We suggest that there is also a need for innovative leadership to help overcome professional demarcations (which can lead to the need for higher staffing levels), to re-define responsibilities and to undertake collaborative ventures within the health service and with local authorities.

The role of the ambulance service in the provision of emergency services in the community

29. We are grateful to the London Ambulance Service NHS Trust (LAS) for valuable written and oral evidence. LAS analyses of calls made by the public show that many Londoners use the emergency “999” system as an entry into health services. Only about 40% of callers require transport to hospital, with about 1570 needing urgent, clinical attention. The LAS is undertaking a number of pilot projects to help develop emergency services within the community to provide the most appropriate response to patient needs. These include the better integration of ambulance services with community health and social care networks and training for paramedic teams to allow them to make informed decisions. We commend this approach to make more flexible use of ambulance services in supporting services outside hospital.

Recommendations

30. A range of ways in which care in the community setting might be enhanced is detailed in this chapter.
- 30.1 We recommend that health authorities should explore further provision of intermediate care facilities, with beds, for rehabilitation, recuperation and respite care. This should provide more appropriate care for patients not requiring hospital services. Health authorities and NHS Trusts should examine ways of making good use of existing NHS estate to provide local and easily accessible care. Research will also be needed into the costs and effectiveness of intermediate care and we so recommend.
- 30.2 Action should be taken to ensure the rational planning and delivery of a range of community and acute services (see chapter 4) and we commend the approach suggested in the Audit Commission report *The Coming of Age* to stimulate work in achieving improved co-ordination in services for elderly people.
- 30.3 Action should be taken to develop further the strategy for child health services.
- 30.4 Community Services NHS Trusts are not all achieving their potential and we recommend that further work is done to review how they will fulfil their roles and to encourage close working with primary care and hospital services.
- 30.5 Supporting recommendations include:–
- a) Nursing staff provide a key link in the smooth transition between different types of care. Efforts should be made to maximise their role in this activity.
 - b) Ambulance services should be encouraged in their efforts to provide a more flexible service to support emergency and other care in the community.
 - c) Ways of supporting team working and overcoming barriers which arise from strict role demarcations should be sought.

8: MENTAL HEALTH SERVICES

1. Of the health services provided in London, those for people with mental illness are widely regarded as being under the most strain. Despite a greater proportion of budgets being spent on mental health compared with other deprived and non-deprived parts of the country, services in much of London are not coping with the heavy demands placed upon them.
2. The demand for mental health services is undoubtedly extreme in London. Inner London has high levels of unemployment, indices of social deprivation, single-person households, homeless people and refugees, each of which are associated with an increased prevalence of mental health problems. The combination of substance misuse, mental illness and dangerous behaviour in individuals has greater prevalence than elsewhere. This, in turn, impacts on the incidence of suicide and self harm and a significantly higher proportion of homicides committed by psychiatric patients in London than elsewhere. There are many more patients in medium secure placements. Despite the considerable resources spent by health authorities and local authorities, we have received consistent evidence that in inner London at least there is a serious mismatch between the needs of mentally ill people and the resources available to meet those needs. This applies across health and local authority services.
3. There have been numerous reports and recommendations on ways in which improvements can be made in meeting the demands placed on services. There are many examples of good practice in putting these into effect, including:

the multidisciplinary approach to providing mental health services for elderly people by the Lewisham & Guy's Mental Health NHS Trust which involves local social services and housing teams. The shared accommodation and resources for staff are seen as critical to the success of team working. The aim is now also to improve working with local GPs. A jointly managed and funded homecare team provides respite care, night sitting and flexible domiciliary support for patients and carers.

integrated community mental health teams serving the areas of Feltham and Hounslow. The teams involve NHS and social services staff led by jointly funded managers. Again, co-location of staff is perceived as critical. Jointly funded managers also give a clear, important message to the teams on the management and accountability for the delivery of services. The teams also consider that integration provides real opportunities for improving communications and the sharing of information.

Hackney has a modern psychiatric inpatient service of outstanding design at the Homerton Hospital which provides locality admission wards, a psychiatric intensive care unit and a longer stay, slow track rehabilitation unit in conditions of low security. There is also good integration of health and social services in four locality mental health teams, each with a single manager responsible for the team's associated admission ward. The teams have achieved a Care Programme Approach coverage of over 90% and this has been cited as a model for community mental health services.

Despite these examples of joint working, we were made forcibly aware of a lack of strong mechanisms to support inter-agency collaboration, particularly between the acute sector and community services. There also appears to be a lack of overall strategic planning across London. As a result, there is a marked variability in levels of service with little evidence of the sharing of good practice across health authority boundaries.

4. Provision for the care of people with mental illness varies widely both in the community and in hospital. Residential places supported by a 24 hour service with skilled staff are generally in short supply. The King's Fund London Commission¹ has reported a ten-fold variation in provision of less intensively staffed residential care. There is an almost complete lack of high intensity 24 hour community services. Home treatment for conditions of moderate intensity is available in only a few places in London.
5. A great deal of funding is channeled into the private sector which provides a high proportion of long term accommodation. According to the Sainsbury Centre for Mental Health (1995), over 90% of NHS spending in the private sector comes through extra-contractual referrals, which are not the most cost effective approach to care. The King's Fund¹ report provides valuable information on the level and costs of inpatient and residential services for mentally ill people. We consider it important to ensure that this sector, too, provides value for money and an approach to clinical care which reflects that available locally.
6. Each of these factors contributes to the high in-patient bed occupancy rates (125% at times). This, in turn, results in a very high threshold for admission so that only those with the most severe forms of psychosis are admitted to hospital, leaving many vulnerable people who would benefit from a period of in-patient care unable to gain access to that care. Long delays are experienced by patients in the provision of basic services. Admission is often delayed, even in the case of mentally disordered offenders.
7. The very high acute psychiatric bed occupancy rates suggest that there is a need for more beds to meet the requirements for hospital care. While this might be the case in the immediate term, as the important elements of care in the community are developed, the ultimate requirement for acute beds may be reduced in the longer term.

Staff

8. In-patients are those with the most severe mental illness, including a high proportion of violent patients. Numbers of assaults on staff are high. This exacerbates the particular problem of poor staff recruitment and highlights the shortage of all grades of staff both within hospitals and in the community. There needs to be a more creative approach to staffing problems. Many highly skilled staff are wholly concerned with "fire-fighting", with little time available to them to plan and develop services. It has been suggested to us that there is a strong case for assessing models of care which do not require high levels of professional staff such as the Richmond Fellowship's approach to caring for people with schizophrenia, the greater involvement of carers and users as in the USA club house model, and the use of support workers – unqualified, generic staff to provide more support to nursing and clinical staff.

¹ London's Mental Health: The report to the King's Fund London Commission. 1997

Primary care and mental health

9. We have received evidence that effective management of mental health problems in primary care can be of great benefit. This requires suitable training for primary care staff, and effective integration with community mental health teams. It has been suggested that there are benefits to be achieved with the development of GP practice based community mental health team services. To achieve this, clinical staff, community mental health teams and social services staff need to relate more closely to GP practice based populations. In this way greater integration may also be achieved with primary health care teams.

Improving multi-agency working

10. Improved co-ordination between the NHS and local government has long been a desirable aim but satisfactory solutions have only been achieved in a few places. In chapter 4 we describe our vision of a collaborative structure within which the NHS and local government can work together to plan and deliver seamless services from a locality base at one end to a pan-London strategic body at the other. These need to draw in health, local government, housing and the criminal justice system. The Inner London Mental Health Group has provided a positive start in this direction. We are less persuaded of the need for a separate Mental Health Authority for London. We see the development of a more collaborative strategy for mental health services as a critical element of the work of the pan-London body described in chapter 4.

Minimum data sets for mental health

11. Local purchasers and providers need to be accountable for delivering mental health services to match the strategy. While we have been given evidence of encouraging progress in developing strategies, delivery can be more problematic. We understand that agencies have been hampered in this by failures to share information, and by deficiencies in the information available in each agency. For example, detailed, patient-based data is only collected for admissions to hospital; other care has been covered in simple tables describing the activities of staff. It is not possible to relate patients' overall care to the nature and severity of their problems and care outcomes may not be recorded. We welcome the initiative to harmonise the management information database on mental health performance which will assist in monitoring this achievement.

Service priorities

12. Particular attention should be paid to a number of immediate desirable changes. There is a conspicuous lack of intermediate care which, in the case of mental illness, includes high support residential placement, supported tenancy, and community team intensive support at home. Investment in suitable housing plays a critical part in improving this element of the service. This will require new and recurrent expenditure but some savings may also be achieved by diverting resources currently spent purchasing long-term private care and accommodation.
13. There is also considerable need for services in the community to support carers and families, particularly for elderly people with dementia. It is critical that more is done to improve the involvement of and communications with carers. This is an important part of joint working between those providing care, including GPs, NHS Trusts, local government and the voluntary and private sectors.

14. Consideration should also be given to providing an increase in short term acute psychiatric facilities during a transitional period to allow sufficient time for greater investment in and development of community services.
15. Further attention should be paid to the provision of support for vulnerable people to help them to continue to live independently. The Homeless Mentally Ill Initiative has been a valuable example we would recommend. The criteria for assessing client eligibility have been criticised and should be reviewed.
16. Minimum standards of services applicable across London should be developed. These should include maximum waits for appropriate residential care, speed of response of community teams, and availability of 24 hour support services. Greater efforts should be made to maximise the safety of staff caring for violent patients with plans and implementations monitored.

Resource allocation

17. It has been put to us that the current formula for allocating resources to purchasing authorities does not reflect the burden of mental illness in London. We recommend that further work be done on assessing whether the current formula is fair and equitable and, in particular, whether a closer examination of the York formula should be pursued as suggested by the King's Fund London Commission Report on mental health services in London. Professor Sir David Goldberg and his colleagues also provided valuable oral evidence to the Panel.
18. We acknowledge the important contribution made by the King's Fund London Commission in its assessment of mental health services in London and the intense pressure on those services, and welcome their further investment in this area.

Recommendations

19. Here we make recommendations to try to improve serious deficiencies in mental health services.
 - 19.1 Central direction to secure improved co-ordination of NHS, local government and other services, including health, social services, housing and the criminal justice system should be provided by Government.
 - 19.2 The development of a mental health strategy for London should be a key task for the NHS Executive across London. The two Regional Offices should work together in generating a pan-London strategy pending the institution of a single Office.
 - 19.3 There is a need for greater investment in a range of community services for patients with mental illness. Joint planning and funding as recommended in chapter 4 should help ensure that mental illness receives the greater attention it deserves.
 - 19.4 Minimum standards of services applicable across London should be developed. These should include maximum waits for appropriate residential care, speed of response of community teams, and availability of 24 hour support services.

19.5 Hospital acute psychiatric services should be enhanced pending more investment in and development of community services.

19.6 Further work is recommended

- a) to assess whether the current weighted cavitation formula reflects the burden of mental health need in London.
- b) on more innovative approaches to resolving skills and staff shortages with the aim of maximizing support for staff caring for violent patients; helping to overcome the isolation of some staff working within psychiatric units; and freeing up highly qualified staff to develop services.
- c) mental health databases and information management systems should be harmonised and information management systems developed taking account of current initiatives in this area.

9: HOSPITAL CARE

1. In chapter 3, we highlighted some of the trends in London's hospital services over recent years. This chapter considers some of the main issues surrounding the provision of secondary and tertiary care in each of the five London health sectors, and the extent to which there are coherent plans for their future development. We also touch on implications for teaching and research.
2. Before describing issues specific to each sector's hospitals, we discuss some of the factors influencing hospital care in general.
3. Most hospitals we visited were under heavy pressure and were concerned about the difficulties in admitting patients with acute illness and those on waiting lists for elective care. These problems are discussed more fully in chapter 3, where the point is made that further reduction in hospital beds in London is currently unwarranted.
4. Distances may be short in London but access to services is very variable. Travel time is only one contributor to this variability. The speed with which people can be seen by their GP, receive their care in an A&E department or gain access to elective care depends not so much on the location of the facilities as on sufficient services being available.
5. While it is clear that efficiencies should be constantly sought we did not wish to be dominated by an unfruitful search for savings in service reorganisations. The NHS Centre for Reviews and Dissemination and researchers at the University of York have suggested that economies of scale associated with hospital rationalisation may be limited. Increased efficiency and cost savings are also achieved by NHS Trusts rationalizing their services by avoiding duplication across multiple sites.

Secondary and tertiary care

6. Secondary care is provided largely for patients living in a local catchment area and ideally should comprise:
 - a) efficient and timely acute and elective services in all the major specialties covered by general medicine, general surgery, paediatrics and obstetrics and gynecology.
 - b) efficient provision of non-core secondary services through collaboration between neighboring secondary providers, with different hospitals being the hub for different services.
 - c) continuous emergency access via appropriately staffed and supported A & E departments.
 - d) strong links with relevant local community and other health agencies.
 - e) appropriate access to tertiary services and links with tertiary centres.

- f) continually evolving evidence-based practice, sound clinical protocols and the successful integration of clinical services with teaching and research.
7. These roles are all played in London’s hospitals, apart from some of the highly specialised ex-SHA hospitals. In particular they represent the prime responsibility of a ring of hospitals outside inner London. We have visited a number of these hospitals in the course of the review, and have been strongly impressed by their positive approach, usually in difficult circumstances. These hospitals need to be encouraged.
 8. These responsibilities are also fulfilled by the inner London teaching hospitals, often faced with very deprived and sick local populations. Teaching hospitals also have other responsibilities and these sometimes seem to conflict with their local responsibilities. Tertiary care within “regional” and “supra-regional” specialties is expensive. This gives the impression that desperately needed local funding is being diverted to highly specialised care. In addition, teaching and research activities are sometimes seen as an expensive luxury. We came to the conclusion that there is a need for greater clarity in the tertiary and secondary funding streams.
 9. Our evidence did not confirm that funding for secondary services was being diverted to support tertiary care, or that Londoners were more likely to receive care in tertiary services than the rest of England. The figures are:

Regional as % of non-regional specialist activity

	by FCES	by bed-days
London	890	11 %
England	8 %	10%

Teaching and research

10. It is hard to over-estimate the importance of teaching and research to London’s health services. 70% of England’s NHS funding for research goes to the Thames Regions – predominantly in London, providing income of £239m for major London hospitals in 1997/98 alone.
11. There are several important factors which explain and support the high level of activity:
 - ◆ London contains a number of major specialist hospitals (including teaching hospitals and ex-SHA hospitals) providing excellence in clinical and scientific research. This research activity is supported and enhanced by the close relationships that exist between these major hospitals and their associated medical schools and institutes.
 - ◆ Links to undergraduate clinical education: London has a higher density of medical schools than elsewhere. 42% of England’s medical undergraduates train here and much non-medical clinical education is also based around medical school departments.

- ◆ Links to postgraduate clinical education: 50% of all overseas doctors who visit the UK, and 40% of all “home” doctors take courses in London, some of which will include research training.
 - ◆ Links to industrial research: There is a very strong concentration of relevant commercial sector research in London (and the South East). This covers the biotechnology, pharmaceutical and medical systems industries.
12. In addition, the 1996 HEFCE Research Assessment Exercise (RAE) demonstrated the high quality of clinical and basic medical research in London. There are important interactions between teaching, research and service funding streams that affect the viability of NHS Trusts. Simultaneous changes in research, education and health care create turbulence that is magnified the more closely these issues are intertwined.

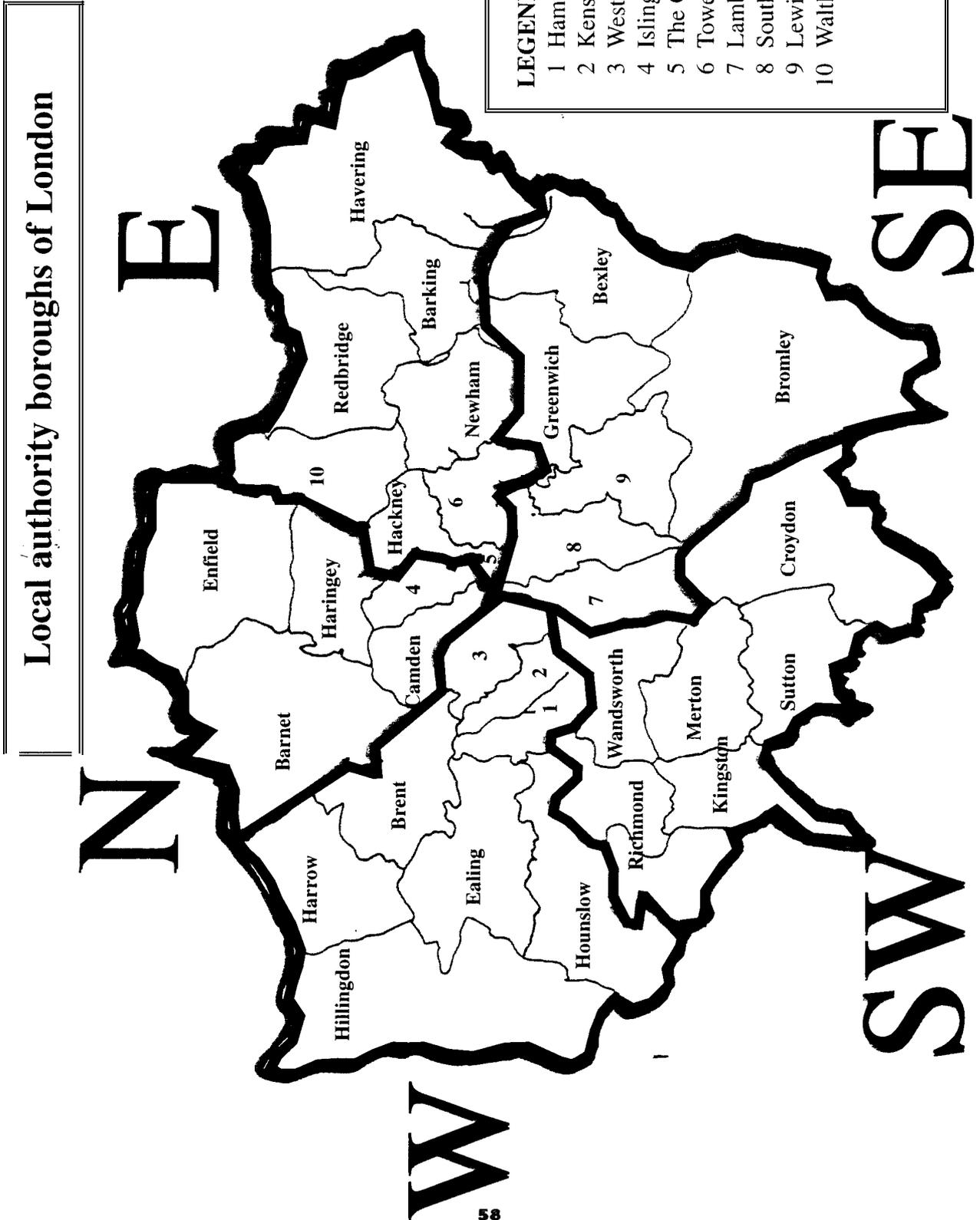
Other factors driving change in hospitals

13. Changing policy in medical staffing has an important impact on configuration of acute hospitals. The three main initiatives have been
- ◆ changes in specialist medical training towards more structured, competency-based and organised learning
 - ◆ increasing requirements for sub-specialisation in many specialties, but in particular those considered in the Calman-Hine report on cancer services
 - ◆ the New Deal on junior doctors’ hours, which set maximum limits for safe hours on duty for junior doctors and effectively reduced the supply of junior doctors.
14. All three of these initiatives are planned to improve standards of care for patients. In doing so the effect, in practice, is a requirement for doctors to work in larger teams which can be most economically deployed in larger multi-specialty hospitals. This supports a move to rationalise and consolidate services.

The hospital workforce

15. Above, we have highlighted changes which impact on medical education and manpower in London’s hospitals. Written and oral evidence has also highlighted a number of problems in ensuring that London has access to a trained, stable, workforce, particularly nursing staff but also other health care professionals such as occupational therapists and physiotherapists. That evidence drew attention to the need to address a number of issues involving terms and conditions of service but was particularly concerned that action be taken to ‘ensure appropriate workforce planning, to improve opportunities for staff training and professional development, to reduce costly high staff turnover and to improve the retention of skilled staff in London’s health service.

FIGURE 5



16. Although there are shortages in all professional staff groups, those amongst nurses have given rise to public concern. There is a recruitment problem generally, but key areas with difficulties are children's services, general surgery, cardiac, renal and women's services. Wastage from training is high – varying with the nurse student intake – but can reach levels of 30%. These shortages of both staff and skills will impact on the configuration of London's acute services, which must reflect the availability of an appropriately trained nurse workforce.
17. The traditional role of teaching hospitals in nurse training in specific specialist clinical skills continues. We also welcome the development of NHS education and training consortia, which are coming together to address workforce planning issues. Although the Project 2000 nurse education and training programme has national benefits, there is evidence to suggest that implementation in London (where factors such as cost of living and often poor working environment do not attract student intake) has run into problems which severely affect nurse manpower supply. We recommend that action be taken to explore ways in which NHS Trusts can be supported in addressing changes in nurse education and training and in recruiting and retaining staff. In this context, we have drawn attention elsewhere in this report to the need to improve the representation of ethnic minority communities in the workforce. This will call for considerably more community involvement in recruitment initiatives.

Size of A&E departments

18. The A&E department is at the interface between primary and secondary care and should be viewed as part of the community as well as a department within an acute hospital setting. Where problems are visible in the A&E department, these are often a reflection of pressures elsewhere in the hospital, where there should be a full range of facilities for emergency admissions, treatment and discharge to enable care to be provided effectively. There should be enough beds to admit both emergencies and elective cases.
19. We needed to take a view on the desirable size of an A&E department. In doing so, we have drawn heavily on the 1995 unpublished report on this subject, commissioned by LIG from a Panel chaired by Professor Sir Norman Browse, which we consider to be still valid. This concluded that for quality control and supervision, an accident and emergency department should be dealing with no fewer than 50,000 new attendance per annum and no more than 100,000 per annum. Since about 15 to 20% of patients attending are admitted as in-patients, it is possible to gain an impression of the number of beds required in a hospital for the emergency element of their work. Such factors should help determine the necessary size of hospital service the population requires.
20. The Browse report analysis suggested scope for reducing the number of A&E departments in inner London without compromising safe access for patients. This is a hard message for many local people who treasure immediate access to their hospital. Closures should therefore only be planned where access to patients is not compromised, the number of patients attending remaining A&E departments is not so large that it overwhelms the staff and accommodation, and the number of beds available is sufficient to cope with the increased admissions.
21. So-called minor injuries units can provide a good local service for the less severe end of the spectrum of A&E attendance and can support the rationalisation of A&E departments. Close working relationships with A&E departments and other hospitals are vital for the success of such units.

Issues specific to London's sectors

22. There is a rational basis for defining London's health services in terms of five sectors (Fig.5). These show a good match with traditional flows for specialist care from outer to inner London. These are used by Directors of Social Services when considering cross-boundary issues in social care and these also match the sectors used by the University of London in analysing the main areas of interest for each college.
23. The development of collaborative mechanisms in different forms has been improving the coherence of planning in London's acute sector. The medical schools have been an important positive influence in directing these changes. The pace of change should improve if the moves described in chapter 4 are implemented, in particular the decrease in market competition, and increases in strategic planning and leverage in the five sectors and on a pan-London basis.

Capital developments

24. We have been asked to consider a number of specific developments in addition to those set out in our terms of reference, namely the proposals for the Queen Elizabeth Hospital, Greenwich and for University College Hospital. For both these and the three specific questions set us, we agreed in advance that we would examine proposals in the light of

- ◆ improvements in quality of care, either directly or through the release of funds to be diverted elsewhere
- ◆ access to services for local residents
- ◆ ability to adapt flexibly to future changes in health service provision
- ◆ impact on local primary, community and social care
- ◆ impact on other providers of acute services – is there any duplication of services?
- ◆ where relevant, the impact on teaching and research
- ◆ how were the views of local stakeholders taken into account?
- ◆ what were the financial implications of the proposals?

We have written separate sections on the hospitals included in the terms of reference, and have alluded to the Greenwich and UCLH developments in the sections below.

South East London

25. In South East London, the health authorities have led a collaborative exercise to build clinical links across the five outer south east London acute sites. This is one example of the increased trend towards collaboration and clinical linking, and we support these moves strongly.

26. The merger of the Guy's & St Thomas' NHS Trusts has allowed the development of proposals for rationalizing services across the two sites. Further consideration has also been given to a rational distribution of specialised services between the King's Healthcare NHS Trust and the Guy's & St Thomas' NHS Trust, and we wish to encourage the ongoing debate about these programmed for change.
27. Two matters were drawn to our attention: the capacity of the A&E department at St Thomas' Hospital to absorb the increased load following closure of the Guy's A&E department and the proposal to build new accommodation on the St Thomas' site at the same time as some recently built accommodation at Guy's would be vacated.
28. In looking at the future provision of emergency services in the sector, we also visited Lewisham and King's College Hospitals as well as the two sites most closely concerned, and we sought details of the plans for handling emergency care after Guy's Hospital ceases to receive blue light ambulance borne cases. Guy's and St Thomas' Hospitals together currently handle some 160,000 attendance annually. Current calculations assume that some of these will be cared for at Lewisham and King's College Hospitals (where facilities and accommodation already exist) and others in a minor injuries unit on the Guy's Hospital site. Concerns remain, however, as to whether the number of residual cases will be too large (ie over 100,000 per annum), particularly if current annual increase in A&E attendance in London continues at the pace of the last few years. We recommend that careful attention should be given now to evaluating the predictions of A&E attendance and that the situation should be monitored by the South Thames Regional Office.
29. The case was also made to us that the plans to transfer further services to the St Thomas' site, involving a major capital development, were illogical when the Guy's site appeared to have suitable accommodation for the purpose. In the longer term, the Guy's and St Thomas' NHS Trust and its purchasers will need to consider which configuration of services provides the best clinical care, and how the revenue implications affect their ability to provide and purchase services. We would expect this NHS Trust to justify fully the building of new facilities given the condition of the estate on the Guy's site, and the NHS Executive be satisfied that this will be the best use of resources. Lewisham Hospital provides an example of strong secondary care, collaborating well with other local health and social services. We also endorse the existing strategic direction for the King's Healthcare NHS Trust and would wish to see prompt implementation of their plans.
30. We were also asked to look at the scheme for re-building acute services for the local population of Bexley and Greenwich, which involves a major capital scheme to develop the Queen Elizabeth Hospital to replace services at Greenwich DGH. Using the criteria we described above, we were very impressed with the planning, preparation and consultation which had been undertaken to put forward this scheme. Collaboration between agencies was well advanced. We supported this development.

South West London

31. In this sector moves to rationalise services between the Atkinson Morley Hospital and St George's Hospital were well in train and further developments on the St George's site (particularly for cardiology) seemed entirely appropriate.

32. We address separately the issue of the future of Queen Mary’s Hospital, Roehampton, where there is an urgent need to develop a coherent and credible arrangement for collaboration between local providers. Partly as a result of the problems at Queen Mary’s Hospital, the two closest hospitals, St George’s and Kingston are under great pressure from emergency work. They are both dealing with the situation imaginatively, but the system is under strain. There is a need to address the future collaboration arrangements between acute sites in this sector, and we welcome the work begun by health authorities to facilitate that collaboration.

West London

33. The medical school mergers with Imperial College in this sector have brought together the St Mary’s, Charing Cross & Westminster and the Royal Postgraduate Medical Schools and a number of postgraduate institutes. This has given impetus to the more rational distribution of specialist services. The direction of change promoted by these moves is one we would strongly endorse. However, much remains to be achieved and we would encourage further enhanced collaborative efforts amongst the NHS Trusts concerned. The health authorities should facilitate this approach and ensure its continuation.
34. We were impressed by the Chelsea and Westminster Healthcare NHS Trust’s approach of close collaboration with other providers of tertiary services in that locale, so that inefficient duplication is avoided. The Hammersmith Hospitals NHS Trust is making progress in integrating the work of the Charing Cross and Hammersmith Hospitals and this should be further promoted.
35. These issues are of particular concern at the Hammersmith Hospital, which plays such an important role in the nation’s research endeavors. It is the major focus of investment by the Medical Research Council and many other research funders in terms of both buildings and staff. This investment is dependent on a viable clinical base but this is relatively small and faces pressures on its financial viability. It is therefore vital for further work to be done by the relevant health authorities and NHS Trusts to follow the approach taken by Imperial College in its systematic consideration of the distribution of services across the whole sector. The proposal to transfer the services of Queen Charlotte’s Hospital to the Hammersmith Hospital site should be pursued actively.
36. The transfer of St Mark’s Hospital, with its name and ethos, to the Northwick Park Hospital site has demonstrated how clinical excellence can be maintained while services are integrated into a new site. This model could offer an example for other centres of clinical excellence.

North London

37. We were impressed by the work being carried out to increase the collaboration between the UCLHS NHS Trust and the Royal Free Hospital NHS Trust, involving academic and service interests to improve patient care.
38. We were asked to consider the development by the UCLHS NHS Trust. This scheme met all our criteria on the grounds of clinical need, coherence with other strategies and local support. It is a sorely needed development, and we strongly support its progress. —

39. The Whittington Hospital, despite its dilapidated condition, is an example of the local secondary care hospitals described earlier, which seeks to retain and enhance its core role as a DGH; serving a local population, yet remaining a significant centre for medical education. We support this NHS Trust in its ambitions to build new strategic alliances with local secondary and tertiary service providers and to develop primary care interface and outreach services with local community NHS Trusts and GPs.
40. We also welcome the collaboration developing in this sector through the synergy review, involving the health authorities, local authorities, NHS Trusts, the North Thames Regional Office and the University of London. This is precisely the sort of development which we envisage in each of the sectors to ensure that key priorities for improving care are planned and implemented jointly.

East London

41. We have commented separately on the plans for the Harold Wood and Oldchurch Hospitals and the Royal Hospitals NHS Trust. The health needs of the people of East London have been a recurring theme in this report; these represented the starkest mismatch between needs and services available. We have visited the Newham and Homerton Hospitals, which carry out a vital role in difficult circumstances. Newharn Hospital, in particular, is in urgent need of capital development. There is also a need for these hospitals to be supported by clinical excellence from the local medical school. Overall, it is important to ensure that efforts continue to support reasonably integrated hospital services across the sector and some of our recommendations later in this report emphasise this.

Recommendations

42. Here we take account of the fact that there is not an excess of beds in London in making recommendations about directions of change in general and about some specific hospital plans.
- 42.1 Health authorities and NHS Trusts should plan services for the local, sectoral and pan-London populations in a co-ordinated way. Our recommendations on planning at sectoral and pan-London level are designed to address this issue. The University of London Colleges have provided a valuable model for rationalizing activities across several sites which could be emulated.
- 42.2 There should be greater clarity about funding for tertiary services so that potential conflicts with funding for local communities are avoided.
- 42.3 Hospitals in the “outer ring”, away from the centre of London, should be supported and planned in relation to the local needs of the communities they serve and the need to work closely with tertiary centres, largely in their own sector.
- 42.4 Accident and emergency departments should not close unless the conditions described in chapter 9 are met. Facilities such as Minor Injuries Units should only be introduced with properly developed and managed communication plans locally to ensure that these are well publicised.

42.5 **Guy 's/St Thomas' proposals:**

- a) the closure of Guy's Hospital A&E department should be carefully re-evaluated to ensure that services are able to cope.
- b) Before proceeding with major capital development on the St Thomas' site, the Guy's and St Thomas' NHS Trust needs to demonstrate the validity of its plans.

42.6. **Hammersmith Hospital**

A long term plan should be developed for the Hammersmith Hospital to ensure that its role in national and international research is fostered. Rational plans for service distribution across the sector should be encouraged to help achieve this aim.

42.7. The plans for development of the Queen Elizabeth Hospital, Greenwich, and for UCLH are supported by the Panel. We also believe the Whittington and Newham Hospitals are in urgent need of capital investment.

42.8. London's hospitals need more effective ways to address problems in recruiting and retaining nursing and other professional non-medical staff. This should include action to support the changes introduced in nurse training and education, improvements in the physical environment in which many staff work, and innovative recruitment initiatives that attract staff into the health service.

10: QUEEN MARY'S UNIVERSITY HOSPITAL, ROEHAMPTON

1. Queen Mary's Hospital Roehampton (QMR) is part of the Richmond, Twickenham and Roehampton NHS Trust, which provides acute and community care for a population in the north west of Merton, Sutton and Wandsworth Health Authority, and the north east of Kingston and Richmond Health Authority. At the time of this report, the hospital contained 250 beds for acute medical care and rehabilitation, with 64 acute mental health beds.
2. When we were asked to consider the hospital's future, it was already included in a local review of services following the recent transfer of a range of services from the site. Non-elective surgery, women's and children's services ceased to be provided there in April 1997 and, as a result, the Accident and Emergency Service at the hospital no longer accepts major trauma, emergencies thought to be surgical or gynecological, or medically ill children. Some elective surgery was transferred to Queen Mary's Hospital from Kingston Hospital to use the resulting spare capacity.
3. We were informed of the rapid changes which were in progress and we agreed that these needed urgent attention to avert the immediate problems outside the scope of this review.
4. The two health authorities involved initiated a second review of services in May 1997. The outcome of that review is to be issued for public consultation at the end of the year. We did not wish to prejudice the outcome of that consultation, and we will accordingly confine ourselves to a commentary on the approach taken by the Review Team and the robustness of their preferred option. In doing so, we considered the criteria set out in chapter 9 on hospital services.

Improvements in quality of care

5. The Steering Group did consider clinical viability – and hence safety of service to patients – in its option appraisal, and weighted this more highly than any other criterion. We note that the preferred option is made up of the preferred service models of each of the clinical sub-groups, making it consistent with the views of those local clinicians and GPs who contributed to the process. The Steering Group included flexibility in a judgement which also included tests for robustness in fitting national and local policy, and offered sufficient capacity to accommodate short, medium and long term activity levels. The evidence which we have received from external bodies noted consistent concern about the capacity of Kingston Hospital and St George's Hospital to take on extra in-patient work in the short term. In the longer term, it was also alleged that the Kingston Hospital site was too constrained to sustain more services, both on grounds of the building space and the volume of traffic it would generate.

Access to services for local residents

6. The Steering Group considered levels of car ownership and public transport links. It selected an option which retains access at Roehampton for out-patient services, minor injuries, and longer stay rehabilitation, but which would require further travel for in-patient and day case treatment.

Impact on local primary, community and social care

7. The Steering Group considered the impact on non-acute services provided by the RTR NHS Trust, namely in-patient and day care facilities for geriatrics and mental health. It did not, at this stage, consider the impact on other services. We understand, however, that the consultation process is intended to gather this information and that no decision will be taken without this. In particular, the London Boroughs concerned are to be asked to comment on how each of the options would affect their services. Reviews of the future pattern of community and primary care services are also taking place, involving general practitioners and community staff working together to ensure that their services are co-ordinated to deal effectively with the changes.

What are the financial implications of the proposals?..

8. The Steering Group has considered the capital and revenue consequences of the proposals as far as acute services are concerned. We have not evaluated these implications in any depth, as this is a task for the health authorities before they reach any decisions.

Conclusion

9. Our examination of the situation in south west London gave us some serious concerns about the long-term future of patient care. We are pleased that health services locally have now been able to develop options for public consultation. We consider that the option preferred by the Steering Group provides a reasonable solution. However, we do expect local views to be fully considered in the consultation process, which should be followed with a commitment to deliver the eventual outcome.
10. Before reaching any decisions, the two health authorities concerned will need to ensure that any .. financial and operational consequences for other services have also been taken into account in calculations. We see this as a critical element in the process – changes in acute services should not be taking place without the assurance that these match the pattern of services provided in the community.
11. There is a need for a clear, unambiguous commitment to a credible plan which sets out where patients will be cared for, both immediately and in the longer term. The solutions for these two time scales may not necessarily be the same.
12. Public transport links should be taken into account in the event of any option being selected which involves further travel. We understand that bus routes have been changed in the past to cater for this and would recommend that these be kept under review over time if patients and their families are to be expected to travel to services.
13. There are a number of background factors which we would like to highlight, which provide pointers to ways in which similar situations should be handled in the future:
 - a) piecemeal erosion of services over a long period of time should be avoided. Health service professionals are often able to identify at an early stage health trends that will require changes in services. They need to embrace the responsibility to communicate these factors to the public and to local politicians.

- b) this pattern of erosion leads to accusations of “broken promises”, and reduces credibility and confidence in proposals emanating from NHS Trusts and the health authorities.
- c) it is vital for such difficult and often painful exercises to be accompanied by full and consistent communication in order to retain the trust of staff, GPs and users. Without such efforts services are affected by an inability to retain staff anxious about their personal futures.

Recommendations

- 14. We consider that the option preferred by the local Steering Group provides a reasonable solution. However, we expect local views to be fully considered in the consultation process, which should be followed with a commitment to deliver the eventual outcome.
- 14.1 There is a need for a clear, unambiguous commitment to fulfil a credible plan which sets out where patients will be cared for, both immediately and in the longer term. The solutions for these two time scales may not necessarily be the same.

11: HAROLD WOOD AND OLDCHURCH HOSPITALS

Background

1. The Havering Hospitals NHS Trust delivers acute care from Harold Wood and Oldchurch Hospitals, principally to the populations of the London Boroughs of Havering and Barking & Dagenham, and some residents of South Essex. Whilst there has been investment at Harold Wood Hospital in recent years, some facilities there are still of poor quality. Oldchurch Hospital's estate is predominantly old, poor quality stock, ill-suited for modern health care and difficult to re-develop. We were asked to look at the local plans for bringing acute services to a standard suitable for modern health care.
2. During 1994, the NHS Trust faced problems in delivering a clinically safe A&E service from both of its sites and these were temporarily centralised on the Oldchurch Hospital site. Over the years, a number of hospitals have closed in this locality, leaving the London Borough of Barking & Dagenham without a local hospital. This has created suspicions in the local population that the current plans for centralisation on the Harold Wood Hospital site will lead to the eventual closure of Oldchurch Hospital.

Outline of the scheme

3. In 1994, Barking & Havering Health Authority consulted on the provision of local accident and emergency services. Following public consultation, the decision was taken to provide A&E services at the Harold Wood site. This was principally because the Oldchurch site was difficult to re-develop, involving delay and expense, and recent development of obstetric, gynecology and pediatric facilities at Harold Wood Hospital needed to be co-located with A&E services.

Options considered

4. The NHS Trust has also developed an outline business case for investment in its acute services. A number of options were examined, including a minimum investment to meet statutory standards, dual site options with A&E services at Harold Wood Hospital and reduced facilities at Oldchurch Hospital, and a single site option concentrating all services at Harold Wood and selling off Oldchurch. The options (which did not include a single site option at Oldchurch) were scored against service quality, value for money and timescale for implementation. The option that satisfied service need and value for money was to centralise A&E services at Harold Wood Hospital and develop Oldchurch Hospital as a centre for planned care. Under the PFI process, three consortia were invited to submit detailed proposals. The NHS Trust has received proposals from each of the consortia, with one also developing a variant bid proposing a single site solution.

Access to services for local residents

5. We received representations from over 500 residents in the local area, evenly divided between support for services to be concentrated at Oldchurch or Harold Wood, depending on which was their closest hospital. We also received a petition from the Brentwood Gazette in support of the development of Harold Wood Hospital.

6. Oldchurch Hospital has better access for the majority of the local population than Harold Wood. Housing developments in Barking mean that the population is also expected to grow significantly by 2011, with Romford remaining closer to the centre of population than Harold Wood. Barking & Dagenham is the eighteenth most deprived Borough in England, with a correspondingly high level of illness in the population, and a high proportion of the population without access to a car. Although Brentwood District Council has expressed its strong opposition to any transfer of services from the Harold Wood site, it was noted that this local authority does not provide the social services which link with health care provision.
7. These factors argue, on balance, that Oldchurch is preferable to Harold Wood for access by those residents most likely to need emergency care. Nevertheless, both sites are within four miles of each other and have reasonable access by public and private transport. Oldchurch is nearer to King George's Hospital, Ilford, and this could have an impact. We were however persuaded that King George's Hospital also has a substantial patient workload and can expect to retain its A&E workload of 61,000 attendance a year. In line with developments elsewhere, the two NHS Trusts concerned will need to collaborate in providing elective specialties. We did not consider that an Oldchurch development would have significant impact further afield.

Improvements in quality of care

8. Both the dual and single site options would bring improvements in acute clinical care. The Havering Hospitals NHS Trust's Clinical Management Board's view is that a single site option would be optimal, providing improved patient care, strengthening operational efficiency and greater staff effectiveness and avoiding duplication of services. They also believed that the current two site plans could be deliverable and would address many of the anomalies in the current services. Their greatest concern was that a clear decision be implemented and that failure to make an early decision would have an adverse effect on clinical care and affect staff recruitment and retention.
.....
9. There are a number of spin-offs for other sectors of care in a capital scheme that would release savings in running costs. For example, a great deal of local mental health care resources remain tied up in support for Warley Hospital, a large psychiatric institution. The Health Authority needs to be able to support the closure of this facility with local re-provision of services. A more efficient acute service will enable them to do this.
10. A more efficient acute service will also help release funds for improvements in primary care. Local general practitioners who gave evidence supported an acute site based nearer the main population at Oldchurch. They are seeking more effective collaboration between GP practices, shared local clinic services and acute outreach clinics, to help reduce the number of patients having to attend appointments for minor treatment and consultant appointments at the main acute hospital site.
11. Although we support the need for re-development at Oldchurch, we were also aware that further attention should be paid to the health needs of the Brentwood population (70,000 people), including access to services. Brentwood lies within the county of Essex. Until recently, its needs have been considered with those people living within outer London Boroughs. Those historic referral patterns and links to service provision in east London remain. We recommend that further consideration be given to ways in which the health needs of the people of Brentwood are included in coherent local plans for the delivery of services.

Conclusion

12. There is urgency to take this forward. We understand that the local health services, the Local Medical Committee and the two local London Boroughs are committed to working together in detail on the development of the Oldchurch Park solution and other health and social care strategies which are in the best interests of the local population. We endorse this collaborative work. Furthermore, we endorse the single site Oldchurch area proposal as optimal on the grounds of access to a large proportion of the most deprived population and the strong support from the local authorities and GPs. Further work is necessary to develop this solution to show it is based on a sound financial footing in the local health economy.

Recommendation

13. We endorse the single site Oldchurch area proposal as optimal on the grounds of access to a large proportion of the most deprived population and the strong support from the local authorities and GPs. Further work is necessary to develop this solution to show it is based on a sound financial footing in the local health economy.

12: PROPOSALS TO RATIONALISE SERVICES IN THE ROYAL HOSPITALS NHS TRUST

Background

1. Recommendations made in the Tomlinson Report included the redevelopment of the Royal London Hospital site at Whitechapel with a transfer to it of all services from St Bartholomew's Hospital, followed by its closure. The recommendation was based on the premise that it would provide a more efficient service and release some sorely needed funds to improve primary and community services in the East End of London. It was also partly based on the assumption that there were too many beds in London.
2. Following the Government's endorsement of this plan much work has been done in the intervening five years to try to take this recommendation forward.
3. We were asked to take a fresh look at the proposals against a background of strongly polarised views in the public and amongst the staff of the two hospitals, played out in high-profile press coverage. We have therefore been at pains to gain the views and opinions of as wide a spectrum as possible of those directly concerned within both the community and the health services in this part of London. We have also paid particular attention to teasing out the basis on which current proposals have been reached and on which our own recommendations can be made.
4. There is much common ground on the needs which should be addressed:
 - ◆ the population of East London is amongst the most deprived in the UK – deprivation indicators place Tower Hamlets at the top of the league.
 - ◆ it seems likely too that adequate account may not have been taken of indices of deprivation in the funding formula. Furthermore it was probable that the resident population was greater than that used in resource allocations and calculations.
 - ◆ the services currently provided in primary care, in the community, and in the hospitals, are failing to meet needs.
 - ◆ the Royal London Hospital buildings are in a poor state; old stock inefficiently arranged and poorly maintained. A new hospital on this site is desperately needed.
 - ◆ Newham and Homerton Hospitals are to the east and north amongst populations with high health care needs and their services should be supported. They should not be threatened by proposals for change in Whitechapel and at St Bartholomew's Hospital.
 - ◆ against the background that Londoners as a whole can ill afford to lose more beds, loss in this particularly deprived part of London would require special justification.

- ◆ as well as a requirement to remedy the gaps in the services for the “local population the Trust has a wider responsibility for education and training, for research and for specialised tertiary services to the rest of the region and outside it. There is a tension between funding for these responsibilities and for those to the local community.
- ◆ the status quo is unsustainable and there is a desperate need to remove the uncertainty surrounding the future of the Royal London and St Bartholomew’s Hospitals.
- ◆ proposals should be examined in the context of other developments in London, particularly at UCLH, Guy’s and St Thomas’ Hospitals.
- ◆ we were told that the medical school could fulfil its responsibilities for teaching and research in a one or two site option.

Status of the existing plan

5. In this climate we were asked to look at the future of St Bartholomew’s Hospital. The most commonly quoted options given to us have been either to close all facilities at St Bartholomew’s Hospital and centralise all services provided by the Trust in new buildings on the Whitechapel site, or to build a smaller new hospital at Whitechapel, and create a new configuration of services at Smithfield.
6. The centralisation of services at the Whitechapel site under the existing plan is the favoured solution clinically for the following reasons:-
 - ◆ brings all clinical services together and therefore enables more efficient running.
 - ◆ enables better communication between staff and more ready availability of case notes and other information.
 - ◆ eases referral of patients between specialties.
 - ◆ enhances collaboration between specialties.
 - ◆ avoids duplication of support services.
 - ◆ eliminates travel between hospitals for patients and staff.
7. A single site option of sufficient size to fulfil all of its responsibilities to the population it serves in East London and beyond it seems therefore to have persuasive advantages over a dual site option. Against this, the development of a 1200 bed hospital at Whitechapel represents a larger hospital development than has been seen in England for many years. There is some concern too about the efficiency gain associated with concentrating services on one site when the size of hospital becomes greater than 600 beds.¹ These researchers could not find evidence of increasing efficiencies much above this figure where services have already been rationalised between sites. Finally, provision of services from one very large hospital loses some of the flexibility for the future compared with that

¹NHS Centre for Reviews and Dissemination, University of York

provided from two sites. Building on the cramped Whitechapel site amongst existing buildings is likely to be complicated, expensive and time-consuming. Current estimates of completion dates are conservative at five or six years. Estimates of its cost have ranged from £250 million to £308 million, and these have been questioned as being low, compared with the cost of building smaller hospitals in London. We had concerns that the worst possible outcome could arise, of a smaller hospital being built, while all other facilities were closed, reducing total capacity for patients and diminishing the ability to foster teaching and research in the area.

Proposals for two sites

8. It has been put to us that a dual site option, retaining facilities on the Smithfield site, would be preferable to this worst outcome. Advantages include:

- ◆ preservation of a hospital currently providing high quality care, especially tertiary care.
- ◆ patient support.
- ◆ good modern education accommodation on site.
- ◆ significant research accommodated in Charterhouse Square, which cannot be transferred easily.
- ◆ a potential degree of flexibility to allow some tertiary services to continue in the face of intense demand for local secondary care.
- ◆ flexibility for other potential non-NHS clinical developments which would complement the NHS.
- ◆ retained benefit of the recent investment in upgraded facilities such as wards and operating theatres.

Disadvantages include:

- ◆ potential for inefficient duplication of services.
- ◆ difficulties in communication between specialties.
- ◆ cross-referral more time-consuming.
- ◆ collaboration/co-operation between specialists inhibited.
- ◆ travel time for staff between hospitals increased.
- ◆ local resident population is small in number (but see comments later on the daytime commuter population and South Islington residents).

9. On the basis of these considerations, we could not envisage as viable a dual site option which simply left two hospitals each providing similar services. This would not be efficient for patient care – the Trust in its careful calculations of the running costs of such an option have shown that it would be a much more expensive option (estimates have varied between £9 million and £28 million per annum). There is therefore no good clinical or economic justification for such an option.
10. The only possibility for a dual site proposal would have to incorporate a rational distribution of services between the hospitals, so that the two sites were run as one with complementarily and not duplication. Furthermore, the services at each hospital would have to provide those which are relevant to their siting. On this basis it seems most rational to recommend that all secondary care at least should be provided on the Whitechapel site near the centre of the vast majority of the population. We also recommend that there is no case for re-opening A&E services on the St Bartholomew's Hospital site. In so recommending we have taken account of the close proximity of the University College, London, Hospital and other A&E departments serving the small local population in the City and the larger population of South Islington.
11. We have therefore only examined further the relative merits of the one site option and a two site option in which some specialised tertiary and associated services are provided at the St Bartholomew's Hospital site, and the remainder at the Royal London, the two sites complementing each other in a rational way. A new building on the Whitechapel site is required for either option.
12. Optimizing services provided from more than one site can be shown to work effectively and good examples of this arrangement exist or are planned in London.
13. The key question is how much more expensive would it be to run a two site versus a one site operation? Estimates of the cost of building a smaller new hospital at Whitechapel, taking into account the loss of potential sale value of St Bartholomew's Hospital, reveal modest differences between these capital costs and those of a single site option. These estimates, although carefully made, are subject to variability in the future, but in any case do not materially affect the argument which is much more dependent on calculation of the revenue costs of running the two options. These comprise capital charges, clinical and clinical support costs and the costs of servicing the buildings. Operational costs are very dependent on assumptions made about staffing and working practices as well as bed numbers and other measures of utilisation. Such assumptions become more tenuous the longer the timescale over which they are projected. In this case we are considering projected costs for beyond 2003.
14. On our behalf independent financial experts worked with health service providers and the NHS Executive to analyse the gap between the affordability of different options, concentrating on the difference between a single site option and a dual site option with a tertiary centre on the Smithfield site. In the timescale available to our review it has not proved possible to make an accurate assessment of the likely extent of the difference in the affordability of these two types of option, although the dual site would be more expensive.

Fixed points in planning

15. We see both the preceding options as being too definitive for the current state of knowledge about the future health needs of the people of East London. We believe that the people of East London must have sufficient size and range of services available to meet their needs - this represents some 1200

beds to cover the range of services currently provided by the NHS Trust, chiefly providing secondary care for the people of Tower Hamlets and the City, and tertiary services for a wider regional and national population. They also need a centre of excellence for teaching and research. How can these facilities best be ensured for the future?

16. In the first instance, in line with our recommendation in chapter 7, intermediate care beds and community services need to be built up without delay. This should relieve some of the pressure on acute services, and these facilities can be provided more rapidly than waiting for a large capital development. The health service should be examining options to use its existing sites flexibly to provide these facilities, and should also be working with the local authority to identify any suitable properties which they may have available. The opportunity provided by the Government's recent announcement of more funds to support care for elderly people, particularly in the community, also offers scope for this proposal.
17. Secondary care needs to be looked at more broadly than simply in relation to the single NHS Trust. Both the Homerton and Newham Hospitals need to be supported. The Homerton has two closed wards because funding for them has not been available. Three wards at St Andrew's Hospital are also closed. Newham Hospital needs capital development to replace sub-standard facilities at St Andrew's on the Newham site, and to provide extra capacity for local secondary care. This would also provide an opportunity for secondary facilities to link more closely with teaching, as happens in other sectors of London.
18. Meanwhile, a rather smaller development should take place on the Whitechapel site, probably of the order of 900 beds, combining local secondary care and some tertiary facilities.
19. There is a continuing need for St Bartholomew's Hospital to fulfil its service, teaching and research responsibilities and we are concerned that these could be impaired by a long, slow, erosion before new facilities are built at the Whitechapel site in seven or eight years' time. The standards of service on the site must continue to be of the highest order. During this interim phase the NHS Trust will need to ensure that the services across the two sites can be provided in a rational, efficient and acceptable way. This will also include some decanting of services during building on the Whitechapel site. St Bartholomew's should then focus on a small number of tertiary services and currently the most favoured options are for cardiac and oncology services. There is a good case for a daytime minor injuries unit on this site too.
20. Although plans for the future have to be formalised now, their full realisation will not occur for several years. It is notoriously difficult to predict changes in the provision of health services, and it is essential that they are not damaged pending the opening of new facilities. These proposals will therefore need to be kept under review as health care needs, and ways of meeting them, change over the years.

Recommendations

21. We recommend a package of services to meet the needs of the deprived local population, and also to ensure that tertiary services and teaching and research responsibilities are supported. These proposals will need to be kept under review as health care needs, and ways of meeting them, change over the years.

- 21.1 Investment in intermediate care beds and community services should be made now and advantage taken of the recent Government initiatives on community services for elderly people.
- 21.2 Capacity at Homerton and Newham General hospitals should be fully utilised.
- 21.3 A new hospital at Whitechapel is sorely needed and should include about 900 beds for secondary and tertiary care.
- 21.4 Some tertiary services should be maintained on the Smithfield site with a particular focus on cardiac and cancer services.

Appendix

CONTRIBUTORS

Health Authorities

Barking & Havering HA
 Bexley & Greenwich HA
 Brent & Harrow HA
 Camden & Islington HA
 Ealing, Hammersmith & Hounslow HA
 East London & the City HA
 Enfield & Haringey HA
 Kensington & Chelsea and Westminster HA
 Kingston & Richmond HA
 Lambeth, Southwark & Lewisham HA
 Merton, Sutton & Wandsworth HA
 Redbridge & Waltham Forest HA
 West Kent HA

NHS Trusts

Bethlem & Maudsley NHS Trust
 BHB Community Health Care NHS Trust
 Bournemouth NHS Trust
 Camden & Islington Community Health Services NHS Trust
 Chase Farm Hospitals NHS Trust
 Chelsea & Westminster Healthcare NHS Trust
 City & Hackney Community Services NHS Trust
 Enfield Community Care NHS Trust
 Essex Ambulance Service NHS Trust
 Forest Healthcare NHS Trust
 Great Ormond Street Hospital for Children NHS Trust
 Guy's & St Thomas' Hospital NHS Trust
 Hammersmith Hospitals NHS Trust
 Haringey Healthcare NHS Trust
 Havering Hospitals NHS Trust
 Homerton Hospital NHS Trust
 King's Healthcare NHS Trust
 Lewisham & Guy's Mental Health NHS Trust
 Lewisham Hospital NHS Trust
 London Ambulance Service NHS Trust

Newham Community Health Services NHS Trust
 Newham Healthcare NHS Trust
 North Middlesex Hospital NHS Trust
 Northwick Park & St Mark's Hospitals NHS Trust
 Optimum Health Services NHS Trust
 Parkside Health NHS Trust
 Queen Mary's, Sidcup NHS Trust
 Redbridge Health Care NHS Trust
 Richmond, Twickenham and Roehampton Healthcare NHS Trust
 Riverside Community Healthcare NHS Trust
 Riverside Mental Health NHS Trust
 Royal Brompton Hospital NHS Trust
 Royal Free Hampstead NHS Trust
 Royal Hospitals NHS Trust
 St George's Healthcare NHS Trust
 St Helier NHS Trust
 St Mary's NHS Trust
 Tower Hamlets Healthcare NHS Trust
 University College, London Hospitals NHS Trust
 Wandsworth Community Health NHS Trust
 Whittington Hospital NHS Trust

Local Authorities

Association of London Government
 LB Barking & Dagenham
 LB Barnet
 LB Bexley
 Brentwood District Council
 LB Camden
 LB Greenwich
 LB Hackney
 LB Hammersmith & Fulham
 LB Harrow
 LB Havering
 LB Islington
 LB Kensington & Chelsea
 LB Kingston Upon Thames
 LB Lambeth

LB Lewisham
 LB Newham
 LB Redbridge
 LB Richmond upon Thames
 LB Southwark
 LB Sutton
 LB Tower Hamlets
 LB Waltham Forest
 LB Wandsworth

Community Health Councils

Barking, Dagenham & Havering
 Basset
 City & Hackney
 Greater London Association of CHCS
 Islington
 Lewisham
 Newham
 Redbridge
 Southwark
 Tower Hamlets
 Wandsworth
 Waltham Forest

Colleges

College of Occupational Therapists
 Imperial College of Science, Technology & Medicine
 London School of Hygiene & Tropical Medicine
 Royal College of General Practitioners
 Royal College of Obstetricians & Gynecologists
 Royal College of Midwives
 Royal College of Nursing
 Royal College of Pathologists
 Royal College of Physicians
 Royal College of Psychiatrists
 Royal College of Radiologists
 Royal College of Surgeons of England
 Queen Mary and Westfield College
 City University, St Bartholomew's School of Nursing & Midwifery

St Bartholomew's & the Royal London School of Medicine & Dentistry
 St George's Hospital Medical School
 UMDS at Guy's & St Thomas' Hospitals
 University College, London

Other Organisations & Associations

Age Concern
 Alfayed Charitable Foundation
 Alzheimer's Disease Society
 Andersen Consulting
 London Branch of Association of Directors of Social Services
 Barking & Waltham Forest Local Medical Committees
 Barking, Havering, Redbridge and Waltham Forest Local Pharmaceutical Committees
 Bart's Hearts
 British Dental Association
 British Medical Association
 Bromley by Bow Centre
 Central & East London Education Consortium
 Chartered Society of Physiotherapy
 City & East London Local Medical Committee
 Community Practitioners & Health Visitors' Association
 Corporation of the City of London
 Dagenham Constituency Labour Party
 Disablement Association of Barking & Dagenham
 Doctors' Save Bart's Society
 East London Communities Organisation (TELCO)
 East London Education & Training Consortium
 East London Mosque Trust Ltd
 Elizabeth Garrett Anderson Appeal Trust
 Emergency Bed Service
 Greater London Forum for the Elderly
 Greater London Pensioners Association
 Hands Off Greenwich NHS
 Health Action for Homeless People
 HEFCE
 Joint Forum on Mental Health & Hopelessness
 Joint GP Fora of East London
 Joint Medical Council of St Bartholomew's, Royal London, London Chest & Queen Elizabeth's Hospitals

Imperial Cancer Research Fund
 Independent Health Care Association
 Islington Pensioners Forum
 King's Fund
 London & Middlesex Local Medical Committees
 London Fire & Civil Defence Authority
 London Health Alliance
 London Health Emergency
 London Health Partnership
 London Research Centre
 London Voluntary Service Council
 Maudsley Institute of Psychiatry
 MENCAP
 MIND
 MPA Health Strategy & Planning
 MSF
 National Pharmaceutical Association
 Newham Inner City Multifund
 Patients Forum
 Pharmaceutical Services Negotiating Committee
 Public Health Laboratory Service
 Relatives Association
 Redbridge & Waltham Forest Local Medical
 Committee
 Retinoblastoma Society
 Robson Planning Consultancy
 Royal Pharmaceutical Society of Great Britain
 Save Bart's Campaign
 Save Bart's Patients Campaign
 SHELTER
 SICK
 South London Organisation Of Vocational Training
 Schemes
 Special Trustees for St Bartholomew's
 St Bartholomew's Alumni
 St Bartholomew's Medical Council
 Stroke Association
 UNISON
 Women for EGA

Members and former Members of Parliament

Mr N Beard
 Mr T Brake
 Mr P Brooke
 Mr P Burstow
 Mr V Cable
 Mr D Campbell-Savours
 Ms J Church
 Ms A Clwyd
 Mr H Cohen
 Mr T Colman
 Mr J Corbyn
 Mr J Cryer
 Mr K Darvill
 Mr E Davey
 Mr J Fitzpatrick
 Mr M Gapes
 Ms E Gordon
 The Rt Hon Sir E Heath
 Ms M Hedge
 Ms K Hoey
 Mr S Hughes
 Ms O King
 Mr A Love
 Mr T McNulty
 The Rt Hon R Moyle
 Mr S Newens (Euro MP)
 Sir M Neubert
 The Rt Hon Sir I Percival
 Ms L Perham
 Ms J Ryan
 Mr B Sedgemore
 The Rt Hon C Smith
 Mr S Timms
 Ms J Tonge
 Mr S Twigg