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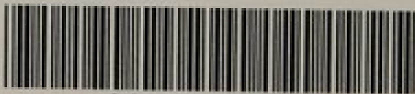

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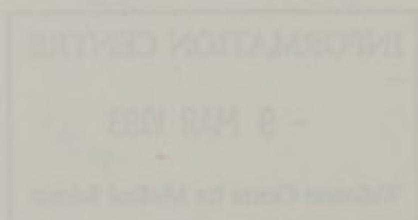

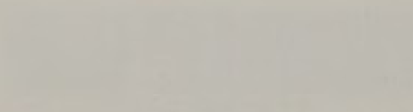

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# MAKING LONDON BETTER

**Introduction**

1. Improving London's health service will require radical change. This is undisputed. The opportunity for progress and the need for improvements are supported by Professor Sir Bernard Tomlinson's Report published last autumn and by numerous other studies down the years.

2. London's health problems are longstanding and well understood.Although they have been documented in at least twenty reports during the last hundred years, effective action has not resulted. We are determined to put that right and bring about major improvements to health services in the capital.

3. This document sets out how the Government and the health service will make improvements in London a reality. It establishes the direction we will follow and the framework within which change will take place.

4. The main aim is to use the resources available to secure the best possible health service and improvements in health for those who live and work in the capital. This document presents a strategy for achieving that end. It does not give all the answers; it sets out a tight timetable for change. In some areas, further work is needed before we can be sure of the way to proceed. In others, the right approach is now clearer and the document spells this out.

5. The Government welcomed the broad thrust of the Tomlinson Report's analysis. So did many informed commentators. But we took the view that others, particularly those directly affected by the report's recommendations, should also have an opportunity to put forward their ideas for London's NHS.

6. We therefore undertook extensive informal consultations, discussing the best way forward with those involved. The Minister for Health visited the institutions concerned and has held discussions with over 30 groups and organisations. We also studied a large number of written submissions. In drawing up the proposals which follow, we have taken careful account of the views and evidence put forward. Where appropriate there will be statutory consultation before decisions are taken.

**A Strategy for the Future**

7. Our strategy to improve health and health care in London is based on four central principles:

- People who live and work in London must have ready access to the full range of health services which they need.
- Services must be of a good standard and cost-effective.
- The internal health market should work in London, as elsewhere.
- High quality medical education and research must be sustained and fostered.

8. There are four main elements:

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

9. This major programme will require energy and commitment to accomplish. The Government can set the framework for change. But change must be driven locally and, above all, by patients' needs. The operation of the NHS internal market will determine the precise patterns of health care in London in the future, just as it is a major influence for good elsewhere. A better health service will not be achieved by central planning, no matter how skilful is its execution. It is for those operating on the ground to establish what is best for patients and to ensure that the health service responds and changes.

10. District health authorities and general practitioners as purchasers of hospital services have a key role in driving change. Decisions about where services are to be provided in future must have their support, and reflect what they, in consultation with representatives of local communities, consider best for their patients. The four Thames Regional Health Authorities are to strengthen this health purchasing function. The process is under way and will bring considerable benefits.

**Implementation**

11. Changes in London's health services on the scale needed require careful management over several years. The Government recognises the concern that hospital rationalisation will be forced by the decisions of purchasing authorities before the necessary improvements in primary and community services are in place. We intend to guard against this by early investment in primary care and community services, by providing transitional funding for hospitals and by setting up an implementation group to drive forward and monitor the changes.

12. The London Implementation Group (LIG) will operate through existing health agencies working closely with the purchasers and providers of health care and other key bodies. Its main role will be to secure agreement among the interested parties on the detailed way forward and to oversee the implementation of change to a tight timetable. It will advise Ministers on progress. LIG will also consider the recommendations in the Tomlinson Report, especially those relating to mental health, which are not covered in this document. It will put forward proposals to

Ministers. Details of the structure, responsibilities and terms of reference of LIG are at Annex A.

**A Vision of Primary Health Care in London**

13. Family doctors and community nurses are the public's first contact with the health services - and often their sole contact. These services need to be properly resourced and co-ordinated if patients are to receive the standard of care they have a right to expect and the standard of care NHS staff wish to give.

14. Too often, in London, services have fallen short of the best standards. More GPs in London than elsewhere work on their own, in outdated premises, where they can offer only limited access to a narrow range of services. Team working between doctors, nurses and other professionals cannot develop as it should. Many Londoners do not enjoy the sort of service that is taken for granted elsewhere.

15. Primary health care is more easily accessible outside London and extends to a wider range of services. A good practice surgery might bring together a team of professionals - nurses, physiotherapists, chiropodists, counsellors, social workers. Each provides an aspect of care to which local people have easy access. Often, particularly where the practice has taken charge of its own budget under the fundholding initiative, more tests and treatments are now available in the surgery itself. A growing number of specialists travel to the patient rather than the other way round.

16. These are key features of the modern health service. People outside the capital increasingly expect access to this wider range of services through their local primary health care teams. The Government wants Londoners to have these benefits too.

17. Poor primary health care can also have major consequences for the demands on hospitals. A typical London accident and emergency department receives many patients who, away from London, would have gone to their GP. This makes it more difficult for the accident and emergency department to deal with genuine emergencies.

18. Where local health and social services are unsatisfactory, patients are kept in hospital after their treatment for longer than is necessary. One teaching hospital, for example, reported that around 10% of its beds are inappropriately used every day of the year because of this. The result is more pressure on waiting lists and waiting times.

19. Improvements have taken place in recent years. More young GPs and more women GPs are now working in London compared with 10 years ago. London GPs have begun to respond to the opportunities of the 1990 new contract. There has been investment in practice teams. Numbers of practice nurses increased by some 167% in inner London between 1989 and 1992, greater than the national increase of 93%.

20. The benefits of these changes include higher childhood immunisation. The past 18 months have seen an increase of almost 50% in the number of Inner London GPs achieving targets. More practices now have computers.

21. Community Nurses around the country are creatively developing services - caring for adults and children at home who would previously have been admitted to, or kept longer in, hospital. Nurses provide pre and post operative care and a variety of other procedures (such as peritoneal dialysis, intravenous administration of drugs, and epidural analgesia), making possible day surgery and the management of acute and chronic disease in the community.

22. The number and variety of community nursing services available have increased, for example, through walk-in and telephone advice, counselling, and support groups and help for those facing crisis and long term illness. In London some of these initiatives are already underway. The pace of change can be speeded up.

23. While London has been improving the rest of the country has been moving still further forward. Now is the time for a concentrated effort which will bring London's local health services into line with the rest of the country, and prepare them for the forthcoming changes in the pattern of hospital services.

24. To achieve the necessary improvements, the Government will create immediately a London Initiative Zone (LIZ). Within the initiative zone opportunities will be taken to stimulate urgent action across those areas of inner London where population needs are great, existing services are below standard and changes to hospital provision will pose further challenges. LIZ will be a focus for new investment, new approaches and new ideas, mobilising action not just within the NHS but from all public, private and voluntary sector organisations concerned with different aspects of primary care.

25. We envisage that LIZ will have a limited lifespan of perhaps five years. Work will start now. The London Implementation Group will establish a Primary Health Care Forum to develop an agenda for change with the Thames Regions and local interests and report back on a programme for the first two years by 1st April 1993. The focus will be on change to improve primary care for London's population and to pave the way for more cost effective use of London's hospitals. Further details of LIZ are at Annex B.

**Action: LIG - April 1993**

26. First we must get the basics right. Within the LIZ area we will invest in new and improved premises where they are needed. Doctors and nurses need well-equipped buildings which enable them to work together to offer a wider range of services. Patients want convenient access to them. We want to see schemes which adapt premises for primary care use where appropriate, and which introduce primary care facilities into shops, sports centres, schools and offices. There will be investment in the construction of primary care centres, where an expanded range of services, perhaps for patients of several practices, might be provided.

27. We need to attract and retain high quality staff in London. We will provide more joint training and professional support for family doctors, nurses and other professional staff. We will make it possible for experienced hospital nurses to work in the community. We are prepared to invest in more training practices so that London can develop its own supply of GPs, and we will develop nurse training practices. We will bring experienced GPs into the capital, perhaps on short-term appointments.

28. These improvements will take determination and money to bring about. The patient and the taxpayer are entitled to a proper return on the investment. We will set quality standards which must be reached. Access to new resources will be conditional on commitment to achieving high standards of service.

29. We also want to explore new approaches to primary care and bring in fresh ideas. We do not simply want more of the same for London's basic health services, but provided out of better buildings. We need to look at how we can build teams in the community who will provide a wide range of services outside hospitals.

30. We look to social services departments and providers to play their full part in ensuring effective integration of local health and social services at all levels. Patients, particularly if they are elderly or handicapped, must have their social as well as health care needs met.

31. Important elements make up the process of modernising primary health care in London:

- Expanding the community nursing service and extending the role of nurses and other health workers, such as pharmacists, in the community.

- Looking at new ways of getting a consistent, high-quality round the clock family doctor service in inner London to meet urgent needs and extending out-of-hours nursing and support services.

- Devising accessible services for Londoners with special needs such as those who are mentally ill or who misuse drugs or other substances.

- Developing a range of services to meet the specific needs of those from diverse ethnic backgrounds.

- Working with existing agencies to consider employing some GPs directly to provide certain services, such as for homeless people, refugees and those not registered with a practice or to divert people away from hospital accident and emergency services.

- Reviewing, together with the profession, relevant aspects of the GP contract, such as the current system of deprivation payments.

- Making best use of primary health care professionals to provide services in the community for people with chronic disease, such as diabetes, asthma and stroke.

- Encouraging local health and social services authorities to work closely together so that patients receive coherent services - such as a coordinated home help/health care assistant service.

- Encouraging voluntary and independent sector initiatives.

32. These elements, and others, will form the basis of change which will create services likely to become the mainstay of 21st century health care. There will be more cost effective care outside hospital. London will be part of this change. The

community is the future setting of much health care. This will mean, among other things:

- high intensity home support services based on, for example, `hospital at home' schemes.

- exploration of the scope for polyclinics and community care centres which offer combinations of outpatient services, rehabilitation, and nurse/GP managed in-patient beds for patients who do not need the full services of an acute hospital.

- respite support, beyond what is possible in the individual's own home.

- injecting dynamism into purchasing by helping those GPs who wish and are able to do so to become fundholders, and involving all GPs actively in the purchasing of secondary services.

LIG will ensure that the ideas set out in this and the preceding paragraph are taken on board in developing the programme for primary and community care development.

33. Over £1 billion will be spent on GP, community health and social services in the LIZ area in 1993-4. A first priority must be to ensure that existing resources buy the best services available. The Thames regions are already planning to redeploy funds towards primary health care in London.

34. The Government recognises that the proposals outlined above will require further initial investment together with a continuing commitment to shifting the balance of funds towards primary care. We will be investing £170m of additional expenditure on capital projects over the next 6 years. Substantial additional recurring revenue expenditure will also be needed. This will help to bring London's primary care services up to an appropriate standard. This estimate will be revised as the regional programmes develop.

35. For the next year, an extra £40m will be available for investment in London's primary care. This will provide a vigorous start to the work required.

36. At the same time, the Government wishes to stimulate the work of voluntary sector organisations within the LIZ area. We intend to build on the special contribution that organisations like Age Concern, the Cancer Relief MacMillan Fund, the Crossroads Care Attendant Scheme, the Marie Curie Foundation, and the hospice movement have to offer in developing home and community-based services to meet special needs.

37. We shall make available an extra £7.5m over 3 years to pump-prime further developments with the voluntary sector. This will complement our programme of action to strengthen London's mainstream primary and community health services, offering more comprehensive, individually tailored care outside hospital to those who most need such support.

| **Action: LIG** |
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38. We want to create a focus for innovation and experiment in primary and community care in the London Initiative Zone. We shall therefore make resources available to fund a new London Primary Health Care Challenge Fund.

39. Money will be available to fund certain experimental and innovative schemes, on a competitive bidding basis, especially those which aim to bring local and hospital care closer together. Priority will be given to joint initiatives between the NHS and the voluntary, independent or social services sectors. The Government is making up to £1m available to launch the Challenge Fund in 1993-4 and invites others with an interest in promoting local primary health services to commit support to it.

40. The Government's proposals, developed locally with initiative and enthusiasm, and backed by substantial new investment, totalling £43.5m in 1993/4 alone, will accomplish the much-needed shift in London from a health service over-dependent on hospitals to one where effective care at community level is a consistent reality.

**The Acute Sector**

41. Implementation of the ideas set out in the preceding section will mean a shift in resources from acute hospitals to primary care. This will mean fewer hospital beds, and fewer sites where acute hospital care is delivered.

42. The case for action is overwhelming. Inner London has nearly 4 acute hospital beds for every 1,000 people. The national average is 2.5. London has about twice as many consultants per head of the population compared with the national average. Health authorities outside the capital are beginning to send more of their patients for treatment locally, lessening the demand on London beds. Advances in medical diagnostic and treatment techniques, which mean that patients need spend less time in hospital, and the growth in day surgery, are also reducing the requirement for beds, as will the proposed rationalisation of specialties.

43. With these factors at work, we believe it is both possible and desirable to deliver acute services in London equally well, but more cost-effectively, from fewer sites. The resulting savings are essential if we are to see the proper and complementary development of local health services as described in the preceding section.

44. Whilst it is impossible to predict precisely the speed with which these changes will develop in the next few years, the substantial loss of contract income, about £50m, in London hospitals this year, and the forecast loss of a further £50m in 1993-94, give a pointer. A cautious estimate is that there could be 15-20 per cent fewer acute beds (2000-2500) in four to five years' time. In view of this, the Government has decided to begin a phased programme of change to bring the pattern of acute sector provision in London more into line with current and future demand. Our proposals for the first phase of the programme are set out below. In addition, further changes or reductions at hospitals which are not identified in this document may arise, as they respond to the NHS health market.

45. Hospital beds must be used to best effect. Patients neither want to, nor should they, remain in hospital longer than necessary. Ways of reducing inappropriate hospital attendances need to be found. The increasing numbers of old people, and those with mental illness problems, in London's acute hospitals mean that effective forms of care must be developed in the community.

46. We have asked the London Implementation Group and Thames regions to pursue vigorously a number of options and report back in six months. The options include mobile clinical rehabilitation teams, GP beds, flexible nursing home care recognising the mixed economy of care, 'hospital at home' schemes for the elderly, respite care and the development of nursing rehabilitation wards and minimum care wards. These developments will then be taken forward within the LIZ primary and community care agenda.

**Action: LIG with the Thames regions - September 1993**

47. We recognise that changes of the nature described above will have wide consequences. A typical inner London hospital comprises not only routine acute beds and beds for the elderly, but is likely to house one or more centres of specialist treatment, and an accident and emergency department. It may also provide facilities for teaching and research. In making changes that affect one part of the hospital's work, account must be taken of the effects on the rest. The next sections of this document consider specialist and accident and emergency (A & E) services. They then deal with proposals to reorganise hospitals followed by consideration of teaching and research and the Special Health Authorities.

### The Specialty Reviews

48. As the Tomlinson Report pointed out, there is considerable duplication of specialist services in London. There are, for example, 14 centres providing cardiac services, 13 for cancer services, 13 in neurosciences and 9 in plastic surgery. The Government accepts the proposition in the Tomlinson Report that duplication is not cost-effective and may work against maintaining the standards of excellence for which some of these services in London are internationally recognised.

49. We have therefore set in hand six reviews of individual specialties, to be carried out simultaneously, in the following areas:

- cardiac services;
- cancer services;
- neurosciences;
- renal services;
- plastic surgery;
- specialist children's services.

50. Each will be taken forward on a London-wide basis by an expert working group under the joint leadership of a distinguished clinician from outside London and a senior NHS manager of a purchasing authority. For each specialty, the review groups will assess current and projected needs, define appropriate models of care and criteria for tertiary centres and develop a service specification. They will advise on an appropriate pattern of service for the specialty and on where departments should be located cost-effectively to achieve the best clinical outcome. The work will be co-ordinated and supported by LIG and options developed for Ministers' decisions by the end of May. These reports may, in some cases, lead to the modification of the general proposals for change to acute services set out later in this document. Further details of the reviews are at Annex B.

**Action: LIG - end May 1993**

51. The Tomlinson Report indicated there are other high cost specialties and tertiary referral centres which might require further study. We have therefore asked LIG, in carrying forward option appraisal on site configurations, to work with regions and purchasers to identify other specialties, such as gastroenterology, endocrinology and orthopaedics, which may need special consideration in the light of their referral patterns, the relationship of size and specialisation to quality of care and cost, and the critical mass needed for collaboration with education and research.

**Action: LIG with the Thames regions - September 1993**

52. In addition, there may be opportunities for prestigious specialty units to be transferred out of inner London. This would have the potential benefits of reducing costs and of spreading expertise more widely across the country. We will ask LIG to explore this with regional health authorities.

**Action: LIG with regional health authorities - Autumn 1993**

## Accident and Emergency Services

53. Good emergency services for the full range of cases from the most minor to the most severe must continue to be available. Such services will mainly be provided from hospital A & E departments which are fully staffed and equipped to deal with all major emergencies, and have good access to the full range of specialist services, though not necessarily on site. There will also be an increasingly important role for minor injuries clinics. Such clinics would have strong links both with primary care and the major A & E departments.

54. We are satisfied that at present A & E services should continue to be provided at the following departments: **Central Middlesex, Hammersmith, Chelsea and Westminster, St Mary's, Royal Free, Whittington, North Middlesex, Homerton, Royal London, Newham, Lewisham, King's** (where plans have been approved by the Regional Health Authority to redevelop the A & E department), **Greenwich, Queen Mary's, Roehampton** and **St George's**.

55. However, we propose changes to the current pattern of A&E departments in some parts of London. These are described below.

56. In **West London**, the new **Chelsea and Westminster Hospital** has a large and well-equipped A & E department. As a consequence, Riverside DHA will shortly be consulting on proposals to close the A & E department at **Charing Cross**. A decision will be taken on the basis of this consultation.

**Action: Riverside Health Authority to initiate consultation and report outcome - June 1993**

57. In **Central North London**, most local people will use the **Whittington** or **Royal Free Hospitals**. However, an A & E department needs to be retained at **UCH** or **Middlesex Hospitals**, in order to retain a workable overall pattern and to serve a part of London with a heavy concentration of shoppers and commuters. It will be important to ensure that the use of this A & E department is limited as far as possible to those emergency cases for which it is strategically sited.

58. In **East London**, we propose early consultation on whether to replace the relatively small A & E department at
**St Bartholomew's** with a minor injuries clinic, with surrounding A & E departments absorbing the balance of the **St Bartholomew's** workload.

**Action: North East Thames Regional Health Authority to initiate consultation and report outcome - June 1993**

59. In **South London** it might be feasible to consolidate the A & E departments currently provided at both **Guy's** and **St Thomas'** on a single site. There would be urgent further study of this option in the event of a decision, following the current consultation exercise, to merge the management of the two hospitals.

60. The above pattern is considered workable by the London Ambulance Service (LAS). The LAS itself is being improved, for example through management changes, extra investment in new vehicles and a programme to provide a trained paramedic on each emergency ambulance.

61. There has been much discussion of the possible impact of trauma centres (centres where facilities for treating serious injuries are concentrated in one large department) on the way accident and emergency treatment is provided. The trauma centre at Stoke on Trent is currently being evaluated. Further major changes to the pattern of accident and emergency departments in London are unlikely until this evaluation is complete in two years' time.

**Changes to Acute Hospitals**

62. **West London** contains several major hospitals: **Chelsea and Westminster; St Mary's; StCharles; Charing Cross; Hammersmith; Royal Brompton;** and **Royal Marsden**.
A start has been made to shape a new pattern of acute services in this sector. A great deal of work has been commissioned, by the region, by some of the hospitals concerned and by the NHS Management Executive. From this the following key points emerge:

- **St Mary's Hospital**, Paddington is well-sited in relation to the population it serves. Any development would, however, have to be ranked alongside other priorities.

- The hospitals concerned cannot be considered in isolation from each other, whether in respect of patient services, education or research. They cannot sustain extensive overlap or duplication. The concept of the Chelsea Health Sciences Centre could embrace the **Royal Brompton** and the **Royal Marsden**, their respective Institutes, the **Chelsea and Westminster Hospital** and Imperial College. St Mary's Medical School is already part of Imperial College. This concept would encompass sharing support services, integration of clinical work and strengthened education and research links. LIG will pursue this idea with these organisations and with North West Thames RHA.

**Action: LIG to explore with relevant organisations and to report to Ministers - December 1993**

- We are not convinced of the case for relocating the Chelsea branches of the **Royal Brompton** and **Royal Marsden Hospitals** to **Charing Cross** as proposed in the Tomlinson report. The cost would be substantial. Both the **Royal Brompton** and the **Royal Marsden** may contract once they have entered the health market. The Chelsea Health Sciences Centre may be the best way forward for these hospitals. In addition, we propose that they should submit a joint Trust application to strengthen clinical links, share services and reduce management costs.

**Action: Royal Brompton and Royal Marsden to submit a joint Trust application**

63. In the light of this, we have asked LIG, working with the North West Thames RHA and the local health authorities, to bring forward detailed proposals by the autumn for the future of the **Charing Cross Hospital** having regard to the Tomlinson Report's option for closure, the need to continue to provide the geriatric and mental illness services currently on site and the outcome of the specialty reviews. It will also consider further the future of **Queen Charlotte's Hospital**, also by the autumn. Although there are cost and research arguments for relocation, the balance of advantage between the **Hammersmith** and other sites is unclear. Any proposals for service changes following this further work will be subject to consultation.

**Action: LIG with North West Thames RHA - Autumn 1993**

64. In **Central North London**, the Government accepts the case for retaining a single hospital on one of the two existing sites at **UCH/Middlesex**, partly because of the need for
A & E set out earlier. We therefore propose that **UCH/Middlesex** should continue to work up a proposal for rationalisation as quickly as possible, which would be considered with other priorities and subject to statutory consultation in respect of service changes. A development considerably smaller than the current hospitals combined seems likely.

**Action: UCH/Middlesex to submit rationalisation proposal - Autumn 1993**

65. We will initiate statutory consultation on merging the management of the **Royal National Throat, Nose and Ear NHS Trust** with the **UCH/Middlesex.** In due course we will also consult on moving both the **Royal National Throat, Nose and Ear Hospital** and the **Hospital for Tropical Diseases** onto the rationalised **UCH/Middlesex** site.

66. The Government also wishes to see further progress towards greater integration of services between **UCH/Middlesex, Great Ormond Street** and the **National Hospital for Neurology and Neurosurgery**. We shall look sympathetically at proposals for changes to management arrangements and integration of services, perhaps similar to the Chelsea Health Sciences Centre being considered in West London.

67. Significant changes are needed in **East London** to provide the best pattern of services for the local population. **The Royal London Hospital**, which is well-positioned in relation to its local population, has a secure long term future. We anticipate that it would be linked for service and education to the **Homerton** and **Newham General Hospitals**.

68. The Tomlinson Report recommended the separation of NHS Trusts combining community and acute services associated with teaching hospitals on the grounds that community services would be better protected and developed if they were managed separately. In the light of this recommendation, North East Thames RHA has been asked to institute consultation on separate management arrangements for the community services provided by the Royal London NHS Trust.

| **Action: North East Thames RHA to initiate consultation by May 1993** |
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69. To serve local people in Hackney, the **Homerton** needs to be developed, perhaps by transferring some of the local acute services currently provided at **St Bartholomew's**. The proposal to build a further phase of the **Homerton Hospital** will be considered urgently.

| **Action: North East Thames RHA** |
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70. There is general acceptance that **St Bartholomew's Hospital** cannot continue in its present form. The hospital itself accepts the need for radical change. In the light of the Tomlinson Report's recommendation referred to in paragraph 68, North East Thames RHA initiated consultation about the dissolution of the "shadow" Bart's NHS Trust, which was established with a view to its managing St Bartholomew's (Smithfield), Homerton Hospital and the Community Services Unit from 1April 1993. Having considered responses to this consultation, we have decided that the Bart's NHS Trust should not come into operation on 1 April, and is therefore to be dissolved. The three units which would have been managed by the Trust will therefore remain directly managed units. We envisage that the Homerton Hospital and the Community Services Unit might themselves become separate NHS Trusts in April 1994.

| **Action: LIG/North East Thames RHA** |
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71. The proposals described in the paragraphs above would in our view help to strengthen hospital and community services in the East of London. But they have clear implications for the future of St Bartholomew's. There are, in our judgement, three options for the future of this hospital:

- Closure of the **St Bartholomew's** (Smithfield) site. Some or all of its specialist services to relocate, strengthening other units elsewhere.

- The management of **St Bartholomew's**, the **Royal London** and **London Chest Hospitals** to merge to form a new combined Trust. The management of the combined trust would be responsible for determining how to rationalise services in the light of patient flows in the internal market. This is similar to the course we are pursuing with the proposed merger of Guy's/St Thomas'.

- **St Bartholomew's** to be retained as a much smaller specialist hospital. This option would need to stand the test of the specialty reviews and its costs would have to be acceptable to purchasers.

72. Under any of these options, the academic and research strengths of the work currently undertaken at Charterhouse Square would continue.

73. We have asked LIG with North East Thames RHA to carry out a thorough appraisal of these options, in the light of decisions taken following consultation on A & E services and taking into account the views of purchasing health authorities and GPs, and to make firm proposals by the autumn.

**Action: LIG with North East Thames RHA - Autumn 1993**

74. There will also be statutory consultation on the following proposals:

a. Merging the management of **Northwick Park** and **St Mark's** and, subject to a satisfactory business case being made, the relocation of **St Mark's** to **Northwick Park** as recommended in the Tomlinson Report. This would enable St Mark's to give up its present unsatisfactory premises, achieving a secure base within a modern acute hospital.

**Action: North East Thames/North West Thames RHAs to initiate consultation by May 1993**

b. Merging the management of the **London Chest Hospital** with the **Royal London Hospital** as recommended in the Tomlinson Report. This would enable better integration of cardiac services for the catchment population.

**Action: North East Thames RHA to initiate consultation by May 1993**

c. Merging the management of the **Queen Elizabeth** and **Homerton Hospitals** as recommended in the Tomlinson Report. This would enable a fully integrated paediatric service to be provided for the local population, with consequent clinical benefits.

**Action: North East Thames RHA to initiate consultation by May 1993**

In b. and c. above the merger proposals will be expected to provide for the retention of strong education and research links with the **Royal Brompton** and **Great Ormond Street** respectively.

75. In **South East London**, consultation is underway on the proposal to merge the management of **Guy's** and **St Thomas'**, with **Lewisham Hospital** being established as a Trust in its own right. A decision will be taken in March in light of the outcome of consultation on whether the proposed Trust structure should be put in place. If a Guys/St Thomas' Trust is established, we will ask the new Trust Board to bring forward proposals, within six months, for consolidating the hospital services with a view to these being located on one site. Any proposal should take account of the specialty reviews, purchasers' intentions and other possible uses of the alternative site. The proposal should also include a timetable for implementation.

76. In **South West London**, **St George's** role may be affected by the outcome of any **Guy's/St Thomas'** site appraisal. The services provided at **St George's** also need to be considered in conjunction with those at **Queen Mary's, Roehampton, Kingston** and **St Helier Hospitals**. We have asked LIG, in cooperation with South

West Thames RHA to report further on likely developments in this sector in the autumn.

**Action: LIG with South West Thames RHA - Autumn 1993**

## Medical Education and Research

77. London is a major national and international centre for medical teaching and research. We want to ensure that this high quality is maintained and improved. Increased emphasis will need to be given to teaching in general practice and the community. Changes to the undergraduate curriculum planned by the General Medical Council support this and will require a range of options to be available for medical students. Developments in life sciences are making links between basic science and clinical work increasingly important.

78. The Tomlinson Report recommends, and the Government endorses, linking medical schools to multi-faculty colleges with strong departments of life sciences. This is consistent with the policies pursued for some years by the University of London. Such mergers offer both academic and financial benefits for education and research. London's multi-faculty colleges on average scored better for clinical medicine in the Universities Funding Council's recent research assessment exercise than the free-standing undergraduate medical schools.

79. The Tomlinson Report sees full mergers between the postgraduate institutes and multi-faculty colleges as a longer-term aim. We note that many of the postgraduate schools and institutes are already taking steps to develop such links with multi-faculty colleges. We look forward to continuing progress in this direction.

80. The Tomlinson Report says that, because of the impact of changes in the NHS in London and the need to manage larger intakes in merged medical schools, a reduction in the intake of medical students to London of around 150 will be required from the present level of 1,215. The issues raised in the report about the maintenance of the quality of medical education in London and its cost will need to be considered by the Higher Education Funding Council For England (HEFCE) in discharging its responsibilities for funding individual universities and colleges.

81. The Secretary of State for Education has welcomed the broad conclusions of the Tomlinson Report and has indicated that the principles of the education and research proposals stand on their own merits irrespective of changes in the NHS, although in practice they are closely linked. He has asked the HEFCE to take them forward in consultation with the University of London and the NHS. The HEFCE will be part of the London Implementation Group.

82. Two of the four mergers recommended in the Tomlinson Report have been agreed in principle:-

- Imperial College with the Charing Cross and Westminster Medical School; and

- King's College with the United Medical and Dental Schools of Guy's and St Thomas's.

We wish to see further and sustained progress on the other two:

- University College with the Royal Free Medical School; and

- Queen Mary and Westfield College with the London Hospital Medical College and St Bartholomew's Medical College.

83. The HEFCE's aim in considering merger proposals will be to ensure that the quality of medical education in London is maintained and enhanced in the light of changes in the NHS and that changes are planned and implemented smoothly. It will consider what action might be necessary if desirable changes in the organisation of undergraduate medical education cannot be agreed. It will monitor the effectiveness of links between postgraduate institutes and multi-faculty colleges as they develop. The HEFCE will take decisions on the way forward on medical school mergers and student numbers in the light of the Government's proposals for the NHS in London and its response to the Medical Manpower Standing Advisory Committee's recommendation to increase the national intake of students.

**Action: HEFCE to take forward as necessary in relation to funding for 1994/95 and subsequent years**

**The Special Health Authorities**

84. The Special Health Authorities consist of **The Hospitals for Sick Children; The National Hospital for Neurology and Neurosurgery; Moorfields Eye Hospital; The Bethlem Royal Hospital and the Maudsley Hospital; The Royal Brompton National Heart and Lung Hospitals; The Royal Marsden Hospital; The Eastman Dental Hospital** and **The Hammersmith and Queen Charlotte's Hospitals**. The hospitals and their associated postgraduate institutes carry out postgraduate teaching and research in their individual specialties.

85. The Special Health Authorities need to be in the NHS internal health market and better integrated with other education and research institutions. It is Government policy that SHAs should join the internal health market with other hospitals from April 1994 (as NHS Trusts, subject to consultation) and thereafter participate in a national research market. Currently their NHS costs are funded centrally by the Department of Health. This can insulate them from the pressures for increased efficiency and effectiveness faced by other hospitals and distorts the provision of health care.

86. We have commissioned two studies to address the impact of new funding arrangements on research. The first, by CASPE Consulting Limited, compared the excess costs of SHAs' patient services with similar hospitals and analysed these excess costs.

87. The second study, initiated by the NHSME Director of Research and Development, involves the establishment of a research review of each SHA to assess the quality of its research and its overall contribution to the NHS. Each SHA's scientific and R&D contribution is being examined using external and independent peer review. These reviews are due to report in the Summer.

**Action: NHSME Director of Research and Development to report to Ministers - July 1993**

88. To begin contracting with purchasers of health services the SHAs will need as much notice as possible of the funding arrangements under which they are to operate from April 1994. We therefore propose that the Department of Health will meet their excess costs in line with the CASPE analysis for 1994-95. Over subsequent years, this funding mechanism will be refined to focus much more closely on the core patient workload needed to sustain high-quality, relevant R & D programmes. For the remainder of their activity, the SHAs will need to attract service contracts from health authorities.

89. The excess costs identified by CASPE amount to 30-35 per cent of the SHAs' revenue allocation of some £300 million. This will be paid to the SHAs for 1994-95. The remainder will initially be distributed among health authorities to enable those authorities to continue to fund patients referred from their areas to the SHAs.

90. The Tomlinson Report recommended developing a single system of funding the overheads of academic teaching and research, embracing both the current research and teaching - related funding of the SHAs and the teaching and research elements of SIFTR. (Service Increment for Teaching and Research is special funding to hospitals involved in undergraduate medical education, to help offset the excess costs which they incur as a result of teaching and research.) The formula for allocating funds should deal separately with research and teaching. We find this proposal attractive and are exploring the practicalities.

**Action: NHS Management Executive in consultation with Department for Education to report to Ministers on proposed funding system - December 1993**

**Staff**

91. The changes we are setting in hand have significant implications for staff. It is vital that their skills and commitment are retained in the NHS wherever possible. Staff will be given as much information and help as possible in responding to the changes. We are determined to ensure that London has the staff it needs to deliver the new patterns of care that are envisaged.

92. The prime responsibility for staff rests with their employing authorities, but we will seek to ensure that there is a consistent and coordinated approach across the capital. LIG has set up a human resources sub-group and we shall want to work closely with the health unions, and staff and professional organisations.

93. We expect employing authorities and Trusts in London to discuss the implications of our proposals with their staff. Where there are plans for the relocation of services or the reduction in size of a unit, staff will need advice about the career options available to them, including the scope for re-training and help with finding jobs in other hospitals (perhaps outside London) or in the community or primary care sectors. LIG's human resources sub-group will offer advice and guidance.

**Action: LIG**

94. The human resources sub-group will set up a clearing house to help staff who cannot find alternative employment through the normal local arrangements. Some staff will be highly trained, have specialist skills and look to the national rather than

the local labour market. We must make every effort to keep such skills within the NHS and the clearing house will help towards this end. We will also discuss with employing authorities and staff and professional organisations the possibility of introducing ring fenced arrangements for London to fill some vacancies during periods of major change. Arrangements will also be needed to ensure that where the location of teaching and research changes within London, honorary contracts are transferred as necessary.

**Action: LIG to establish clearing house - April 1993.**

95. Redundancies may, unfortunately, be necessary as a last resort. Staff will, of course, be entitled to their statutory rights including, where eligible, the early payment of benefits under the NHS Pension Scheme.

96. The NHS in London makes a major contribution to the education and training of staff. We are committed to continuing this. But there is a need to make changes to the current pattern in the light of the other changes proposed in this document. Our aim is to work to ensure that the NHS in London has the staff resources and skills it needs to deliver high quality care into the next century. In particular we must ensure that:

- Proper arrangements are made to continue high quality training for junior doctors and dentists whilst maintaining progress in reducing junior doctors' hours. Reductions in junior posts in inner London will be matched by new opportunities elsewhere.
- The location of, and numbers entering, non-medical education particularly nursing and the professions allied to medicine are reviewed and matched to the likely future demand for newly-qualified staff in inner London.
- The scope for retraining existing staff to work in primary or community care is fully explored and new programmes devised.

**Action: LIG with Thames regions and appropriate professional and staff organisations**

97. We appreciate the dedication of NHS staff in London. We are determined to help and support them to make the most of the real opportunities which arise from our proposals.

## Funding

98. The root cause of London's problems is not a lack of resources, as the Tomlinson Report recognised. Indeed, there is a need to reduce funding levels in London, both to reflect changing circumstances and to ensure a fair distribution of money to the rest of the country.

99. The problem arises from two key factors:

- GPs and health authorities outside London are sending fewer patients to London hospitals for treatment and this trend will accelerate as they purchase more health care, cost effectively, locally;

- most districts within London are, for historical reasons, still receiving more than their due share of NHS money. These resources will be transferred over time to districts outside London.

100. To address these large reductions in the demand for the provision of services and thus the income derived from them, major changes need to be made in the size and configuration of services in London.

101. We are currently having to provide financial support to London hospitals (£50m in this financial year) to ensure they can continue in operation during the process of bringing their services into line with current needs. Without fundamental change, this support would have to continue indefinitely and increase in amount. To achieve change, capital investment will be needed over the next few years. This will enable rationalisation of hospitals and specialties to take place, releasing surplus hospital capacity for sale and securing major recurrent reductions in revenue costs. We are satisfied that the changes to the acute sector, together with lesser changes at hospitals not specifically mentioned in this document, are feasible and will release resources for primary care and for patients no longer directed to London.

102. Although waiting times in England as a whole are improving, waiting times in London are still some way behind the national average. We will be providing £10m in 1993/94 to be specifically targeted at improving waiting times for London residents. The London Implementation Group will invite bids against this fund from health authorities, Trusts, and GPFHs. These bids should be submitted by 31 March 1993 and be supported by action plans which aim to deliver demonstrable waiting time benefits for London residents.

**Action: LIG - March 1993**

103. As set out earlier we propose to spend £170m on capital schemes in primary and community health services over the next six years. In addition, we expect to make available substantial additional recurring annual revenue funding over a similar period. In 1993-94 £43.5m over and above current plans will be invested in primary and community services.

104. Further funds will also be needed in the short term to cover transitional support for hospitals, retraining, relocation and redundancy costs. The exact amounts will depend on future decisions and speed of implementation.

## Communicable Disease and Environmental Health

105. The Government endorses the importance which the Tomlinson Report attaches to the management of communicable disease and environmental health. Where outbreaks or incidents cross health authority boundaries, as in central London, it is essential that there are formal mechanisms in place to ensure an effective response. We will pursue this issue with those in the field including the Public Health Laboratory Service.

**Action: LIG with Thames regions and PHLS**

## Conclusion

106. No change in London is no option. The proposals set out in this document will tilt the balance of health spending in London so that more can be invested in improving much-needed primary and community services. At the same time, by tackling the inefficiencies of the present system, we will ensure a fairer share of NHS resources for the rest of the country. The outcome for London will be both a more cost-effective hospital service and improved primary care. We will work towards a better health service, and better health for those who live and work in our Capital City.

**ANNEX A**

## LONDON IMPLEMENTATION GROUP

1. In publishing the Tomlinson Report last October, the Government announced that it accepted the recommendation that a mechanism was needed to co-ordinate implementation of Ministers' decisions on London.

2. The London Implementation Group (LIG) is being established with effect from February 1993. LIG will be part of the NHS Management Executive and will report to Ministers on progress in carrying forward their policies to improve London's health services. LIG will be chaired by Mr Tim Chessells and will have as its Chief Executive Mr Bob Nicholls.

### Terms of Reference

3. These are:

   a. to advise the Secretaries of State for Health and Education on the implementation of decisions on the future development of London's health services and the implications for medical education and research;

   b. to secure agreement among interested parties on the detailed way forward;

   c. to oversee implementation of the changes by the NHS agencies concerned.

### Structure and Members

4. To carry out these functions LIG will have two tiers;

   a. London Health Service Development Forum (the outer tier). This will comprise the LIG Chairman and Chief Executive, the 4Thames Regional Health Authority Chairmen and their Regional General Managers, the Vice-Chancellor of London University and the NHSME Director with responsibility for NHS Trusts or his representative. The Forum is likely to meet on a quarterly basis and its main role will be to secure the continuing commitment of interested parties to the process of change.

   b. **LIG Executive** (the inner tier). This will comprise the LIG Chairman, the Chief Executive, a nominee of the Higher Education Funding Council for England and a small full-time secretariat. In addition, Department of Health and NHS Regional staff may be brought in on a full and part-time secondment basis for work on special projects. The LIG Executive will be responsible for overall project management of the changes and for overseeing Pan Thames projects eg the Specialty Reviews.

5. The LIG Chairman is also a member of the NHS Policy Board and will report regularly to the Secretary of State.

6. LIG will operate mainly through existing statutory authorities working particularly closely with the Thames regions and the two London NHSME Trust outposts. It will also link with SHAs through the Chairman of SHA Chairmen.

7. LIG will seek professional advice through the Department of Health's Chief Medical and Nursing Officers and the NHSME's Director of Research and Development, and from the University of London, the Royal Colleges and professional bodies.

8. LIG has been established for an initial period of 3years to March 1996. The need for it to continue beyond then will be reviewed at that time.

## LONDON INITIATIVE ZONE FOR PRIMARY CARE

### Tomlinson Report, Paragraph 41

1. " ... we recommend that the Department of Health should explore with GPs' representatives the scope for designating parts of London as "primary care development zones" in which some of the normal arrangements could be suspended, or otherwise modified, so as to secure a better service in line with local health needs".

### Purpose of LIZ and a Primary Health Care Forum

2. While the London Implementation Group (LIG) and the proposed London Health Service Development Forum are to oversee the implementation of the health services changes in London, a major focus of these changes is the development of primary and community care. The creation of a London Initiative Zone (LIZ) will concentrate attention and resources on developing primary care in the inner city.

3. The intention behind LIZ is to define a geographical boundary rather than to set up a new piece of bureaucracy. However, a small Primary Health Care Forum is to be established, as part of LIG, to give the issues a high profile and to connect with key professional bodies. It will advise LIG on primary care and especially on the plans being produced by RHAs and FHSAs for the development of primary and community care, making recommendations on the disbursement of special funds made available centrally. The forum would also identify legal and contractual constraints and potential changes needed to progress primary care within the LIZ area, referring them to Ministers and the professions for approval and, where necessary, agreement. It will oversee implementation of the primary care developments in London, monitoring delivery against agreed timescales.

4. Proposed FHSAs to be included in LIZ are:-

Brent (excluding Harrow)
Ealing, Hammersmith & Hounslow
Kensington, Chelsea & Westminster

Barking (excluding Havering)
Camden & Islington
City & East London
Eastern Enfield and Edmonton area of Haringey
Waltham Forest (excluding Redbridge)

Greenwich (excluding Bexley but including Thamesmead)
Lambeth, Southwark & Lewisham

Wandsworth (excluding Sutton & Merton)
Croydon (North only).

5. These FHSAs, and part-FHSAs, cover those areas of London where population needs are high, existing primary care provision is weak and acute sector

rationalisation will pose further challenges. The population covered is some four million.

6. Within the LIZ boundary, it will be for NHS management to develop local programmes with other local interests to improve the quality of primary care, using such additional flexibility and extra resources as may be available for LIZ initiatives.

**Style and Membership of Primary Health Care Forum**

7. The forum should be small and non-executive but challenging and innovative in its approach. It will be NHS management-led but supportive of existing agencies, building on what is already in place rather than setting up an additional management tier. It is intended to include professionals who command the respect of their colleagues but there is a need to balance the need for broad representation with a forum small enough for effective working.

8. The forum will be chaired by Mr Tim Chessells (Chairman of LIG). Its membership will include:

- a Thames Regional Health Authority Regional General Manager;
- a representative of the NHS Management Executive;
- a Regional Nursing Officer;
- an Inner London GP;
- a Professor of General Practice;
- an FHSA Chairman or General Manager;
- a Regional Director of Public Health with a special interest in Primary Care;
- an Independent Adviser;
- a Social Services Director.

9. The forum would be serviced by LIG and while initially it may need to meet monthly this would be expected to drop to quarterly as the work progresses.

# LONDON SPECIALTY REVIEWS

## Objectives of Specialty Reviews

1. The aim is to achieve a more rational disposition of six specialist services (cardiac, cancer, neurosciences, renal, plastics and children's specialist services) avoiding unwarranted duplication and providing a stronger service and academic base for the future.

2. The six reviews will be conducted separately, but in parallel, and are to be completed by end May 1993.

## Management of the Reviews

3. The appointment of a clinician and a purchasing manager to lead each specialty review jointly will be announced shortly.

4. The overall responsibility for the specialty reviews rests with LIG. LIG will facilitate co-ordination across the reviews and linkage with the research reviews of the SHAs which are occurring concurrently with the specialty reviews. LIG will provide medical, project management, information and drafting support to assist the review teams.

## Process of the Reviews

5. Detailed terms of reference are being drawn up for each specialty review taking into account the specific requirements and issues for each specialty. The process of each review will be broadly similar and will incorporate five elements:

- assessment of current and projected need for the services;
- definition of appropriate models of care;
- agreement of criteria for a tertiary centre;
- development of a service specification;
- evaluation of options for service configuration against the specification.

6. The process of each review will ensure that interested parties are able to contribute either by membership of the review group itself or by oral and written evidence, focus groups and consensus conferences.

## Output of Specialty Reviews

7. Each specialty review will report by the end of May 1993. These reports will make recommendations for the future configuration and organisation of the six specialty services in London. They will also indicate the likely financial impact of the proposals and present their supporting evidence, rationales, analyses and judgement.

These reports will then be subject to review by Ministers before formal consultation on any significant proposed changes and final decisions by the autumn.

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# Major Central London Hospitals

Major Teaching Hospitals

- A St Bartholomew's
- B Charing Cross
- C St George's
- D Guy's
- E King's
- F St Mary's
- G Royal Free
- H Royal London, Whitechapel
- I Royal London, Mile End
- J St Thomas'
- K University College Hospital
- L Chelsea and Westminster
- M Middlesex Hospital

Postgraduate Special Health Authorities

- N Royal Brompton
- O London Chest
- P Royal Marsden, Fulham
- Q Royal Marsden, Sutton
- R Great Ormond Street
- S Queen Elizabeth Hackney
- T National Hospital for Neurology & Neurosurgery
- U Hammersmith
- V Queen Charlotte's
- W Moorfields Eye Hospital
- X Eastman Dental
- Y Maudsley

Other Inner London Hospitals

- Z Central Middlesex
- AA Homerton
- AB Lewisham
- AC Newham General
- AD Whittington
- AE St Charles' Hospital
- AF Samaritan / Western Ophthalmic
- AG Hospital For Tropical Diseases
- AH St Mark's
- AI Elizabeth Garrett Anderson
- AJ Royal National Throat Nose & Ear

Selected Outer London Hospitals

- AK Brook General
- AL Ealing
- AM Greenwich District General
- AN St Helier
- AO Kingston
- AP Mayday
- AQ Northwick Park
- AR Queen Mary's, Roehampton
- AS West Middlesex
- AT Whipps Cross
- AU Atkinson Morley
- AV Barnet Green
- AW Bromley
- AX Edgware General
- AY North Middlesex

DHA boundary
London Initiative Zone – proposed area

Scale is 1:217192

DHA boundaries courtesy of NOMIS