MT

confidential filing.

Advisory Group concerning the future of Health Services and medical education in London.

NATIONAL HEALTH

March 1980.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~17.3.80.~~							
~~22.4.80~~							
~~26-1-81.~~							
2-2-81.							

PREM 19/538

Nat. Health

10 DOWNING STREET

From the Private Secretary

2 February 1981

We spoke about the Report of the London Advisory Group on the future level and distribution of acute services in London. You confirmed that Barnet hospitals were not directly affected by the announcement which your Secretary of State intends to make next week, although other health authorities may be pressed to take similar steps in the future.

The Prime Minister is content that your Secretary of State should make his announcement as proposed through a Written Question.

M. A. PATTISON

Don Brereton Esq
Department of Health and Social Security.

10 DOWNING STREET

Prime Minister

Only inner London hospitals are directly affected: but similarly policies may well be pressed on other RHA's in the longer-term.

May Mr Jenkin go ahead?

MF
29/1

Yes pse.

1.

1. MR SANDERS
2. PRIME MINISTER

Patrick Jenkin has now received the Report of his London Advisory Group on the future level and distribution of acute services in London.

It recommends a 15 per cent reduction of acute beds over the next 10 years, to be achieved by concentration in the major hospitals. The implications are that some smaller hospitals will simply be used for non-acute services, whilst others will have to close.

Mr. Jenkin intends to accept the advice and proposes to publish the Report with a statement endorsing its conclusions. The range of opinion represented in the London Advisory Group helps to give weight to the recommendations, but will not prevent some critical attacks on the recommendations. Implementation, as it affects each hospital, will take a number of years, with local planning procedures involved.

Mr. Jenkin intends to make his announcement by Written PQ the week after next (draft at Flag A). Content?

MF

I assume that Barnet Hospitals are not involved!

MF

26 January 1981

JP

cc Press Office

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DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

M Pattison Esq
Private Secretary
10 Downing Street
London SW1

23 January 1981

Dear Mike,

ACUTE HOSPITAL SERVICES IN LONDON

You will recall that my Secretary of State set up a London Advisory Group in April last year to assist him in reaching decisions on some of the major strategic issues facing the health service in London. The Group, which is under the Chairmanship of Sir John Habakkuk, has been considering, inter alia, the future level and distribution of acute services in London and its report (copy attached) has now been submitted to my Secretary of State.

The report concludes that the number of acute hospital beds needs to be reduced by some 15 per cent over the next 10 years and that the best strategy for bringing this about in Central London is to concentrate the remaining acute services in the major hospitals, which are best equipped to provide them. Inevitably this will mean substantial change for the smaller hospitals - some will be used for non-acute services (for the elderly, the mentally ill or mentally handicapped) but others will have to close.

My Secretary of State accepts the Group's advice both as to the scale and nature of change. It is only by making such changes in the acute sector that it will be possible for the health service in London to remedy some of the serious shortcomings of its other, non-acute services without interfering with the programme of balancing resources between London and other parts of the country. He therefore proposes to publish the report under cover of a statement of his own (copy attached) endorsing its conclusions.

Although the report reflects a remarkable consensus in a body which included representatives of the local authorities, the TUC, the BMA and the Labour Party, it is likely to be badly received in some quarters.

E.R.

Although the Secretary of State's foreword emphasises the opportunities which the strategy offers to improve other services it is inevitable that some local commentators will seize on the possible impact on particular local small hospitals in central London. The future of these hospitals is however a matter on which local planning will be needed and individual decisions will fall to be taken over a period of years.

Having discussed the question of timing with Richard Brew of the GLC (who is a member of the Group), my Secretary of State has concluded that publication at an early date is the best course. He therefore proposes to publish the report in the week beginning 9 February by means of a written PQ and press notice both of which will stick closely to the text of the foreword.

I would be grateful for your agreement to this procedure.

I am copying this letter to Robin Birch (Privy Council Office) Murdo Maclean (Chief Whips Office) David Edmonds (Environment) and Geoffrey Green (Education).

Yours ever

D BRERETON

ENC

A

"RESPONSE" BY SECRETARY OF STATE
(covering the publication of LAG report on acute services)

The planning of major changes in the health service is rightly a matter of public concern. I believe that, as far as possible, it should be left to the people appointed to take decisions - that is, the Health Authorities - to decide what to do. Sometimes this is not enough. London requires special consideration, not only because of the number of Authorities responsible for its services, but also because of the need for those Authorities (which include the Boards of Governors of the Post-Graduate Hospitals) to act in concert to achieve the desired objectives.

2. Over the last few years, much thought has gone into considering how to achieve a better balance in London between the acute hospital services where London has, without any doubt, too many acute beds, and other services, particularly those for the elderly and for people who are mentally handicapped or mentally ill. There is marked shortage of geriatric beds in London, while far too many people who are mentally handicapped or mentally ill have to go outside London altogether for in-patient services. There are, too, serious deficiencies in the community health services, particularly for these groups of patient. The key to achieving the better balance which has been sought has, after exhaustive and constructive debate been seen to be the need to reach firm conclusions on the acute services, so that health authorities could press ahead with the planning of services generally. It was for all these reasons that I asked the London Advisory Group to examine this problem in the light of our overall objectives.

3. I have now received their careful and thorough report, for which I am most grateful. The Group has confirmed that there are sound reasons for seeking a reduction in the number of acute medical and surgical hospital beds. Since the debate began, that is in relation to the position in 1977, there has already been a significant reduction; a further 15% or a bit more,

should be achieved over the next six or seven years. I accept that this should be our policy. The strategy proposed is based on the need to make use of hospitals in which capital has already been invested and it is argued that accessibility for patients is not the problem that it is in less densely populated areas. I agree that the need is to make the best use of existing resources and that the most appropriate pattern of services in an area as large as London may need to be different from that which is appropriate elsewhere. Our proposals on the pattern of hospital services, published last year, stressed the need for flexibility to take account of local circumstances and the London strategy illustrated this point. The group notes that these changes may have considerable implications for the training of medical students. I endorse their view that the problems are not insuperable if full use is made of all the available facilities.

4. Although the Report is about the acute services the Group have, as I have said, had in mind the overriding need for a better balance between acute and other services. I very much welcome their recognition that there is a need for a greater emphasis in London on services for the elderly and for the mentally ill and mentally handicapped both in and out of hospital. I shall expect health authorities, guided by this report, to respond by now advancing the development of these services in line with national priorities; and I will be monitoring progress.

5. The Group has recommended that a "large proportion" of the resources saved by the adoption of a policy of reducing the acute beds in London should be deployed in support of the other health services in London. I agree with the thinking which has lead to this conclusion. Of course, how resources are allocated nationally in future will depend on the determination of relative need in the Thames Regions, and in the rest of the country; and decisions will fall to be made at the time, in the light of the total of the resources then available. But it would be misleading to assume that the kind of reductions here envisaged will of themselves always release disposable and therefore transferable resources. In many cases this will not be so; the staff and the buildings will continue to serve the community in other ways.

6. Three further points should be made:-

a. The Group has drawn attention to the difficulties involved in the fact that the community services are the responsibility of different statutory authorities. This is something which I am already considering at national level and I will soon be issuing a consultative paper /later in the year/ about the relations between these groups of statutory authorities.

b. I note the confirmation by the Group that the RHAs concerned have endorsed the recommendations of the London Health Planning Consortium for the rationalisation of supra-Regional specialties such as neurosurgery.

c. I recognise that the changes in acute services will provide an opportunity to rehouse some of the smaller postgraduate hospitals within general teaching hospitals; my Department intends to examine without delay the possibilities that this offers.

7. In general therefore I endorse the strategy proposed by the London Advisory Group. I shall look to the four RHAs to develop plans urgently to implement it, and my Department will be monitoring the progress which they make. In developing their plans the Authorities will of course need to consult in the normal way. I and my Ministerial colleagues will, however, be strongly influenced by the Advisory Group's proposals in considering any individual issues on which we will have to make decisions.

LONDON ADVISORY GROUP

A C U T E H O S P I T A L S E R V I C E S

I N L O N D O N

Report to the Secretary of State
for Social Services

January 1981

Members of the London Advisory Group

Chairman:	Sir John Habakkuk	Principal Jesus College Oxford
Members:	Mr R M Brew	Greater London Council
	Mr A J Collier	Deputy Secretary DHSS
	Mr G F Cockerill	Secretary University Grants Committee
	Sir John Donne	Chairman South East Thames RHA
	Dr N J B Evans	Deputy Chief Medical Officer DHSS
	Miss W Frost	Area Nursing Officer Bedfordshire AHA
	Dr M P Godfrey	Chairman Joint Medical Advisory Committee University of London
	Dr J D J Havard	Secretary British Medical Association
	Dr J P Horder	President Royal College of General Practitioners
	Mr P Jacques	TUC Health Services Committee
	Sir Harry Moore	Chairman North East Thames RHA
	Dame Betty Paterson	Chairman North West Thames RHA
	Baroness Robson	Chairman South West Thames RHA
	Mrs A C R Rumbold	London Boroughs Association
	Professor G Slaney	Professor of Surgery University of Birmingham
	Mr J R Stewart	Principal University of London
	Lord Wells - Pestell	
	Sir Leslie Williams	Chairman London Postgraduate Hospitals Committee

Secretariat and DHSS Support:

Mr S Argyrou (Secretary)
Dr G C Rivett
Miss E White
Mr S A Godber
Mr A M D Crouch

from The Principal

JESUS COLLEGE
OXFORD
OX1 3DW
Oxford 49511

17 December 1980

Dear Secretary of State

ACUTE HOSPITAL SERVICES IN LONDON

In view of the controversy surrounding the proposals by the Health Authorities and the London Health Planning Consortium for reductions in acute hospital services in London, you asked the London Advisory Group to consider what changes were needed and how they should be brought about. In considering this issue, we did not feel that it was our remit to make specific proposals for, or comment in detail on, the future of individual hospitals. These are matters which fall clearly within the responsibility of the health authorities to develop detailed plans in the usual way. But we did feel it to be essential that a consistent approach should be followed throughout central London. Our report, which is enclosed, outlines such an approach.

In submitting our report, I feel that I should draw attention to a number of points which were at the heart of our deliberations. We accept that the order of change identified by the London Health Planning Consortium is broadly correct ie a reduction of 15% in the total number of acute beds in London between 1979 and 1988. With change on this scale in prospect, we believe that health authorities should plan to concentrate the remaining acute services on the major hospitals which are well equipped for the purpose rather than attempt to maintain an acute service role for all hospitals which now have one. We believe that, as part of this exercise, there is scope for some of the postgraduate teaching hospitals which are currently in poor accommodation, to be rehoused within general teaching hospitals; and that the possibilities should be further explored urgently.

From The Principal

JESUS COLLEGE
OXFORD
OX1 3DW
Oxford 49511

In coming to these conclusions about acute services, we were very much aware of the interaction between acute and other services; and, while we hope at a later stage to say more about some of the other services, we felt particularly concerned that acute services should not be looked at in isolation. Although our assessment of the number of acute beds required takes full account of the extra needs of people in London, there are serious shortcomings in some other parts of the health service which need to be made good namely community health services, services for the elderly, the mentally ill and the handicapped and primary care. Reductions in acute services will throw extra burdens on these services and we believe that a large proportion of savings made in the acute field should be made available to develop poorly provided services. But unless local authorities can provide adequate community services and sufficient part III accommodation, it will be difficult to achieve the right balance of care between hospital and the community. We have therefore recommended that the Government should study the interface between the care of sick people in the hospital and their care in the community and in particular consider whether funding adjustments between sectors are required.

Yours sincerely

John Habakkuk

Chairman

London Advisory Group

ACUTE HOSPITAL SERVICES IN LONDON

INTRODUCTION

1. In recent years there has been discussion within London about changes in the provision of health services, particularly about proposals to reduce or rationalise acute hospital services. The plans of the Regional Health Authorities would entail substantial reductions in the number of acute beds. The London Health Planning Consortium (in its 'Profile of Acute Hospital Services') indicated that similar changes were needed. In view of the concern expressed from many quarters, the Secretary of State asked the London Advisory Group to give its view on this question and on some of the issues raised by the London Health Planning Consortium in its report 'Towards a Balance'.

2. This paper is mainly concerned with hospital acute services though we have been conscious, in formulating our views, of the many difficulties faced by the other services in London and of the ways in which services overlap. We are using the term 'acute services' in the technical sense in which it is employed by the DHSS and NHS management, ie describing those facilities - expressed in terms of beds - which are used by consultants in all the medical and surgical specialties* except psychiatry (both mental illness and mental handicap), geriatrics and obstetrics. Thus an elderly patient is not classified as occupying an acute bed if he or she is under the care of a geriatrician or a psychiatrist but is so classified if he of she is under the care of a consultant in an 'acute' specialty.

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* The following specialties are included within the definition of acute services used in this paper: general medicine, paediatrics, infectious diseases, chest diseases, dermatology, neurology, cardiology, rehabilitation, venereology, rheumatology, general surgery, ENT surgery, traumatic and orthopaedic surgery, ophthalmology, radiotherapy, urology, plastic surgery, cardiothoracic surgery, dental surgery, neurosurgery, gynaecology and gp medicine. Specialist acute units separately identified in standard returns are also included.

3. There are two questions to be considered in relation to the acute services:

i. what changes are needed in the level of provision of acute hospital services in London?

ii. what strategy should be followed in bringing those changes about?

A third question is how the services should be organised. The Consortium* laid much emphasis on the development of associations between hospitals both for clinical teaching and the efficient provision of services and made a number of proposals for changes in existing associations. We agree that this is an important subject but we do not feel it would be appropriate to comment now on the Consortium's recommendations. Associations between hospitals will need to be taken into account in setting the boundaries of the new District Health Authorities, along with the views of the University on the organisation of medical schools and the other factors outlined in the Department's circular on restructuring. It will be for the Regional Health Authorities to balance all these considerations in their proposals to the Secretary of State. We would be prepared to examine problems that might flow from these proposals.

THE NEED FOR CHANGE

4. The London Health Planning Consortium's Profile* assessed the need for change in the level of acute hospital services in London. The Profile showed how the distribution of population has changed during this century. From a peak of 4 million inhabitants at the turn of the century the population of inner London has now reduced to 2¾ million and is expected to fall below 2½ million by the end of the 1980's; the population of outer London has also been falling since the end of the second world war. But the distribution of hospitals has not changed in parallel and acute hospitals are still concentrated in inner London. Londoners have relatively easier access to and make greater use of acute hospital services than those living in other parts of the country even though many people still come from further afield for treatment in London hospitals.

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* The London Health Planning Consortium, with members drawn from the officers of the four Thames RHAs, the DHSS and the Boards of Governors, together with representatives of the University of London and the University Grants Committee, published two reports particularly relevant to our work on acute services: a factual report - "Acute Hospital Services in London : a Profile by the London Health Planning Consortium" (HMSO 1979) - referred to as 'The Profile'; and a discussion document - "Towards a Balance : A Framework for Acute Hospital Services in London Reconciling Service with Teaching Needs".

5. Yet London is poorly provided with health services specifically for the elderly, the mentally ill and the mentally handicapped and has deficiencies in primary care. These deficiencies are worse in inner London and are compounded by social and environmental problems which place greater burdens on these services. In consequence, there has been an excessive reliance on the acute hospitals. But this is an expensive way of providing care: it is not an appropriate use of hospital facilities and it is not necessarily in the best interests of patients. London still has a long way to go if it is to achieve a proper balance between the different parts of the health services.

Assessing the Need

6. As a start it is necessary to decide what would be an appropriate level of acute provision within a balanced health service in London. The Consortium developed a way of assessing the number of acute beds required. The assessment suggested that a reasonable level of service could be provided in the later 1980s with considerably fewer beds, partly because improvements in the use of hospital facilities will allow more patients to be treated in a given number of beds and partly because the movement of population away from London means that there will be fewer people needing treatment there.

7. The Consortium concluded that in 1988 some 22,500 beds (in addition to those in the specialist postgraduate teaching hospitals) would be required in London compared with 28,600 in 1977, when they made their study (by 1979 the number had fallen to 26,650). The proposed change was broadly the same across London as a whole, with 3200 fewer beds in inner London* and 2900 in outer London.

8. We felt it to be essential to examine carefully the assumptions on which this assessment was based. The method used considered four main factors:

i. the population to be served. In doing so it took account of the likely size of the population in the future and of its age and sex structure;

ii. the frequency with which people are likely to be admitted to hospital. The Consortium allowed for changes in the frequency of hospitalisation in different medical specialties and in different age groups. Allowance was also made for local variations in morbidity and for the more frequent use of hospitals by people in London.

ii. the time patients are likely to remain in hospital. Again the different pattern of use of hospitals in different specialties and age groups was taken into account; and the generally longer lengths of stay to be found in London;

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* For the purpose of this paper, Inner London is defined as being the City of London and the Boroughs of Newham, Tower Hamlets, Hackney, Islington, Camden, Westminster, Kensington and Chelsea, Hammersmith, Wandsworth, Lambeth, Southwark and Lewisham.

iv. the hospitals used by people in different areas. Although it is possible that fewer people may come to London for treatment as better hospital services are provided near their homes, the Consortium assumed, cautiously, that patients living in different areas would continue to use hospitals in London in the same way as in the past.

We are grateful for the help given to us by Professor Knowleden of Sheffield University in judging the validity of the methods used and the assumptions made in the assessment, and in considering criticisms which have been expressed. We recognise that there is inevitably uncertainty in an exercise of this kind, both in terms of the data used and the projections made for the future. But we have concluded that the assumptions on which the assessment was based are reasonable, that the methods are sound, and that they offer the best available basis for our work. In reaching this conclusion, we had particularly in mind the consideration mentioned below.

9. Population Projections. The method relied on population projections made by the Office of Population Censuses and Surveys. Projections are inevitably hazardous and given to error. But the sensitivity of the assessment to other population projections has been tested. It was shown that the effect of using projections published this year by the GLC on the overall bed requirements was marginal. The method therefore appears to be robust. Some would argue that no decisions should be taken until further data is available (probably during 1982), following the 1981 census; but we do not believe that this new data would materially change the position. Further, postponement of decisions on strategic plans for acute services would delay the much-needed development of non-acute services.

10. Social Deprivation. Inner London faces many social and environmental problems arising from poor housing, homelessness, overcrowding and large immigrant populations. These factors are often associated with high levels of morbidity and a greater need for health services. At the same time, the fragmentation of families and communities and the mobility of the population make it more difficult for sick people to be cared for in the community or to be discharged quickly after hospital treatment. The assessment made by the Consortium has made allowance for these factors.

11. The Elderly. Although London's population is falling, the number of elderly people is remaining more or less constant. Indeed, in outer London, the number of very old people is increasing. It is vital, therefore, that the increasing impact of the elderly on general acute services should be recognised. Almost half the patients using acute hospital beds are over 65 years of age and in most cases their admission to acute beds is entirely appropriate. But conditions in inner London, where for instance a high proportion of elderly people live alone, may require elderly patients to be admitted to hospital more frequently and to stay there longer. Allowance has been made for this in the assessment.

The Interface between the Acute Sector and Other Services

12. We are satisfied, therefore, that the Consortium's assessment takes adequate account of factors affecting the need for acute services; but the shortcomings of other services also have an important impact on the acute sector. London has 15% fewer geriatric beds than the national average. Elderly patients have sometimes to be admitted to general acute beds when the services of a geriatrician might be more relevant; and, once in hospital, it may be more difficult to rehabilitate or discharge patients to more appropriate longer term care. This is not a situation which the health service should be planning to perpetuate and the acute provision should not, in the long term, allow for it; but it will be necessary for the health authorities to plan to remedy the shortfall in geriatric services as acute services are reduced.

13. Nor are primary care and community services at present as well organised or well-financed as we would hope, particularly in the light of London's special problems. For the future these services will need to be further improved if they are to cope with increasing numbers of patients discharged early or needing to be treated in the community. The constraints on local authority spending may also make it more difficult for patients to be supported in the community.

14. The inter-dependence of acute, non-acute, community and primary care services cannot be too strongly emphasised. We regard it as essential for health authorities to develop a balance of services. It will not be easy for this to be achieved in the current climate of resource constraints and when health services in other parts of the Thames Regions and the country as a whole are in need of development. But the rationalisation of the comparatively well-provided acute sector in London offers an opportunity to strengthen those parts of London's services which are poorly provided. We recommend that a large proportion of the resources released should be devoted to this purpose. This is an opportunity which must be taken and to which priority should now be attached.

15. A shift of emphasis will required concerted effort. The health authorities themselves have the primary responsibility for changing the balance of hospital provision. And it is in their hands to make substantial improvements in community health services. But other important changes are outside their control. Improvements in general practitioner services may depend more on action by central government than on local initiative. (We welcome the study of primary health care which has been commissioned by the Consortium). In other fields, the local authorities have an important part to play. Unless local authorities can provide adequate community services and sufficient accommodation for the elderly, it will be difficult to achieve the right balance of care between hospital and the community. We believe that there is an urgent need to examine the interface

between the care of sick people in hospital and their care in the community; and in particular to consider whether funding adjustments between sectors are required. We therefore recommend that the Government should study this problem.

Medical and Nursing Manpower and Training

16. We are aware that changes in the numbers and distribution of acute beds may have considerable implications for the training of medical students; but we believe that the problems are not insuperable if full use is made of all the available facilities.

17. Concern has been expressed about the implications for nurse training although these have not yet been fully quantified. At present London has many large nurse training schools which train nurses who serve in many parts of the country. If acute beds are reduced, the training schools' intake may also need to be reduced. This may have manpower implications beyond London. More important for London, difficulties are being experienced in recruiting and retaining trained nurses and consequently nurses in training have provided a high proportion of the total workforce at least in the acute sector. Difficulties are likely to be still greater in the non-acute sector and in the community not only for nursing but also for other staff. This is an issue which may require further consideration.

The Appropriate Level of Provision

18. In confirming that changes of the order described in the Profile are needed, we have been concerned to see that the levels of provision proposed do not require unacceptable changes from the existing situation. We believe that the method used is, in general, cautious in its assumptions - future trends have been modified where they conflict significantly with existing practice; and it has been assumed, for instance, that the use of central London hospitals by non-Londoners will continue even when local services are readily available. We have examined the actual progress achieved since 1977 against the projections and have found that changes are taking place at least as fast as expected - lengths of stay have continued to reduce for most acute specialties; and the overall bed numbers in London have been falling at a rate faster than the Consortium projected. Between 1977 and 1979, the number of acute beds fell by nearly 7% (1950 beds).

19. Taking all these considerations into account, and in particular the import of paras 14 - 15, we believe that the acute provision proposed by the Consortium for 1988, namely 22,500 beds, is a reasonable basis for planning for London as a whole. We do not regard the detailed figures in the Profile as a blueprint for provision in each specialty or District and for all time. The numbers may require modification in the light of local circumstances and further knowledge. But the order of change proposed is both appropriate and necessary and we recommend its acceptance.

20. In summary, the provision envisaged for London in 1988 compared with beds available in 1979 is as follows*

	1979	1988	Reduction envisaged
Inner London			
NW Thames	3605	3217	388
NE Thames	5352	4400	952
SE Thames	3333	2827	506
SW Thames	1694	1454	240
Total	13984	11898	2086 (14.9%)
Outer London			
NW Thames	4284	3596	688
NE Thames	4074	3308	766
SE Thames	2200	1894	306
SW Thames	2107	1833	274
Total	12665	10631	2034 (16.1%)
Total for London	26649	22529	4120 (15.5%)

HOW SHOULD CHANGES BE BROUGHT ABOUT

21. In considering how the changes should be brought about, we have confined ourselves mainly to inner London (see definition in para 7). In outer London there is no major strategic issue which requires our advice, although the considerations which are discussed below may be relevant. Services there are more local in nature and the overlaps between Districts and between Regions are less pronounced. The health authorities themselves can develop detailed plans to effect the necessary reductions in the numbers of acute beds.

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* We have quoted for ease of reference the precise 1988 figures, derived from the Consortium's Profile Table G3. These figures are 'average available beds' not 'complements', and in practice, it is impossible to plan with this degree of precision.

22. But in inner London, the pattern of service is less well delineated and a different approach is called for. The major hospitals do not serve exclusively their local Districts or a defined community; most of them draw patients from a wide area and often from all the Thames regions. Moreover hospital facilities are needed in support of clinical teaching and research and account must be taken of proposed changes in the organisation of medical schools. We believe that a piecemeal approach to planning the necessary reductions - finding a short-term, ad-hoc solution to every local circumstance - would be unhelpful. There is a risk that available resources would be inefficiently used, and the Service would be less well able to meet its varied responsibilities. We have therefore concluded that the formulation of a more concerted strategy is necessary for effecting change in inner London.

23. Inner London contains acute hospitals with a variety of traditions. Historically, the main providers of acute and specialist services were the teaching hospitals which attracted patients from a wide area, while the former Poor Law hospitals and the local authority hospitals dealt almost entirely with local patients. This pattern has changed in recent years with the teaching hospitals focussing more on the local community and working more closely with the other hospitals in their Districts. Most of the investment in inner London has been directed towards the main teaching hospitals. For instance the Royal Free, Charing Cross and St George's have been or are in the process of being re-built. St Thomas' and Guy's have also been substantially redeveloped and a major project is underway at The London Hospital. In addition, the rebuilding of St Mary's is to begin shortly. Most of the remaining teaching hospitals have maintained reasonable standards of accommodation. The result is that the teaching hospitals are in general well placed to provide acute medical services of a high standard with all the necessary back-up facilities.

24. Of the other hospitals, a number have been or are planned to be redeveloped. For example, St Stephen's Hospital, Fulham, was substantially rebuilt during the 1960s and a major rebuilding programme is planned for the Whittington Hospital. New hospitals are being built in Hackney (the Homerton) and in Newham.

25. In short, the strategy which has been followed has been to develop the major general hospitals as the main acute centres. We see no realistic alternative to continuing this policy.

26. Any alternative strategy would have serious drawbacks. To apportion the reduction uniformly across the board would be to ignore the extent of investment already made. It would inevitably mean that the major hospitals would be less effectively used; it would be more difficult for them to provide specialist services; and the smaller

hospitals which at present have only a limited acute role, would be reduced below a viable size. Nor would it be sensible to retain smaller hospitals to the detriment of the major hospitals. To do so would require the closure of more than one of the major hospitals or a reduction of up to 200 beds in some of them in order to retain the acute role of the others; it would be extremely difficult to justify the preservation of less suitable hospitals with poorer accommodation which would require considerable new investment.

27. Because so many hospitals are concentrated in central London, few of them have become over-large. Accessibility is not on the whole a serious problem in a densely populated area like inner London. Few people living in the area can be more than a reasonable distance from one of the main general hospitals. While it may be argued that the teaching hospitals have in the past concentrated too much on specialist services, they now carry a substantial district load, in addition to their wider responsibilities, and should be expected to do so still more in the future. The issue here is not the further expansion of the major hospitals but to make use of the best stock and facilities that are available.

28. We have also had in mind the important responsibility which the NHS in London carries in supporting medical education and research. If this responsibility is to be discharged adequately the medical schools must be able to obtain ready access to clinical facilities. As it is, the medical schools will need to use all the major hospitals in central London to teach undergraduates. Their task would be more difficult if NHS acute services were excessively diffused.

29. We therefore conclude that, for the future, the strategy to be adopted for inner London should be to make full use of the major hospitals and to effect the necessary reductions in acute services in the other hospitals. We recommend this strategy. Within inner London we would expect the main acute services to be provided by the following major hospitals:

Charing Cross
Dulwich
Guy's
Hammersmith
Homerton, Hackney
King's College
Lewisham
The London (Whitechapel and Mile End)
The Middlesex
Newham
Queen Mary's, Roehampton
Royal Free
St Andrew's, Bow
St Bartholomew's
St Charles'
St George's

St James'
St Mary's
St Stephen's
St Thomas'
UCH
Westminster
Whittington (Royal Northern)

30. We have not sought to specify a number of beds for each of these hospitals or to define in detail the services they should provide. In some of the hospitals it will be necessary to reduce the number of acute beds in order to allow the development of geriatric and psychiatric assessment facilities and to provide a proper base for the full range of local services. But after such adjustments have been made, the major hospitals should be able to accommodate the necessary acute beds.

31. In addition to the hospitals listed above, there is a number of specialised hospitals which will need to be retained and for which no plans for a future change exist. These are:

St Mark's (diseases of the rectum and colon)
Atkinson Morley's (neurosurgery)
Elizabeth Garrett Anderson (services for women)
The Royal London Homoeopathic (homoeopathy)
Coppetts Wood (infectious diseases)
The Western Ophthalmic
The Samaritan (gynaecology)

32. We have thus identified the hospitals in which, in our view, the acute services should be concentrated. A number of the other hospitals will no longer be needed, if the reduced target of acute beds is to be achieved. Some have only a limited acute role now and they would not be able to become viable acute centres without considerable investment. Others are used in part or in total for other services. The proposed reduction in acute beds should free resources some of which could be used to develop services for the elderly, the mentally ill and handicapped and a variety of community services. This could provide the scope for local innovation in these fields and for redressing the imbalance between acute and other facilities.

SPECIALIST SERVICES

33. Some specialties are best provided for a wider population than a District. These specialties have attracted much attention in recent years because of apparent overlaps and unplanned proliferation of specialist units not all of which could be regarded as economically viable or professionally satisfactory. There was a clear case for a London-wide view and the Consortium established independent study groups which considered the future pattern of some of these specialties, namely cardiology and cardiac surgery, radiotherapy and oncology, neurology and neurosurgery, ophthalmology and ENT.

34. Their reports were the subject of extensive consultation. Each of the Consortium's parent bodies collected the views of interested parties and reached its own conclusions. In most cases the general principles adopted by the study groups were endorsed. But the RHAs and the Boards of Governors did not agree with all the proposals and suggested alternatives. The Consortium modified the proposals and issued a report which concluded that there was now a compatible and sensible basis for the future planning of these services.

35. We have noted this conclusion and believe that RHAs and the Boards of Governors, consulting each other as necessary, should now be able to proceed to develop their plans in the specialties concerned, in the knowledge that they will not be cutting across each other's responsibilities. The proposals were developed in relation to London as a whole without reference to the constraints of regional boundaries. We hope that if there are to be changes in the regional boundaries in the light of decisions on the new DHAs they will not be allowed to hinder the implementation of these agreed proposals.

SPECIALIST POSTGRADUATE TEACHING HOSPITALS

36. The bed numbers discussed in this paper do not include those in specialist postgraduate teaching hospitals managed by Boards of Governors. The hospitals have a national role but they are also part of the network of services for the people in London.

37. In most cases, the future service role of the hospitals is clear but it has been accepted for some time that the physical condition of some of the smaller hospitals is unsatisfactory and that they should be rehoused. Since the Report of the Royal Commission on Medical Education (1968) it has been the policy of successive Ministers to rehouse the hospitals concerned in close association with general teaching hospitals in order to enable them to operate in a wider professional environment and to have easier access to all necessary support facilities. We believe that the proposed changes in acute services will provide scope for some of the postgraduates to be rehoused within the existing accommodation of undergraduate teaching hospitals and we recommend that the requirements of the postgraduates should be taken into account in planning these changes.

38. Three of these hospitals (St John's, St Peter's and the Eastman Dental) are in need of total rehousing. In two other cases (Royal National Throat Nose and Ear and Royal National Orthopaedic Hospital), rehousing of the smaller branches of these hospitals is also needed. Many possibilities for the rehousing of all these hospitals have been considered in recent years and with the exception of the Eastman Dental no final decision has been taken. We are not in a position to advise which of the various options are to be preferred but we believe that it is important that decisions on this matter should now be made. Otherwise the opportunity which the current review of acute services offers to resolve this long standing issue will be missed.

CONFIDENTIAL National Heals

10 DOWNING STREET

From the Private Secretary

22 April 1980

Thank you for your letter of 16 April in our continuing correspondence about the London Advisory Group.

The Prime Minister was interested to see the breakdown of staff on the health and personal social services side of the Department. She has noted your description of the responsibility of the Regional Group, and has commented that she finds it extraordinary that the Department needs both to cover this work itself through the Regional Group and then to seek parallel advice from three groups.

I do not think we need take this further at present but the Prime Minister may well raise this issue with your Secretary of State at some future stage, and you will wish to keep us informed well in advance about any future appointments similar to that of Professor Habakkuk.

Don Brereton, Esq.,
Department of Health and Social Security.

GB

CONFIDENTIAL

2

PRIME MINISTER

This letter is a response to your queries at flag B. I have attached the entire correspondence.

ngs

PRIME MINISTER

You asked about numbers of DHSS staff working on health; these figures cover health and personal social services.

MAP 17/4

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

N Sanders Esq
Private Secretary
10 Downing Street
London SW1

18/4

May I have the letter to which this is a reply

16 April 1980

Dear Nick,

I apologise for not replying before now to your letter of 24 March about the London Advisory Group.

My Secretary of State is keenly aware that this group must be seen to be acting as a vigorous aid to the resolution of London problems and Ministers will be keeping in close touch with their work to ensure that progress is made.

At present 2,800 staff work on the health and personal social services side of the Department; this is 6 per cent less than in April 1979. This figure includes administrative, executive and clerical etc staff and their professional colleagues (including doctors, nurses, pharmacists, social work service officers, scientific and technical staff, architects, engineers and surveyors).

The five main Groups dealing with the Department's HPSS work are:

- Services Development	-	300 staff
- Regional	-	280 "
- NHS Personnel	-	480 "
- Finance	-	380 "
- Professional Divisions	-	1,340 "

(including attached Clerical Support)

These Groups are supported by common service Divisions like Legal, Statistics, Information, Research, Management Services and Computers, Establishment and Personnel, and the secretarial, typing and messengerial support services.

London Planning falls within the responsibility of the Regional Group. This Group's functions include interpreting the needs of NHS and Local Authorities as a policy input; ensuring that ministerial policies are carried out in ways that take account of local needs and resources available; overseeing the forward planning of field authorities; developing policy on structure and management arrangements in the NHS; dealing with the supply, industry and export activities of the DHSS in the field of medical, surgical and pharmaceutical supplies.

E.R.

Within the Regional Group, involved in the planning and structure of London's health services, including support for the Advisory Group, are:-

½ Under Secretary

¾ Assistant Secretary

1 Principal

6 Executive clerical staff

1/5 Senior Principal Medical Officer

½ Principal Medical Officer

¼ Principal Nursing Officer

Yours ever

D BRERETON
Private Secretary

FILE

VLG

CONFIDENTIAL

RE 14.4.80

24 March 1980

Advisory Group on London Health Service

The Prime Minister has seen Bernie Merkel's recent letter to Mike Pattison. She has commented that there is no alternative to going ahead with the proposals, including the appointment of Sir John Habakkuk as Chairman, but that she thinks it is a mistake. In her view, the public will feel that a third piece of advice is being prepared in addition to the two already received - one from Flowers and one from the London Consortium. She thinks it is likely to cause delay and to transfer decisions from those whose task it is to make them.

Finally, she has asked to know how many people currently work on the health side of the D.H.S.S., and I should be grateful if you could supply me with this information, together with any comments you may have to make on the number of those who will be involved in this sort of planning.

N. J. SANDERS

Don Brereton, Esq.,
Department of Health and Social Security.

SP

CONFIDENTIAL

CS

B 1

PRIME MINISTER

You queried (flag A) the need for this new quango. In the light of this further explanation, content for Mr Jelkin to appoint Sir J Habakkuk?

MJS 21/3

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mike Pattison Esq
Private Secretary
10 Downing Street
London
SW1

I think this is a mistake but if you have answered it then you have no alternative to go ahead. To the extent that you have already received 2 bits of advice - from Flowers and from the London Consortium. What is the result? A third piece of advice is required from Lib central committee. What it does is delay + weaken decisions for those whose task is to make them.

Dear Mike

Your letter of 17 March asked for clarification of the purpose of the proposed Advisory Group on London.

How many people does DHSS have on the Health side of DHSS? MJS

The problems facing London's health services have been there for many years. In essence, they are an excessive concentration of acute hospitals services in the centre and inadequate services in the suburbs and in the Counties on the periphery. This problem arises mainly because of the enormous, and continuing outflow of population from central London. At the same time, primary care services and services for the elderly, the mentally ill and the mentally handicapped in the centre need to be developed.

In other words, there is a need for a major shift of emphasis and provision from central London to other areas and from the acute to the non-acute sectors. A complicating factor is that London remains a major centre for medical education and research and the changes needed will pose major problems for the medical schools which rely heavily on clinical facilities in central London.

The problems are not new and successive Governments have attempted to solve them. But none has succeeded, largely because of the difficulty of securing commitment to change from the range of interests affected - including academic and local authorities as well as the health authorities for which my Ministers are responsible.

My Ministers are convinced that the time is ripe now. The financial pressure on the health service in London has brought a greater acceptance of the need for change. Much of the necessary ground work has been done in the Department, by the health authorities and through the planning mechanism of the London Health Planning Consortium. The University of London has looked at its own organisation, through the Flowers Report. While the Flowers proposals to the University are not essential to the general strategy (they are running into heavy opposition from many quarters and may well be acceptable only in modified form), it is essential that any decisions reached by the university should be taken fully into account in the inpending restructuring of the health service.

ENC

E.R.

Changes in the pattern of services will not be easy to make and it will be even harder to make them stick. The Royal Commission on the NHS recommended that an independent enquiry should be set up to look at London and the Opposition have continued to press for it; but my Ministers made clear, in Patients First, that they did not accept that this would do more than delay action. They do, however, see the need for the views of the various interests concerned to be taken into account - and to be seen to be taken into account - in the decisions which are made. An abundance of expert knowledge and advice is available; but there is no forum in which the advice and proposals made by expert bodies and the conflicting views expressed on them by health, academic and local authorities can be reconciled. My Ministers believe that the Department should not alone take on the role of sifting the evidence; an advisory group, with a leavening of independent members will be able to give advice which would be more credible and acceptable at the local level where change will have its greatest impact.

There is also a need for the activities of the various authorities concerned to be coordinated in the run-up to health service restructuring. The Regional Health Authorities will be in the lead in preparing proposals for restructuring and it will be important for them to work within guidelines which are consistent throughout London and acceptable to the other authorities concerned. The Advisory Group will have an important role in ensuring this compatibility.

Because of the need to move quickly on restructuring and in handling the various reports which have recently been published on the health service in London, my Ministers decided to move ahead with setting up the Advisory Group, which had been proposed in Patients First, as soon as possible. The Minister for Health therefore announced the Government's intention during debate in Committee on the Health Services Bill; this was in response to an Opposition amendment demanding a full inquiry as envisaged by the Royal Commission. I attach a copy of the press notice issued on the day of the announcement and of a subsequent written answer to Mrs Renee Short which explained how the Group will work.

We have not set a time limit for the Group's work. It will certainly need to continue through the period of restructuring but it is unlikely that it would remain in being for more than three years.

You asked about the full costs of the Group. Our best estimate is that the direct costs of the Advisory Group will be about £14,000 a year. We have estimated that the Group, of 15 members, will need to meet up to 20 times a year - involving the payment of fees amounting to approximately £10,000. The balance of £4,000 would be to cover Members' expenses, including any weekend meetings which the Group might feel are necessary. The Group will be serviced by the DHSS and full allowance for the staff costs has been made in the Department's manpower programme. The Advisory Group will certainly be far less expensive than the kind of full-scale inquiry for which the Opposition are pressing and should ensure that decisions, long overdue, are taken speedily.

I am copying this to Geoffrey Green and Murdo Maclean.

Bernie Merkel

B C MERKEL
Private Secretary

Department of Health
and Social Security

PRESS RELEASE

Telephone 01-407 5522

80/48

26 FEBRUARY 1980

ADVISORY GROUP ON LONDON HEALTH SERVICE TO BE SET UP

Dr Gerard Vaughan, Minister for Health, to-day announced that the Government has decided to go ahead and set up a new Advisory Group to help it in reaching important decisions about the future of the health service in London.

Dr Vaughan was speaking, during the Committee Stage of the Health Services Bill, in reply to an amendment proposing that there should be an independent enquiry into London's problems before any changes in health service structure take place. Rejecting this idea, Dr Vaughan said an enquiry would be a receipt for delay. Many of the problems had been studied already. For example, two important reports had been issued to-day by the University of London and the London Health Planning Consortium. A number of difficult decisions had to be taken on these and other reports and would require co-ordination between many interests if the right answers were to be found. To secure this, the Government had, in 'Patients First', taken the line that a representative Group would be needed to advise Ministers and Authorities on the options available. Dr Vaughan said that this proposal had earlier received much support and since there was a need for action to be taken quickly, the Government had decided to move ahead and establish a Group as soon as possible.

The terms of reference and membership of the Advisory Group will be announced in due course.

Monday 3 March 1980
Written Answer
Tuesday 4 March 1980

PQ 3909/1979/80
Han Ref Vol
Col

FLOWERS COMMITTEE - REPORTS

W.O Mrs Renée Short (La. Wolverhampton North East)

To ask the Secretary of State for Social Services, which bodies and organisations he intends to appoint to the Advisory Committee to look at the reports of the Flowers Committee and the London Health Planning Consortium; what time scale he envisages for representations to be made to the committee and for decisions to be made; and if he will ensure that there is full public discussion before any decisions are reached.

DR GERARD VAUGHAN

The Advisory Group on London which my right hon Friend proposes to establish will include representatives of the Department of Health and Social Security, the University Grants Committee, the University of London, the four Thames Regional Health Authorities, the postgraduate Boards of Governors, the Greater London Council and the London Boroughs Association. It will also include a small number of independent members, including the Chairman. The membership and terms of reference of the Group will be announced in due course.

The purpose of the group will be to assist Ministers in reaching decisions on some of the major issues affecting the health service in London, including those which are of significance for the restructuring of health authorities and to advise on proposals developed by the health authorities for restructuring. A number of relevant reports, including the Flowers Report and the discussion document issued by the London Health Planning Consortium, will need to be considered by the Group. The Group cannot, however, advise on the decisions to be taken on the Flowers report; these are entirely a matter for the University of London but it will need to consider the implications of the University's decision.

PQ 3909/1979/80
Han Ref Vol
Col

The issues and reports which the Advisory Group will be called upon to consider are at present, or will be the subject of wide consultation. The views of interested parties (including community health councils, local authorities and staff interests) will be collected by the responsible authorities. The evidence which they provide will be put, together with the original reports and proposals, to the Advisory Group. There will, therefore, be the fullest opportunities for public debate and a variety of possible solutions will have been explored. It will be the Advisory Group's task to take this evidence, and any further information which it requiries, and to advise Ministers which course of action is to be preferred. That advice will be made public but I would not expect to undertake further formal consultations on it.

B/F 20.3.80

10 DOWNING STREET

From the Private Secretary

17 March 1980

I mentioned to you on the phone this morning that the Prime Minister has some doubts about the new Advisory Group on the future of health services and medical education in London, foreshadowed in "Patients First". This was the subject of Don Brereton's letter to me of 12 March.

The Prime Minister has asked why this new "Quango" is necessary, and whether further advice is required. She would hope that there is already sufficient knowledge and expert advice on these matters available to the Government. She would certainly wish to see a statement of the full costs likely to be incurred in setting up and operating the Group before she agrees that it should go ahead.

Given that the setting up of the Group has already been forecast in "Patients First", I realise that you will want to settle the matter one way or another very quickly. It would be helpful if you could let me have figures which I have requested above in the course of this week.

I am sending copies of this letter to Geoffrey Green (Civil Service Department) and Murdo Maclean (Chief Whip's Office).

M. A. PATTISON

Bernie Merkel, Esq.,
Department of Health and Social Security.

YDS

A.

PRIME MINISTER

Sir J Habakkuk is proposed to chair an Advisory Group on Health Services and Medical Education in London - as proposed in 'Patients First'. Agree?

MAP 13/3

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

12 March 1980

Dear Mike,

It was envisaged in "Patients First" that an Advisory Group should be established to help the Government reach decisions concerning the future of health services and medical education in London. Following consultations with the Public Appointments Unit of the Civil Service Department and the Office of the Chief Whip on a suitable Chairman for this Group, my Secretary of State has considered that Sir John Habakkuk, the former Vice Chancellor of Oxford University, is the best candidate for this post: I enclose a brief CV. Preliminary soundings indicate that Sir John would be able and willing to undertake the task.

I should be grateful if you could let me know whether the Prime Minister is content for the Secretary of State to invite Sir John Habakkuk formally to be the Chairman of this important Group.

I am copying this letter to Geoffrey Green in the Civil Service Department and Murdo MacLean in the Chief Whip's Office.

Why another Quango. Why do we need advice on this. Surely we know ourselves. Looking? is full?

Yours ever

D

D BRERETON
Private Secretary

Enc.

Annex to
Mr Boreton's
letter of 12/3.

DHSS

With the Compliments of
the Private Secretary to
the Secretary of State

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House
Elephant and Castle
London, SE1 6BY

HABAKKUK, Sir John (Hrothgar), Kt 1976; FBA 19[illegible]; Principal of Jesus College, Oxford, since 1967; a Pro-Vice-Chancellor, University of Oxford, since 1970; President, University College, Swansea, since 1975; *b* 13 May 19[illegible]; s of Evan Guest and Anne Habakkuk; *m* 1948, Mary Richards (née Thomas); *d* 1[illegible]; Barry County Sch.; St John's Coll., Cambridge (scholar and Strathcona student); Hon Fellow 1973. Hist. Tripos, Part I, First Class, 1935; Part II, First Class (with distinction), 1936; Fellow, Pembroke Coll., Cambridge, 1936-[illegible]; Hon Fellow 1973; Director of Studies in History and Economics, 1946-50; Temporary Civil Servant, Foreign Office, 1940-42; Board of Trade, 1942-45; University Lecturer in Faculty of Economics, Cambridge, 1945-50; Chichele Prof. of Economic History, Oxford, and Fellow of All Souls Coll., 1950-67; Vice-Chancellor, Oxford Univ., 1973-77; Visiting Lecturer, Harvard University, 1954-55; Ford Research Professor, University of California, Berkeley, 1962-63; Member: Grigg Cttee on Departmental Records, 1952-54; Advisory Council on Public Records, 1958-70; SSRC, 1967-71; Nat. Libraries Cttee, 1967-69; Royal Comm on Historical Manuscripts, 1970-; Admin Bd Internat. Assoc. of Univs, 1975-; Cttee of Vice-Chancellors and Principals of Univs of UK, 1977-[illegible]; Pres. RHistS, 1976-; Foreign Member, Amer. Phil. Soc.; Amer. Acad. of Arts and Sciences; Hon. DLitt, Wales, 1971; Cambridge, 1973; Pennsylvania, 1[illegible]; Kent, 1[illegible]. *Publications:* American and British Technology in the Nineteenth Century, 1[illegible]; Population Growth and Economic Development since 1[illegible]; articles and reviews. *Address:* The Lodgings, Jesus College, Oxford. *T:* Oxford 48140. *Clubs:* United Oxford & Cambridge University.