

Advice to Government on London health services

In October 1991 the then Secretary of State for Health, William Waldegrave, appointed Sir Bernard Tomlinson to act as adviser on health services in London. Early on it was agreed that Sir Bernard would also take account of the role of these services in teaching and research. Previous reports have focused on one or other aspect, e.g. the Todd Report (1966) and Flowers Working Party Report (1979) primarily considered teaching and research while the report of the London Health Planning Consortium (1979) mainly addressed provision of services. While the former two reports have been followed by extensive change in the organisation of medical academic activities in London, there has been much less change in health care delivery. For instance, primary care and community care are still seriously deficient in parts of London while high technology hospital based medical practice, sometimes providing a nationwide service, has survived and sometimes continued to develop in an entrepreneurial way. The problem is riven by academic and professional concerns of nationwide relevance and importance.

Sir Bernard has been assisted in his present task by a small team of advisers including Sir Robert Kilpatrick, the President of the General Medical Council; Ms Pearl Brown, Primary Services Manager at Riverside Health Authority; Dr Mollie McBride, an experienced London general practitioner and Professor Michael Bond, Chairman of the Medical Sub-Committee of the University Funding Council. It is widely felt that, in the present national, financial and political climate, including the NHS reforms, Sir Bernard's advice may be acted upon.

Sir Bernard's terms of references are as follows:

"To advise the Secretaries of State for Health and Education and Science on how the relevant statutory authorities are addressing the provision of health care in inner London, working within the framework of the reformed NHS, including the balance between acute and primary health services; and the organisation and provision of undergraduate medical teaching, post-graduate medical education and research and development; taking account of:

- the health needs of London's resident and day-time population;
- the emerging purchasing plans of health authorities and their likely impact on inner London hospitals;
- future developments in the provision of acute and primary care;
- the need to maintain high quality patient care and, as a foundation for this, high standards of medical teaching and research and development."

Psychiatry is one important part of the health care services being considered by the group. With such services in London divided between four Regions, it was difficult to see how there could be a coherent input from the profession into the Tomlinson Committee. Therefore, the decision of the College, at short notice, to set up a working group on the matter and to approach Sir Bernard proactively, was much appreciated by those of us working in London. The College working group, chaired by Professor Crisp, also included the College advisers to the four Thames Regions, representatives of all the specialty areas; also representation from the Bethlem/Maudsley Special Health Authority. The group met with Sir Bernard and Professor Michael Bond over a working lunch. The meeting was considered by us to be fruitful. Sir Bernard welcomed the initiative and expressed his appreciation of the related portfolio of documents given to him and his colleagues. Copies of these are available for scrutiny at the College by members. Anyone wishing to see them should contact the College Secretary, Mrs Vanessa Cameron. Below is a brief summary of the College statement.

It was recognised that many of the problems of London psychiatry are similar to those elsewhere. However, in some instances they are caricatured in London where there are special social problems and especially severe financial cutbacks, all superimposed upon areas of very impoverished primary care and inadequate social services. The theme was sketched in as being very similar in the London segments of all four Thames Regions. The closure of the old psychiatric hospitals is occurring without proper developments of other acute units. The increasing load of severely disturbed patients, fuelled by large numbers of homeless people, better recognised alcohol and other drug related problems in the population and increased numbers of the elderly psychiatrically ill population was noted. In some London boroughs social service provision has been severely curtailed. Where community based psychiatric services have been developed, they are often overwhelmed with the care of psychotic patients and less attention can be given to neurotic and psychosomatically ill patients either within hospital liaison services or primary care systems. Child psychiatry is besieged with problems such as the withdrawal of social workers from Child Guidance Clinics, the threatened closure of such clinics owned by Education Authorities and the loss of sub-Regional adolescent units. The development of forensic

services, embryonic in places, is further threatened by the premature closure of psychiatric hospitals in some areas before tailor-made Regional Secure Units have been developed. Similar problems, but in respect of community resettlement, are affecting the learning disability psychiatric services. Psychiatric services for the elderly are particularly affected by the lack of community provision and insufficient social work input. Specific substance misuse services are especially affected by the severity and extent of the problem in London, its relationship to homelessness and, again, the absence of facilities for social rehabilitation and aftercare. Finally, Academic

Departments of Psychiatry, within London in particular, have sometimes developed highly specialised services, often bed-based. Such services sometimes demonstrably effective and essential to research, are under special threat because of their idiosyncratic development and perceived irrelevance to local need.

Overall, the establishment of a pan health care system for London, not broken down by Regions, was thought to be worthy of serious consideration.

It is rumoured that Sir Bernard will be reporting to the Secretary of State in October 1992.

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Chairman of the Working Party

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Revised guidelines for collaboration between physicians in geriatric medicine and psychiatrists of old age

Since 1979, consultants in psychiatry of old age and geriatric medicine have used the excellent guidelines drawn up by Professor T. Arie and agreed by the Standing Joint Committee of the British Geriatrics Society and the Royal College of Psychiatrists to determine which patients each group should be responsible for. Then, as now, there were concerns that some patients might fall between two stools.

The NHS reorganisation and the enactment of new community care legislation have made it essential that psychiatrists and physicians have a close and effective working relationship. The emphasis on purchaser/providers and the need to assess all patients in order to plan individual packages of care make it crucial that the expertise in geriatric medicine and psychiatry of old age be utilised. The two specialties need to work closely together to ensure that assessments and necessary care be carried out efficiently, without overlap or undue delay.

The two specialties need to agree principles of collaboration which are most likely to improve quality of clinical care, as opposed to mere expediency. Such guidelines should be widely publicised among the medical profession, management and the general public.

The following principles should apply.

1. Specialist health services for the elderly should be a unity for "consumers" (i.e. patients, carers, referrers). Transfers should be smooth and mutually agreed by the professionals, even when an initial referral was inappropriate, to ensure the most appropriate management of individual patients.
2. Unity does not mean blurring of the specificity of the particular professions and

facilities within the service or the patients' right of access to them.

3. Assessment by physicians in geriatric medicine and psychiatrists in the care of the elderly must be included as an essential component of services in directly managed and self-governing "trust" hospitals. Liaison between the two specialties should be included in "job plans", "service agreements" and "business plans".
4. Adequate resources in the whole range of geriatric medicine, the psychiatry of old age and social services provision are required to draw up community care plans and for the best management of individual elderly patients. There should be sufficient health provision for long term care. Inadequate resources inhibit collaboration.
5. Clear criteria for division of responsibility must be known and accepted both inside and outside the specialties, and should not be influenced by lack of resources; *a psychiatric patient does not become geriatric simply because there are no psychiatric beds or vice versa*.
6. Effective collaboration depends on mutual confidence and trust. Collaboration should involve not only physicians and psychiatrists, but also other members of the "multidisciplinary team".
7. Mutual confidence requires understanding of each other's disciplines. Some reciprocal training in each other's specialty should be mandatory for accreditation for higher professional training. The presence of a physician