

The Tomlinson Report and After: Reshaping London's Health Services, 1992- 1997

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Centre for History in Public Health,
London School of Hygiene and Tropical
Medicine

ICBH Witness Seminar Programme

The Tomlinson Report and After: Reshaping London's Health Services, 1992-1997

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Contributors

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Witnesses:

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Professor Sir Michael Bond – Member, Tomlinson Enquiry (1991-92); Professor of Psychological Medicine, University of Glasgow, 1973-98, now Emeritus Professor.

Baroness Bottomley (Virginia Bottomley) – Minister of State, Department of Health 1989-92; Secretary of State for Health 1992-95.

Professor Sir Cyril Chantler – Guy's Hospital; Professor of Paediatric Nephrology, 1980-2000; General Manager, 1985-88; Clinical Dean, Principal, UMDS, 1989-92, 1992-98; Vice Principal King's College, London and Dean King's, Guy's and St Thomas's Hospitals medical and dental schools, 1998-2000; member NHS policy board, 1989-95.

Ainna Fawcett-Henesy – Nurse Advisor in Primary Care, RCN, 1980-88; Chief Nurse/Director of Quality, Ealing Health Authority, 1988-91; Regional Director of Nursing and Quality, South East Thames RHA, 1991-95; Nurse Advisor, London Implementation Group, 1993-95; Acting Regional Adviser, Nursing and Midwifery, WHO Regional Office for Europe 1995-1998; Regional Adviser, Nursing and Midwifery, WHO Regional Office for Europe 1998-2006.

Professor Sir Malcolm Green – Consultant Physician, Royal Brompton Hospital, 1975-2006, St Bartholemew's Hospital, 1975-86; Dean, National Heart and Lung Institute, 1988-90; Director, British Postgraduate Medical Federation, 1991-96.

Professor Sir Brian Jarman – Member, Health Services in London (Turnberg) Strategic Review, 1997; GP, Lisson Grove Health Centre, 1971-98; Professor of Primary Health Care and General Practice, St Mary's Hospital Medical School, 1984-98; Emeritus Professor of Primary Health Care, Imperial College, 1998-; Member, London Health Planning Consortium (Acheson Committee), 1980-81.

Robert (Bob) Nicholls – Regional General Manager/Chief Executive, Oxford RHA, 1988-93; Director, London Implementation Group, NHS Management Executive, 1993-96; President, Institute of Health Service Managers, 1983-84.

Dr Tony Stanton – Former GP; Secretary, later Chief Executive, Londonwide Local Medical Committees, 1992-2010; Deputy Chairman, General Practitioners Committee, British Medical Association, 1989-93.

Jonathan Stopes-Roe – Head of Support Unit, Tomlinson Enquiry, 1991-2; senior civil servant, Department of Health, 1975-2011.

Lord Turnberg (Leslie Turnberg) – Chair, Health Services in London Strategic Review, 1997; Professor of Medicine , University of Manchester, 1973-97; Dean of Faculty of Medicine , University of Manchester, 1983-86; President, Royal College of Physicians, 1992-97.

Introductory speaker:

Geoffrey Rivett – Retired medical civil servant, Department of Health, 1972-1992; vice chair of the governors of a London Foundation Trust; historian of the NHS and the hospitals in London. DH representative, London Health Planning Consortium, 1977-1983.

Also in Attendance:

John Bacon – Chair, Sussex Partnership NHS Foundation Trust. Former finance / performance director, London Region, Director of Service Delivery Department of Health.

Dr Howard Baderman – Consultant and Clinical Director of A&E medicine at University College Hospital, 1970-2000; Consultant Adviser for A&E medicine to the Chief Medical Officer, 1989-2000; member of various national and WHO committees on A&E services and ambulance services, 1968-2000.

Professor Virginia Berridge – Professor of History, London School of Hygiene and Tropical Medicine.

Professor Nick Black – Professor of Health Services Research, London School of Hygiene and Tropical Medicine.

Pearl Brown – Member of the Tomlinson Enquiry 1991-92. Chief Executive Riverside Community Health Care NHS Trust 1994-2002; OBE for services to healthcare in London, 2000.

Peter Coe – Regional Director of Service and Capital Planning , North West Thames RHA, 1982-9; Chief Executive East and North Hertfordshire 1989-1992; Chief executive East London and the City Health Authority 1992-2000.

Robert Creighton - Chief executive of Great Ormond Street Hospital for Children 1995-2001, then of NHS Ealing 2001-2011; civil servant at Department of Health, 1988-95; Principal Private Secretary under Virginia Bottomley, 1992-94; Director responsible for public health transition in London, 2011-present.

Sir Graham Hart - Former Permanent Secretary, Department of Health.

Christine Hogg - Honorary Research Associate, London Metropolitan University. Former committee member of the Greater London Association of Community Health Councils.

Matthew Isom - Chief Executive, Dispensing Doctors Association.

Professor Rudolf Klein - Emeritus Professor of Social Policy, University of Bath.

David Noyce - Associate Director London & East England Higher Education Funding Council. Former HEFCE support officer to London Implementation Group.

Professor Martin Powell - Professor of Health and Social Policy, University of Birmingham.

Peter Simpson - Former Medical Director London Implementation Group.

Christopher Sirrs - PhD candidate London School of Hygiene and Tropical Medicine.

Stephanie Snow - Senior Research Associate, University of Manchester.

Chris Spry - Director OD Partnerships. Former Regional General. Manager of South Thames Regional Health Authority.

Convenors

Martin Gorsky - Senior Lecturer in History, London School of Hygiene and Tropical Medicine

Michael Kandiah – Director of the Witness Seminar Programme, Institute of Contemporary British History.

Virginia Preston – Deputy Director, Institute of Contemporary British History

Organising/advisory committee: Nick Black, Martin Gorsky, Rudolf Klein, Bob Nicholls

TIMELINE OF KEY EVENTS

- 1976 Resource Allocation Working Party: new NHS funding formula begins resource redistribution away from well-provided regions such as London.
- 1980 Flowers Report on medical education proposes amalgamations of academic institutions. London Health Planning Consortium (LPHC) report *Towards a Balance* proposes shift of acute beds to outer London and better hospital/ medical school links to provide sufficient teaching facilities to maintain student intakes.
- 1981 *Primary Health Care in Inner London*, report by Donald Acheson commissioned by LPHC demonstrates reliance on single-GP practices, poor facilities and comparably low standards.
- 1988 Kenneth Clarke, Health Secretary (July).
- 1990 NHS: *Working for Patients* published; NHS Act sees introduction of internal market, fund holding and trusts, increasing pressure on high cost inner London hospitals.
William Waldegrave, Health Secretary (November).
- 1991 Appointment of Kings Fund London Commission. Waldegrave announces review of London's health service, medical education and research, by Sir Bernard Tomlinson, chair of the Northern Regional Health Authority.
- 1992 Conservative election victory under John Major, against predictions; Virginia Bottomley Health Secretary (Apr).
King's Fund's *London Health Care 2010* (June), based on 12 research reports, identifies the very high costs and lower throughput of central London hospitals, recommends reduction in acute services and parallel improvements in primary care.
Tomlinson Inquiry Report (October) emphasises need to raise primary care to national standards and provide better services for the mentally ill and the homeless. Proposes amalgamations of medical schools and post graduate institutions with multi-faculty colleges. Primary care improvement seen as pre-requisite to major reduction in acute beds. Specific proposals for mergers, for major capital investment in some hospitals and closures of others.
- 1993 *Making London Better* (Feb) – Government's response to Tomlinson largely accepting its proposals, setting up London Implementation Group (LIG) to oversee the changes and establishing the London Initiative Zone (LIZ), with freedoms from some national contracting rules, to improve premises, recruit more and a new cadre of GPs, and to develop primary care teams and encourage innovative practice.
- 1994 Family Health Service Authorities and Districts merge into Health Authorities.
- 1995 Stephen Dorrell, Health Secretary (July)
- 1996 NHS Regions replaced by 8 regional outposts of the Department, with two for London .
- 1997 Labour electoral victory under Tony Blair. Frank Dobson, Health Secretary (May). 5 SHAs for London replace District Health Authorities. Primary Care Groups developed.

Kings Fund London Commission publishes *Transforming Health in London* following research reports on five major themes – Mental Health The London Health Care System, The Health and Care of Older People, Rethinking Development, The Health Economy of London. Concludes that despite progress in grouping into four the development of specialist medical services, teaching and research, and some improvement in primary care, health services in the capital were under intense strain and there were growing health inequalities. Calls for greater integration of care and broader partnership approach to tackling health issues.

The Turnberg Report (Nov), *London Strategic Review – a report by an Independent Advisory Panel*, echoes several King's Fund conclusions and calls for more intermediate and other types of community care, further improvements in both primary care and mental health services and reviews of some of the planned hospital changes given that services are under great pressure; it does not establish an excess of hospital beds.

1999 NICE set up. Alan Milburn, Health Secretary (Oct). NHS Plan published. A single London directorate within Department of Health established.

Copies of the Tomlinson and Turnberg Reports may be found on Geoffrey Rivett's 'NHS History' website. Readers should click the links in his chapter 'From Districts to Trusts - London's hospitals from 1982-2012' to be taken through to the text of the original documents. See: http://www.nhshistory.net/districtstotrusts.html#The_Drivers_of_change

Part One

Martin Gorsky: Welcome, everybody, to this afternoon's witness seminar. I'm Martin Gorsky of the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine and this meeting is jointly convened by our centre and the Institute of Contemporary British History here at King's. The aim of a witness seminar is to begin creating a historical record of events in the relatively recent past. We might aim to uncover new knowledge, or gain better insight into the motives and understandings of actors in past events and it is also terribly useful to historians in shaping the sorts of questions which we can then go on to ask about those events using other sources. The original inspiration for this one came from a discussion between me and Rudolf Klein and Bob Nicholls; the one an academic policy analyst, the other an actor himself in some of these events. Bob, as some of you will know from the phone calls, has gone on to be a convenor of this session.

Our starting proposition is that this short period, 1992-97, although obviously part of a much longer continuum, is worth treating as a significant, discrete phase in the history of London's health services, of medical education, of the structure of acute care and also primary and community health services. This is what we want to try to get at today. It was bookended by these two sets of reports, by the King's Fund and by Government, and it saw a dynamic phase of policymaking, implementation and then reflection and hot debate on the fallout as the 1990s moved on. This is what we are hoping to explore in the session. Although we don't proceed with any naïve assumptions about the 'lessons' that history can give us for the future, we also had in our minds, in convening today's meeting, the thought that reflecting on this period, thinking about the facilitators and barriers to change, could certainly feed in to current discourse in a fruitful way. Finally, I want to

acknowledge that we invited Sir Bernard Tomlinson¹ and Robert Maxwell² of the King's Fund but they were unable to come, and also Sir Tim Chessels,³ who chaired the London Implementation Group (LIG) so if anyone is wondering about their absence, that is the reason.

I will now hand you to Nick Timmins, who is going to chair the session.

Nick Timmins: Great. Thank you all very much for coming. Like several of you, I have done one or two of these before and I think this is going to be rather difficult, because not only does it technically cover a five to seven-year period, but there is a lot of pre-history and post-history to all this. Furthermore, it is a landscape dotted with thousands of players, some large egos, lots of services and hospitals – community, primary, teaching, research – and what felt, even at the time, like endless reorganisations of the NHS structure to go alongside it. It could be quite difficult to



¹ Sir Bernard Tomlinson (b.1920) was appointed Consultant Neuropathologist at the General Hospital, Newcastle-upon-Tyne and Honorary Professor of Pathology at the University of Newcastle upon Tyne in 1972 (Emeritus Professor since 1985) and Chair of the Northern Regional Health Authority in 1982. In 1991 he was appointed to lead the Inquiry into London's Health Service, Medical Education and Research, which reported in 1992.

² Dr Robert Maxwell (b.1934) was Secretary and Chief Executive of the King's Fund, 1980-97.

³ Sir Arthur David (Tim) Chessels (b.1941) chaired the North East Thames Regional Health Authority, 1990-92, and was chairman, 1992-95, of the London Implementation Group, established following the Tomlinson Inquiry.

corral this and make it work. Nonetheless, as you can see from the programme, we have divided it into four sections. So we will try to do Tomlinson, the Government's response to that, then a particular strand on primary and community care and then Turnberg and what followed and some attempt to see what we might learn from this. So it is a large agenda.

We will go about this in the usual way. We will have a set of key witnesses, some responses and I hope that you will all come in at some point. When you first speak, because this is being recorded, please say who you are, where you are from and what your role is in this; if you don't I will try to make sure that you do, without being too rude. Let us start with Geoffrey who is going to give us some of the background history for ten minutes, just to get us up and running.

Geoffrey Rivett: Were I at the livery company I would occupy my ten minutes by going through 'My Lords, Ladies...' and all the other titles. Please forgive this omission. It is a great honour to be here among so many colleagues and old friends.

On 14 August 1920 the Lancet in an editorial said: 'The embarrassing position of London in matters of health administration has always been recognised by those who study local organisation and the problems of developing and, where necessary, remodelling that administration, where the health of so vast and heterogeneous a population is concerned is admittedly one of unending difficulty'. Seldom was a truer word spoken.

London's size and the number of its hospitals meant that the problems were not only bigger but of a different nature than elsewhere. The capital drew transient populations of the highest and lowest social classes, multiple medical schools, often wholly-owned subsidiaries of a voluntary hospital, were not just uncoordinated but bitter rivals, a university model of education common outside London was late in its arrival, but London was nevertheless the centre of British and Empire medicine of the royal colleges. A world city with a growing population, London suffered a decline in

its central population from around 1900, though, as a result of trains and trams, the suburbs were expanding. The populations were on the move ever outwards; the great hospitals stayed where they were, near the sources of wealth and Harley Street.



The need to refashion hospital and healthcare in the metropolis had long been known. Among the plethora of reports some stand out. In 1897 Henry Burdett, later Sir Henry, doyen of hospital administrators, had fed the Prince of Wales with the idea of a hospital fund for London, a fund which rapidly recognised poor distribution of hospitals, their inefficiency and overlapping services. Later, as the King's Fund, it pressed for the relocation of King's College Hospital to Denmark Hill and its amalgamation committee provided funds to hospitals prepared to join forces, such as the many orthopedic hospitals. The fund recognised that uniting the management of hospitals made it possible to reorganise services long before the vogue for mega-mergers we are currently experiencing. The House of Lords Select Committee in the early 1890s wished to foster

the appropriate use of charitable funds for healthcare, the Webbs had influence within the nascent Labour Party and the newly-established London County Council and 110 years ago, in 1902, the *Daily Mail* published its famous map of where hospitals were wanted and where they currently were. Competition between voluntary hospitals and those under local authority control did nothing to improve matters. Financial crises between the wars made problems more pressing, but it was the wartime emergency hospital service and Hitler, and the NHS which replaced the King's Fund and the LCC as prime movers in rationalisation that provided new opportunities.

When regions were established thought was given to the pattern most conducive to change. Two patterns vied for acceptance; central and radial. The London doughnut, with all the jam in the middle, was inevitably favoured by the London County Council and would have made central planning easier, though it could have been so powerful that the counties around London would always have played second fiddle. Bevan vetoed it; Morrison supported it as he saw it would make it easier for local authorities to take control of London medicine under a future administration. The starfish, with its radial arrangement, would unite parts of the centre with the periphery and would mirror the way patients often flowed into the centre of London. In recent years the advantages of the doughnut with NHS London have become clearer, while those of the starfish were particularly appreciated by Turnberg. Health boundaries have always influenced planning and rationalisation.

The teaching hospitals were outside the remit of the regions until 1974, but a little progress was made with the absorption of some regional board hospitals by teaching hospital boards. One south London teaching hospital was known as the greatest asset-stripper in the business. The Pickering report on specialist post-graduate hospitals looked at a specific aspect of London health care, the pros and cons of the postgraduate hospitals' clear mission and specialisation, in comparison with the increasing need for multi-disciplinary working within a larger general medical school. To the

Department of Health⁴ goes the prize for action, albeit delayed. Dame Albertine Winner, a deputy chief medical officer, chaired a joint working party between '65-72, soon followed by a joint coordinating committee of regional representatives to 'coordinate the provision of health services in Greater London with reference to the matching of medical education and service need and securing rational distribution of specialized health services.'⁵ These terms of reference could hardly be bettered, save that action rather than coordination was needed. It recognised the interplay of education and service. The London Health Planning Consortium (LHPC), in which I participated, and the universities Flowers Committee⁶ and report followed, as did the short-lived London Advisory Group.⁷ All took note of the super-specialties. The LHPC commissioned the Acheson report on primary healthcare in 1981⁸ which made it impossible for any future study to avoid the interplay between services inside and outside hospitals.

That brings us to Tomlinson and Turnberg, on which I will not comment, but the saga does not stop with them. Darzi and the recent wave of mergers are part of the same story.⁹ Darzi had its multiple working groups looking in detail at services such as those for children and the dying. Merger-mania, though it seems to some a movement born of desperation and in south London has already failed, also has an upside. Were mergers to be handled brilliantly, mega-trusts could be at least as effective as the old regional health authorities and provide a basis for academic medical science centres. However, they are essentially inward-looking and not likely to take a pan-London

⁴ The Ministry of Health was established in 1919, and in 1968 was combined with the Ministry of Social Security to become the Department of Health and Social Security.

⁵ Terms of reference: London Co-ordinating Committee, 1975.

⁶ The Working Party on Medical and Dental Resources in the University of London, chaired by Lord Flowers, Rector of Imperial College, had been established in 1979 by the Vice-Chancellor of the University of London; it reported in 1980, recommending that London's 34 medical and dental schools should be amalgamated to create six large institutions.

⁷ Geoffrey Rivett adds: London Health Planning Consortium was an officer group from the Department, regions, University of London etc.

⁸ DHSS, *Primary Health Care in London*, Report of Study Group, London: HMSO, 1981 (Acheson Report)

⁹ Lord Darzi of Denham (Ara Darzi)(b.1960) was appointed Chair of Surgery at Imperial College in 1998; in 2006 he was asked by NHS London to devise a strategy for health in London, and his report, *Healthcare for London: A Framework for Action* (2007) is remembered both for its proposals for hospital reorganisation and for polyclinics, to improve primary and community care; he joined the House of Lords in 2007, and was Parliamentary Under-Secretary (Department of Health) 2007-9, during which time he led the 'NHS Next Stage Review'.

view. Each of these initiatives built on its predecessors but achieved less than its protagonists hoped, though more than its opponents feared. These attempts, paralleled by repetitive organizations of the service, bring us to the period covered today.

What are the motives for these initiatives and reports? The first is financial stringency. Amalgamation provides stronger centralized management and the possibility of reducing services and saving money. Mega-mergers will accelerate this process and some are similar in size to the smaller of the old regional health authorities. The second is equity. The Resource Allocation Working Party¹⁰ in 1976 showed that too much in one place meant too little in another – the south compared with the north, the centre of conurbations compared with the shire counties and acute services compared with long-term conditions. The London Health Planning Consortium, in particular, saw the need to level the playing field. The third is outcomes. Centralisation leading to higher volume frequently improves the quality of service and, in the case of academic health science centres, research teaching and translational activities. The centralisation of heart attack, strokes and trauma are excellent examples of this.

What are the hazards? There is the self-interest of institutions that fight for survival, and sometimes fight dirty, in a world in which inertia often seems to win. Secondly, there is the difficulty in proving that change is in the public interest and that statistics are solid and reliable. Calculations are invariably challenged, as were those of the King's Fund Commission and, repeatedly, those of McKinsey. HL Mencken of the *Baltimore Sun* famously said that for every difficult problem there is a

¹⁰ The report of the Resource Allocation Working Party (RAWP) in 1976 initiated a new formula for allocating regional budgets within the NHS to hospitals and community services. It used the principle of 'weighted capitation', essentially a calculation of per capita need arrived at by adjusting national utilisation rates first to reflect the age and sex composition of the local population, then adjusting further by using the region's standardised mortality rate as an index of local morbidity. Its effect was to disrupt historical patterns of resource flows established in the early NHS which had tended to privilege London and the South East.

solution that is logical, simple, neat and wrong.¹¹ Forgetting the past, time after time the Department of Health established a knowledgeable team developing experience, contacts and an understanding of realpolitik, only to disperse the team after a few years thus allowing proposals to wither on the vine. Finally, there is the political dimension, when campaigns are launched that are populist and may result in the waste of public money. ‘Who will bell the cat?’ the *BMJ* asked on one occasion. We have, in the audience, one brave enough to try and whose thanks were appalling comments from a political opponent who overturned a decision, imposing costs and creating problems that are still with us.

The period we are considering today is neither the first nor the last epoch in which analysis and change are undertaken. The NHS presents us with wicked problems. These are difficult or impossible to solve because of incomplete, contradictory and changing requirements, and the problems are often hard to define. Sometimes those seeking to solve the problems are also causing them. Often, a wicked problem is merely a symptom of another problem. Solutions to wicked problems are better or worse, not right or wrong. London healthcare is a wicked problem of premier league. We are lucky today to have many amongst us who have experienced and, indeed, have been blooded by London. What have they learned, what are their lessons for the future? What was the immediate context of Tomlinson? Why then? What was the rationale for the Government’s response and for the reaction of the interest groups? What were the achievements and the challenges in developing primary and community care initiatives? What worked, what didn’t and what policy lessons might be drawn? Thank you.

¹¹ Henry L. Mencken (1880-1956) wrote in ‘The Divine Afflatus’, *New York Evening Mail*, 16 November 1917: ‘Explanations exist; they have existed for all times, for there is always an easy solution to every human problem - neat, plausible and wrong.’ See also H.L. Mencken, *Prejudices: Second Series*, Alfred A. Knopf, 1920, 158.

Nick Timmins: Geoffrey, thank you very much indeed. Let's start by asking what led to two reports six months apart, one from the King's Fund Commission, with Virginia Beardshaw the Secretary of it, and then the Tomlinson inquiry, how the two interacted and what triggered them? Virginia, would you like to start, given that yours was published first? When did it begin? Was it before or after Waldegrave announced the Tomlinson inquiry and what triggered it?



Virginia Beardshaw: Okay. The King's Fund Commission set off about a year before William Waldegrave made his announcement about Tomlinson.¹² There were four elements that contributed to our being established. One, as Geoffrey mentioned, was that the Resource Allocation Working Party had been grinding away, moving resources from the south-east to the north and this was biting on London which has always had a more expensive pattern of healthcare than anywhere else in the country. The second and more immediate cause was the birth of the internal market. There were widespread fears in London that the very much more expensive pattern of care in London would be

¹² Baron Waldegrave of North Hill (William Waldegrave) (b.1946) was Member of Parliament for Bristol West, 1979-1997, and served as Secretary of State for Health, 1990-92.

undermined as resource flows changed in the light of the market. Actually, that turned out to be a wrong assumption, which is quite interesting – we might come on to that later.

Nick Timmins: The assumption was that patients would stay in outer London and not come into inner London?

Virginia Beardshaw: Yes; that there would be strong financial incentives for not sending patients in. Actually, I do hope we get on to that because, as ever, the London hospitals proved themselves to be magnificently entrepreneurial, (SHE LAUGHS) which is a story in itself. The third reason was that the King's Fund's mission, which Geoffrey has again touched on, it was originally the King Edward VII Hospital Fund for London and had a remit to look London-wide, and nobody else did in those days. The GLC had been abolished in 1985 or 1986 – mid '80s in any case – the regions went out to Bedfordshire, furthest Sussex.¹³ And although I think that people involved in the regions would be annoyed to be reminded of this, the Fund had already produced a very controversial report about three years before us called *Back to back planning*, which made the point that, actually, the Thames regions didn't plan for the capital as a whole. Those are the reasons we got going a year before William Waldegrave set up Tomlinson.

Nick Timmins: Right. Jonathan Stopes-Roe, who was the civil servant at the head of the Tomlinson inquiry, and Sir Michael Bond, who was on it, can you do the origins of the Tomlinson inquiry? Was the fact that the King's Fund was doing this part of the trigger?

¹³ The Greater London Council (GLC) was established in 1965 when it replaced the London County Council, taking in both inner and outer London boroughs. It was abolished in 1985, while under Labour control, by Margaret Thatcher's government, which argued that its powers could be devolved to the boroughs.



Jonathan Stopes-Roe: I should start by saying that there are others far better qualified to report on discussions that may have taken place on the fourth floor of Richmond House. Virginia Bottomley is here; she may have better insights into her predecessor's thinking than I do. But as Virginia Beardshaw has just said, the NHS reforms, which, incidentally, I'd also been a part of, writing *Working For Patients*, were in place and there was naturally anxiety about radical effects, especially in London. I don't think that there was any dispute, any doubt, that the factors Virginia has mentioned – the effect of the internal market and

weighted capitation - were likely to mean, over a period of five or ten years, less use of inner London hospitals and the necessity of developing primary and community services to enable the acute sector to change in the way it should. And of course what all that might mean for medical education and research, which was, in itself, pretty poorly organized, built around the historic teaching hospitals and some pretty scattered single specialty hospitals. All of this should have come as no surprise to anyone, it seems to me, and so the King's Fund started on that work. I guess that the simple explanation was that ministers were concerned at how these things might pan out and wanted a safe pair of hands to ensure that the King's Fund didn't run away with the ball. That is one way of putting it. Certainly I should defer to the actual members of the team, Professor Michael Bond and Pearl Brown – apologies, we couldn't find Mollie McBride.¹⁴ Really, I shouldn't be usurping them. In fact, I should have declined your invitation to speak first; it is out of order of me.

¹⁴ Dr Mollie McBride was the fourth member, with Pearl Brown, Michael Bond and Bernard Tomlinson, of the Inquiry team.

I shall shut up in just a moment, but I will say that there was not really any doubt that there were the issues that we've all identified and Ministers would inevitably want advice on what was coming out when the King's Fund eventually produced their report. Bernard Tomlinson and his three colleagues were eminently well qualified – eight 'safe' hands, really – to take forward a parallel, and it was parallel, one might almost say convergent review. There was quite a lot of traffic between us and between our teams of analysts, wasn't there, Virginia?

Virginia Beardshaw: There was.

Nick Timmins: There was a lot of data exchanged?

Jonathan Stopes-Roe: A fair amount, yes. I hesitate to quantify it in megabytes after 20 years.

Virginia Beardshaw: We had had a year's start. We had some kind of a lunch, or something, when you got going, and we said that we'd share anything you wanted. The King's Fund London Initiative, which I ran as well, for my sins, that had various reports and as soon as one was completed, we sent it over to Jonathan.

Jonathan Stopes-Roe: And I'd plagiarise it!

Virginia Beardshaw: Well, no: they were then published; there was no reason why you shouldn't have had them instantly. It was all above board, but it brings me to a really important point, which is how little data there was. If you compare that era, which is only 20 years ago, to now, there was no

data on health services in London. Loads of it had to be constructed for the King's Fund commission.

Jonathan Stopes-Roe: To reverse engineer the concept of inner London, which wasn't so easy.

Michael Bond: To add one point to what Jonathan said, you might say, why did Bernard Tomlinson get this job?

Nick Timmins: I was about to ask you that question.

Michael Bond: I think that is important. There is the question of why it should have been done anyway. We have heard why it was wanted. I think the answer is that Bernard, who had been chairman of the North East Health Authority, had gone through a similar exercise in Newcastle, where conditions were very similar to London, but on a much smaller scale, and he had dealt with that very efficiently.

Nick Timmins: This is the Freeman and the RVI?¹⁵

Michael Bond: Exactly. He had gained a reputation of being able to cope with the sort of difficulties that could be envisaged in London, and did, indeed, occur when he got going. I think that that is why he came into this and was chosen for the job.



¹⁵ The Freeman and the Royal Victoria Infirmary (RVI) are major hospitals in Newcastle-upon-Tyne.

Nick Timmins: Right. He was not entirely dispassionate, because I think he trained at UCH, didn't he?

Virginia Beardshaw: Yes. Everybody found that out in about a nanosecond. It was really typical!

Jonathan Stopes-Roe: I must say there were quite a few vitriolic attacks which still smart.

Michael Bond: I can honestly say I never detected any partisan behaviour on his part as far as UCH was concerned.

Bob Nicholls: No-one has mentioned that there was an election coming up. I always think that politics plays a part and a good civil servant wouldn't dare mention it, but I wasn't a civil servant, so I can. Just at this time the market had just started – interesting that Virginia didn't feel that was a bigger threat than has been made out. There were two big building schemes, St Mary's and somewhere else, and if I'm a politician facing the fact that Maggie had gone and Major wasn't going to win, what do you do?¹⁶ You have a commission.

¹⁶ Baroness Thatcher (Margaret 'Maggie' Thatcher) (1925-2013), Conservative Member of Parliament for Finchley (1959-92), had resigned as Prime Minister in November 1990. She was succeeded by Sir John Major (b.1943), Conservative Member of Parliament for Huntingdon (1979-2001), who called an election for 9 April 1992; the polls predicted a tight result or Labour victory in the 'soapbox election' (so-called due to Major's campaigning style) though in the event the Conservatives won with a small majority.



Virginia Beardshaw: I was going to bring that up. The strong view that we got from the Department, who, of course, we were talking to all the time as well, was that William Waldegrave had been presented with a big building scheme at St Mary's and a big one at UCH – Cyril is nodding, so this is doubtless true—and he just said, which I can well imagine William Waldegrave saying, 'I have no rational basis for making this choice'.¹⁷ And, of course, that then led to Tomlinson; that was the story at the time. I was looking hard at Virginia Bottomley to see whether she was going to give anything away. Is that right?

Virginia Bottomley: There was a bit of, 'there's an election coming up'. It wasn't the time to make those decisions.

Nick Timmins: Yes, the timing was good. Cyril Chantler.

Cyril Chantler: Yes, I have that recollection. There were two things. One was the notion that it would cost £300 million, I think it was, to rebuild UCLH. It is important that UCLH is recognised

¹⁷ UCH: University College Hospital.

as a very important hospital. I don't just say that because I'm now working in conjunction with UCLH, but it is, when you think about it, going back to Haldane and Flexner, really the only hospital in London that actually had a university connected to it. King's had had and then they'd moved away from that. UCL and UCLH were very closely combined. The rationale to some of the later changes was to create a science base for medical education in London at last, after nearly 100 years. UCLH had it, so to contemplate the closure of UCLH was not something that could be done lightly. So the notion of how you spend £300 million on a hospital that you're not sure anybody wants in that part of London was a problem. The other was, and it was connected, that the market had just begun to operate and contracts were talked of moving from UCLH to the Royal Free. Of course, that would have led to the decline of UCLH and, for the reasons I have just mentioned, that wasn't a good idea either. So I think the report and the coming general election was designed to look in detail at that.

Nick Timmins: Virginia, is there anything else you'd like to say about the origins of it that we haven't touched on? Pearl, can I ask the same question of you?

Virginia Bottomley: No, I'll wind it all up.

Pearl Brown: I just have one comment. Sorry to point it to out, but there were three doctors on this committee— it was led by a doctor and there were two other doctor members of the team. The story I heard at the time was that Ann Poole¹⁸ who was the Chief Nurse at the Department of Health was rather irked by this; not because there were three doctors, which was fair enough, they were looking at healthcare across London, but that there was no nursing representative. I happened

¹⁸ Dame Anne Poole (b.1934) was Chief Nursing Officer, Department of Health, 1982-92.

to be a nurse in London with a community health service background. I have a very clear memory of going to my boss at the time, who shall be nameless, and I had to tell him I'd been invited to do this and I'd accepted and he said, why you? (LAUGHTER) I trundled this story out – well, I happen to be a nurse and I believe the chief nurse at the Department of Health would like a nurse. So I think that was my way in.

Nick Timmins: Moving on, you made the point, Virginia, about the lack of data. The two reports came up with very similar analyses, partly because of what has just been explained. Was any thought given to a completely different way of looking at it? We will come back to the overbedding argument, there was the cost argument. I remember trying to write a piece at the time asking, how is this going to be analysed? Why not just look at the fabric, look at the state of the hospital buildings? On that basis, you would shut UCH. It was totally unsuitable for modern medicine and there was this big building project happening. It is clear that UCH survived because of the quality of the science base, but you could have moved that to Barts, for example, and not had a hospital smack in the middle of London. We had by that stage reached the point where paramedics could keep you alive to get you to an A&E, so there was a different solution from the one that came up – was that sort of thing ever looked at, or did the available data drive the analysis to what was an inevitable conclusion? Michael Bond?

Michael Bond: No other possible model was ever discussed that I heard. It was all set in motion, when I joined the team. It had gone beyond the point of there being an alternative model when I joined. Jonathan may have other memories.

Jonathan Stopes-Roe: Speaking as a good civil servant – which, incidentally, I am not any longer; I retired from the Department of Health 13 months ago and never looked back – but imagining there were a good civil servant here, he or she might turn to the actual terms of reference given to Tomlinson. Those were couched very much in terms of working within the framework of the reformed NHS: radical new options were not uppermost in Tomlinson’s mind, given those terms of reference.

Nick Timmins: Right. Geoffrey.

Geoffrey Rivett: Two little points. Okay, the data may have been less than perfect, but London Health Planning Consortium did spend a very large amount of time looking at data. We had economists. I am surprised that the data was as bad as all that, because these exercises had been data-driven in the past. Secondly, at the time of the LHPC we had already had the ‘Todd pairs’ and the advantages of merger were well known. Potentially there was Unisex (University College Hospital and the Middlesex), and the ‘sides’ – Canal-side, Riverside, Thames-side. We saw the need for international-class organizations – and put the Middlesex and UCH together with UCL. We saw the potential of two hospitals, both with an academic tradition, coming together to be in the international league. That was very much on Patrick Jenkin’s¹⁹ mind way before Tomlinson.

Virginia Beardshaw: On the question of the estate, we had reports, or a report, as part of the London Initiative. I haven’t read it for 25 years, but it basically said the whole estate was rotten to the core, which it was. Every single setting was substandard in some way or other, and that is certainly my recollection of the estate at the time, but I think the terms of reference of these

¹⁹ Baron Jenkin of Roding (Patrick Jenkin) (b.1926) was Member of Parliament for Wanstead and Woodford, 1964-87, and served as Secretary of State for Social Services, 1979-81.

inquiries is important in terms of whether they came up with other solutions. We, Robert Maxwell and I, spent a long time on the terms of reference, which were to look at acute services in the context of health, social care and general practice with an eye to medical education and scientific and technical trends. I think we were the first to really say out loud and in public that medicine and healthcare is changing very radically and therefore the base, coming back to your estate point, needed to change.

Nick Timmins: Brian Jarman.

Brian Jarman: My name is Brian Jarman, I was a GP in London. I want to say something in relation to the estate. The estate in primary care was possibly even worse. I started in practice in Lisson Grove in 1971. I'd actually just come from being resident in medicine in one of the Harvard hospitals in Boston that was 'super medicine', I went to this practice of Harry Levitt which was a shop-front surgery for three doctors with no lavatory and two rooms. One room acted as the reception, the notes, et cetera, and the other was the consulting room. During the middle of one of my consultations my senior partner, Harry Levitt,²⁰ entered, got into an argument with my patient and struck him off the list during my consultation. One of the difficulties, it had been in larger premises before that, but it was bombed during the war; Harry Levitt was there. Our practice actually went back to the 19th century and Harry Levitt had been planning to get into a health centre from 1951. I joined on the basis that we were about to go into this wonderful health centre which actually never happened. That was where I actually first got into medical politics. I had a job at St

²⁰ Dr Harry Levitt qualified in medicine LMSSA Lond in 1935 and obtained a Diploma in Public Health 1963; he became a fellow of the Royal College of General Practitioners in 1967.

Mary's on the medical unit with Stan Peart.²¹ There were a large number of doctors who were over 75, even over 85, one used to go at over 90, with his chauffeur, actually, to visit patients. Later I got into this inner London multifund and these doctors that I had been writing this report when I was on the Acheson committee in '81 and we developed this deprivation score from that and the doctors that were doing all this, what I thought was terrible practice I then met in this planning group with the multifund and I suddenly realised why they were doing what they were doing, and the type of practice that had developed in London. I might say that our LMC, the medical committee was the one where AJ Cronin²² ... the father of the chairman of our LMC was in practice with AJ Cronin in Westbourne Grove and there is still the voice tube from the road to the top, which we tried to get a blue plaque for, the other day with Brian Hurwitz.²³ So I think it wasn't only the hospitals, because Cronin really spelled out very clearly the contrast between a general practitioner in London and a hospital doctor at the time.



²¹ Professor Sir William Stanley (Stan) Peart (b.1922) was Professor of Medicine at St Mary's Hospital Medical School, 1956-87.

²² Archibald (A.J.) Cronin (1896-1981) was a Scottish doctor and novelist, best remembered today for creating the character Dr Finlay, who featured in long-running BBC television and radio drama series. His 1937 novel, *The Citadel*, which was partly set in a West London private medical practice, provided a broad-ranging critique of the pre-NHS health system, and is sometimes credited with preparing public opinion for the reform.

²³ Brian Hurwitz is a medical practitioner and D'Oyly Carte Professor of Medicine and the Arts in the Department of English at King's College London, where he directs the Centre for the Humanities and Health.

Nick Timmins: Indeed, and we will get more into primary care in the third session. But one of the big things in both reports was that it was a decade on from the Acheson report by this stage but there had not been that much improvement.

Brian Jarman: None.

Nick Timmins: The underlying assumption behind both reports is that none of this will work without a big improvement in primary care, which almost felt like a cracked record playing round again a decade after Acheson. Leslie Turnberg.

Leslie Turnberg: Leslie Turnberg. If we're in reminiscing mode, I spent most of my working life in Manchester but did a registrar job at UCH in 1961-63. I used to park my little car on the Odeon site,



which was a bomb site on the corner of Tottenham Court Road and I was told, you won't be able to park here for very much longer, we're going to build a new hospital. (LAUGHTER) This was 1963, so it was on the agenda then. Of course, they did close the Middlesex hospital, the Elizabeth Garrett Anderson and the maternity hospital – they all came to UCH in the end.

Nick Timmins: Indeed. Can I ask a question about the process of this? The King's Fund Commission cheerfully said we need to close about 15 hospitals, I seem to remember, without naming them.

Virginia Beardshaw: Yes.

Nick Timmins: Tomlinson got into the business of naming them.

Michael Bond: We did.

Nick Timmins: In the course of the inquiry, what was the lobbying like?

Jonathan Stopes-Roe: Fierce, some of it.

Michael Bond: Downright insulting.

Nick Timmins: Expand on that.

Michael Bond: Sorry. Feelings were running high – at one particular hospital, very high.

Nick Timmins: What particular hospital?

Michael Bond: Actually, there is a bit of history, because in 1982 I became a member of the UGC²⁴ medical committee and Colin Dollery was the chairman.²⁵ Many people here remember Colin because he had ferocious rows. There was a proposal at that time that Barts medical school should be closed down and Barts took out an injunction, which was successful. So I think that when we came along and made proposals relating to Barts and the London they were already very sensitised to anybody wishing to attack their status and that led to some really awesome... discussions, put it that way.

Jonathan Stopes-Roe: Table banging: 'We'll see you in court – we saw off the last lot'.

Nick Timmins: This was during the inquiry?



Jonathan Stopes-Roe: Yes. We went round, Bernard and the team went round.

²⁴ The University Grants Committee (UGC) was a governmental advisory committee responsible for the distribution of grants to British Universities. It was dissolved in 1989.

²⁵ Professor Sir Colin Dollery (b.1931) is a clinical pharmacologist whose academic career was spent principally at the Royal Postgraduate Medical School, Hammersmith Hospital, where he served as Dean, 1991-96.

Michael Bond: But there were other situations that certainly weren't like that. Discussions we had with the Royal Free and UCH weren't like that at all; they were very positive indeed.

Virginia Beardshaw: When we started from the Fund – I was thinking back about it and, Bob, you were agreeing with me – there was a kind of insularity, an inability to look anywhere but internally and an institutional focus that I really think you wouldn't have today. I went round and everybody without exception said there were too many hospitals in London and the one next door should shut. That's what it was like.

Geoffrey Rivett: This was nothing new.

Virginia Beardshaw: No!

Geoffrey Rivett: 20 years previously, with the LHPC, there were the same vehement reactions. I remember being taken to pieces by the house governor at the Westminster who said, 'the Westminster is Parliament's hospital, it will never be shut.' I was on a rescue mission, I was trying to put three small postgraduate hospitals into Westminster and turn it into a post-graduate centre; they said, in effect, 'Go away, little boy, we don't need you'.

Nick Timmins: Part of this problem, of course, was the mistakes that were made in the 1960s when, to put it crudely, Charing Cross should have been moved to Reading and George's should have moved to Southampton. All we did was move them out into the periphery of London, so in a sense we were paying the price for a bunch of earlier mistakes that landed everybody in this position in the first place.

Geoffrey Rivett: University of London was responsible for the problem of Charing Cross and the Royal Free through not wanting them to go too far from the centre of the university. Tooting was not a bad place for St George's – it did need a hospital.

Virginia Beardshaw: The real drivers though, and various people have touched on this, were the medical schools. They could see, and the University of London could see what was coming down the pipe in terms of globalisation and the need for international excellence. At the time I thought they were moving like the proverbial snail, but actually it was the proverbial tortoise: I wouldn't say they got there entirely in the end, but that process, which was kicked off by Flowers in 1981²⁶, was the really powerful one, I believe; it was the real change maker.

Nick Timmins: Right. We will finish this section shortly and we may come back to some of the criticism of the analysis in the next bit. But when you were doing this was anybody arguing or trying to make the case that London wasn't massively over-bedded or that that might not have been the right conclusion?

Virginia Beardshaw: Well, Brian was.

Michael Bond: Brian wrote a paper.

Brian Jarman: I wrote a paper in the *BMJ* saying that London was relatively underbedded.²⁷

²⁶ The Flowers Working Party published its report on 26 February 1980.

²⁷ Brian Jarman, 'Is London overbedded?', *BMJ*, 306, 1993, 979-82.

Nick Timmins: I know, but the paper came out afterwards. Were you arguing it in the course of the inquiry?

Brian Jarman: My original feeling that something was wrong was that I couldn't get patients admitted and increasingly over the preceding few years I had had to use EBS²⁸, and so I recommended to Tomlinson right at the earliest that they should get EBS data. And in the report, at paragraph 80, it says 'We are pleased to see there's been a big reduction in EBS usage', but it looked at the very last 18 months, where there was a 2% reduction, rather than the preceding six years, where there had been a near 300% increase. I felt that was a little misleading.

Nick Timmins: Right. There are two hands at the back. Three.

Peter Simpson: We're talking of hospitals as though they had one point of view. I can remember at St Thomas's in the 1960s that there was definitely a group of the consultant staff that wanted to move to Guildford and they and their colleagues were regularly in discussion about it, their feeling being that you just didn't have the footfall of patients and Waterloo station just didn't make up for it.



²⁸ Brian Jarman adds: among other things the Emergency Bed Service distributed patients around London when a local hospital was full.

Howard Baderman: Howard Baderman, I was the CMO's²⁹ adviser for A&E, which turned out to be fairly crucial to these discussions and sat on Norman Browse's³⁰ implementation group a little bit further down the line. There are two things, perhaps, to say at this stage. I remember quite tetchy battles amongst the consultant body in UCH because two or three very far-sighted people, including Professor Prankerd,³¹ who was the dean, who both Leslie Turnberg and I worked for as registrars at the time, persuaded, with great difficulty, UCH to reapply for inclusion under the umbrella of UCL



because he foresaw anchoring UCH to a multi-faculty university of scientific excellence was likely to be key to the survival of UCH. There were a lot of consultants at UCH who said, we don't want any linkage with UCL lawyers or the departments of French and Arabic studies and so on. He and one or two other people won the day. I can't remember, nor could I find the paperwork, where that decision was actually taken, but I was present as a newly appointed consultant at the consultants' committee when

the decision was taken. It needed an Act of Parliament to reintegrate UCH with UCL. We knew that various other teaching hospitals had pooh-poohed any such move.

²⁹ The Chief Medical Officer (CMO) in this period was Sir Kenneth Calman (b.1941) who held the post from 1991 to 1997.

³⁰ Professor Sir Norman Browse (b.1931) appointed Professor of Vascular Surgery at St Thomas's Hospital in 1972, then Head of Department in 1982; President of the Royal College of Surgeons of England 1992-5. Chaired A&E Reference Group established by LIG in Oct 1993 to advise on changes in the pattern of services in London; to facilitate agreement between interested parties on future configurations; and to explore and advise on the longer-term development of A&E services in the capital.

³¹ Professor T.A.J. Prankerd, (b.1924) was professor of Clinical Haematology, 1965-79, and Dean, 1972-77, at University College Hospital Medical School

The second thing, on a completely different tack, and we may be coming to this a bit later on, from my involvement in the process, albeit under the umbrella of reorganising A&E services in London, although that had massive implications for the hospitals to which they were attached, we were anxious about the lack of hard data upon which to base or confirm any recommendations that we made. There was data about how many attendances there were in the capital's A&E departments and where those patients might go if hospital A were to go, or hospital B and so on. There were tables of how many beds there were. There was no data, and maybe we didn't see its significance or have the tools to find it, about quality of outcomes, which, after all, is key to what we were all about. Would it improve the quality of services if you moved department A to hospital B or you closed department C and so on? As a very lame attempt to rectify this myself, I trudged on foot, around all the London teaching hospitals, and counted the number of bus stops within 200 yards, the number of underground stations and the lines they dealt with to try to get a handle on access. For instance, access to Guy's A&E department was very difficult, particularly if it needed to be expanded if St Thomas's closed. Access to the Royal Free was not bad, but a bit out on a limb if you increased the catchment area, as it were. I remember spending an interesting afternoon with the people at King's Cross saying, if they build the Eurostar or the high-speed link to come into Kings Cross and St Pancras, what will that do to the number of people trooping around? They might not live there – they didn't live there, because our catchment population was very small at UCH – but would that increase the need for hospital services, and so on. So it was all pretty naïve stuff. In particular, I still feel the lack of understanding about what the clinical outcomes are likely to be following major relocations and closures.

Nick Timmins: I am sure we will come back to the impact of geography and transport – that is a live issue even today.

Howard Baderman: I have also got a very vituperative letter which I won't read out unless you ask me to, from the chairman of a regional health authority to somebody at the Department of Health saying, 'Inertia is terrible and if you don't pick up a bit the credibility of the Department of Health will be severely impugned' and so on. It finishes with a last small paragraph which I would like to read – it's only three lines. 'We have seen how aberrant information introduced by..' Professor So-and-so '...with regard to site appraisals has caused chaos. May I request some positive direction from 'on high' which does not leave all decisions to the whim of the congenitally expansionist tendencies of clinicians.' (LAUGHTER) A sample of the sorts of things I am sure you've received, and maybe worse.

Nick Timmins: Some of it worse?

Michael Bond: It was not couched in quite those terms. I wouldn't say so.

Nick Timmins: At this point we need to move on to the next bit, so could I move the panel round one? Could we have Virginia Bottomley, Malcolm Green, Cyril Chantler and Bob Nicholls up here? Pearl, I didn't come back to you.

Pearl Brown: I want to make one point on the estate business, something that irked particularly Sir Bernard, which Jonathan and Michael will remember, is the role of the charitable funds in the London hospitals. It is all very well to merge institutions, but we are talking about the estate. I remember a couple of examples. The Hammersmith had just put up a brand new research building for around £40 million; Tommy's had just put up new theatres – did they need them – for around £20 million. I remember Sir Bernard getting particularly exercised about this, asking what could he



do about the way charitable funds were used to increase the estate of buildings that we'd otherwise want to rationalize. It particularly affected the Hammersmith – there was a lot of discussion about whether that site should remain where it was.

Obviously the Hammersmith itself

would remain, but they'd just put up a £40 million new block there on the site and although it was peripheral to the main building, it was distorting what you might want to do politically or rationally to merge estates and organizations.

Part Two

Nick Timmins: Great. So, next stage. Virginia, you've got a brand-new job then someone delivers this time bomb in your lap. What happened?

Virginia Bottomley: I was there. I'll try to encapsulate my thinking about all this. First of all, was there a problem? There was a problem. In London there were 45 hospitals with around 250 beds; the primary and community mental health system was lousy and actually, for all the talk, our research and medical education reputation in London was falling. There was a problem; I couldn't wish that problem away. Did I have a personal perspective? I did have a personal perspective. I come from a medical mafia; my great-uncle was senior physician at Guys; my father had been involved at St Thomas's as had my daughter; my cousin was at the Royal Free; another at the



Charing Cross; my grandfather trained at Barts; one of our neighbours worked at the London. Furthermore there was no hospital with which I was not connected, but I had a lot of close friends, including Malcolm Green, to whom I could not pretend this was not a serious issue. Thirdly, I knew from my own experience when our children were young, when we lived in Stockwell. If they were ill we took them straight to the A&E at St Thomas's. Everything Brian says, I knew. We would scarcely dream of going to a GP; the GP had no lavatory. Signs on the door said 'go to the hospital'. From all the years I worked in Bethnal Green for Frank Field, for the CPAG³², and then in Brixton and Peckham, chairing a juvenile court: I knew the GPs who keenly prescribed valium. They were overwhelmed and overworked, couldn't cope, with lousy premises. Some were making a killing: they gave some people a pill or a referral, it was brilliant, you got them out of your surgery. The joy to me of both fundholding and the GP contract is that they incentivised laggards to immunise, to cancer screen, to do all the things they should have done. So it was dreadful and I couldn't pretend other. And then, having had my inner-London experiences, I became the MP for Surrey, near Guildford. Peter was in Greenwich.³³ We could see what was happening. Why should my constituents come to London? I could not persuade myself that this was an issue that could be washed away. Rather like dismissing climate change: 'it doesn't really exist'. (LAUGHTER)

³² Frank Field (b.1942) has been Labour Member of Parliament for Birkenhead since 1979; the Child Poverty Action Group (CPAG) is a charity which campaigns to end poverty among children and young people in the UK; it was founded following a meeting March 1965, and Frank Field was its Director from 1969 to 1979.

³³ Sir Peter Bottomley (b.1944) was elected Conservative Member of Parliament for Woolwich West (later Eltham) from 1975 to 1997, then Worthing West from 1997; the Bottomleys married in 1967.

Politics next. Well, it was hopeless, wasn't it? Tories like institutions; many don't know much about the health service. This was the Andrew Lansley³⁴ situation; there is a tremendous gap. If you are in the Department you become completely obsessed, transfixed, you talk a different language, you are from another planet, you don't need to go to the House of Commons – it seems the most appalling waste of time, with a lot of windbags. The politics is hopeless. And then, for a Tory to say they are going to shut Barts – how terrible is that?

(LAUGHTER) And I don't think I'm very good at politics; I'm good at being principled, brave, steadfast and courageous, (LAUGHTER)



but politics, humouring people, is not my strong card. So, next, let's go to the principles. Well, my principles. I'm a horribly stoical person. I had all these great-uncles who died in the first war, we were taught that when the whistle blows you get out of the trench and you walk towards the guns. That is what I was brought up to do, to get out of the trench and walk towards the guns. I had been chairman of the juvenile court in Lambeth at 32: one of the worst things one can ever do is to tell a parent of an 18-month-old child that the child is going into care, that they are to lose their child. So

³⁴ Andrew Lansley (b.1956) has been Conservative Member of Parliament for South Cambridgeshire since 1997 and Secretary for State for Health, 2004-10; he was the architect of the Health and Social Care Act, 2012, which received criticism during its passage from outside and within the Conservative Party.

I am wired to be stoical. Seeing Graham Hart there, I was thinking about Cyril Clothier³⁵ the other day; I insisted that he should hold a private inquiry, not a public inquiry into the Beverley Allitt³⁶ situation, because more people would tell the truth in private. I didn't mind about the fact that the public said a public inquiry is what they wanted; I knew that would just become a show trial and no-one would tell the truth. I recognize stoicism is unfashionable in a politician. I had told John Major, I knew the report was coming up. I said I will do the heavy lifting, the dirty stuff and then I can move off before the election. Perhaps not many people have my masochistic personality. 'No-one gets a salary and a round of applause' was my principle, therefore, since I was getting a salary, I believed I had to do the difficult things. My first Secretary of State Nicholas Ridley³⁷ used to say, 'As Secretary of State you do the difficult stuff and you let the junior Ministers do the easy stuff'.

Then there were the crucial moments, I think with Christopher Bland.³⁸ We had two memorable meetings, one when Colin Dollery came in to bully me – I think with Christopher. And then another meeting, the Barts situation was revving up: Admiral Sir William Staveley³⁹ and General Sir Derek Boorman⁴⁰ came into my office and said, 'Now, Secretary of State, if you stand in the way of this we will both resign'. Cowardly in the line of fire? Not me! But the point about this was that the decisions were ever going to be 9-1, 8-2 or 7-3. There were options, any number of options, but

³⁵ Sir Cecil Clothier QC (1919-2010) became a judge in 1965 and held the post of first Parliamentary and Health Service Ombudsman, 1979-84; he subsequently was chair of the Police Complaints Authority, 1985-89.

³⁶ Beverley Allitt was a pediatric nurse suffering from Munchausen's syndrome by proxy who received 13 life sentences in 1991 after killing four children and attacking others while working at Grantham and Kesteven Hospital, Lincolnshire; Sir Cecil Clothier chaired the inquiry into her crime, C.Clothier *The Allitt Inquiry. Independent Inquiry Relating to Deaths and Injuries on the Children's Ward at Grantham and Kesteven General Hospital during the period February to April 1991*, London: HMSO, 1994.

³⁷ Baron Ridley of Liddesdale (Nicholas Ridley) (1929-1993) was Conservative Member of Parliament for Cirencester and Tewkesbury 1959-1992; he held various Cabinet posts, and was Secretary of State for the Environment, 1986-1989, when Virginia Bottomley served as Parliamentary Under-Secretary.

³⁸ Sir Christopher Bland (b.1938) became chairman of London Weekend Television in 1984, and chaired the BBC's Board of Governors, 1996-2001; he was chair of the Hammersmith and Queen Charlotte's Hospitals NHS special health authority, 1982-1994.

³⁹ Admiral Sir William Staveley (1928-1997) was First Sea Lord 1985-9, and in retirement became Chairman of the Royal London Hospital and Associated Community Services NHS Trust 1991-2, Chairman of the North East Thames Regional Health Authority (RHA) 1993-4, and North Thames RHA 1994-6.

⁴⁰ Lieutenant-General Sir Derek Boorman (b.1930) commanded the 51st Brigade in Hong Kong; after retiring from the army he was Chairman of the Royal Hospitals Trust, 1992-1998.

it was beyond options, we had to move to action. Many hospitals were seeking to protect their interests by building themselves into a long-term survival. It was getting worse. I was convinced about the arguments for critical mass and community services. The way I finally convinced somebody who really didn't get it was to say: 'Look, Tesco has moved to have superstores and Tesco Express; that is the way it has gone'. It is the same with health services – we have large institutions requiring critical mass for costly equipment, doctors on duty overnight, different teams of professionals, and we have small local, improved facilities. But Tesco plans everything ahead and so between announcing it and delivering is around three months. In the public sector, the minute anything is announced the whistle blows for campaigning, marching, protesting and lawyers. I feel proud I never had a judicial review against me. I was determined that it should be done properly and fairly on the basis of the evidence. We held specialty reviews and research reviews, but at the end of it all, decisions had to be made.

Why was I so stoical? Partly because, up and down the country, everybody else was making these decisions. It was not only Newcastle; it was Manchester, it was Birmingham, it was everywhere. If the Secretary of State chickened out and ducked it would be obvious to everybody that I had set a lousy example. Another dilemma is what Andrew Lansley has recently faced. Chris Patten⁴¹ used to say, 'resources go where there's most noise'. There's belief in the health service that the more noise you make, the more likely you are to get money. I remember being beaten up by Dr Sandy Macara⁴² on the radio one day – by the loveable John Humphrys⁴³, probably – when we came out afterwards he said, 'Well, I hope that was helpful with the Treasury, Virginia.' It is almost a point

⁴¹ Lord Patten of Barnes (Chris Patten) (b.1944) was Conservative Member of Parliament for Bath, 1979-92; he held several Cabinet posts and subsequently became Governor of Hong Kong (1992-97) and, since 2011, Chair of the BBC Trust.

⁴² Sir Alexander (Sandy) Macara (1932-2012) was a doctor who pursued an academic career in public health at the LSHTM and Bristol University; he was chairman of the council of the British Medical Association, 1993-1998.

⁴³ John Humphrys (b.1943) is a broadcaster, author and journalist, best known as presenter of BBC TV's *Nine O'Clock News* (1981-87) and, since 1987, BBC Radio's *Today* programme.

of principle that you need to fight. There is nothing the newspapers like more than a ‘Save our Hospital’ story: you could scarcely sell a newspaper if you didn’t have a ‘Save our Hospital’ story.

Lastly, I will say a word about people. The people were very important. I was determined that I was going to keep the clinicians involved, so we had all sorts of meetings; I insisted that the Chief Medical Officer, whom I much admired, Sir Ken Calman, and our director of research, Sir Michael Peckham⁴⁴, should be in the room. The easiest thing in the world would have been for them subsequently to say to their colleagues in any of the hospitals, ‘It wasn’t really me’, or ‘I wasn’t at the meeting – it was Duncan Nichol’⁴⁵ – they could have blamed the Chief Executive, or anybody else. Everybody’s fingerprints had to be on the decisions. There were many people whom I completely trusted and respected. The person we haven’t mentioned, Julia (now Baroness) Cumberlege, had been on the King’s Fund report.⁴⁶ She was the junior Minister I asked to have with me. That was a very strong bridge. This was a real issue we had to address. Cyril was a sort of godfather of the whole matter: always involved. (LAUGHTER) Bob, Tim, Malcolm – there were so many people who knew we had to do this together. It was never going to be easy. Do you know, Brian, every time I read your figures I thought, tell me he’s right, I’ll talk to one of our civil servants, make sure he’s right, tell me I don’t have to do this. No politician wants to make these decisions, you do it because you know that the greater good of research, medical education, community services and the acute service are going to benefit from it. One of the best people was Ron Oxburgh⁴⁷ at Imperial. When politicians leave the job, you move on, but each time anything changed, Ron Oxburgh used to ring up from Imperial and say, because you made that decision we are able to do this, that or the other. I

⁴⁴ Professor Sir Michael Peckham (b.1935) was professor at the Institute of Cancer Research, 1974-86, and its dean, 1984-86; he was Director of the British Postgraduate Medical Federation 1986-90, and then became Director of Research and Development at the Department of Health, 1991-95.

⁴⁵ Sir Duncan Nichol (b.1941) was Chief Executive of the NHS Management Executive from 1989 to 1994

⁴⁶ Baroness Cumberlege (Julia Cumberlege) (b.1943) is a Conservative peer who joined the House of Lords in 1990; she served as Junior Health Minister, 1992-1997.

⁴⁷ Lord Oxburgh (Ernest Ronald (Ron) Oxburgh) (b.1934) was Professor of Mineralogy and Petrology at the University of Cambridge, 1978-91 and Rector, Imperial College of Science, Technology and Medicine, 1993-2001.

had a high regard, respect and trust in the officials, the clinicians and the people working on the team. Had I lacked confidence in those around me, it could have been a very different story indeed.

Nick Timmins: Picking up something you said, in a sense what was needed was a solution and there was no obviously right one. There were clearly stupid options, but there were a whole bunch of options that you could have come up with which would have been as good or as bad, but the point was that once you had got one, you had to stick to it under fire, because a solution was required, as opposed to the perfect one.

Virginia Bottomley: A lot of solutions are four and a half or five and a half, but you can't have that many hospitals; you had to find a way of reducing the number.

Nick Timmins: Right. The London Implementation Group was set up. You could say that that had responsibility but no power: the power it had was political backing for it?

Virginia Bottomley: That is because, had it been a statutory authority, it would have required legislation, so, wait another year, see whether it happens, and everybody argy-bargys about it. In Parliament too often they don't want answers, they want arguments. It is the same with many academics, they don't want an answer, they want an argument. The best energy goes into arguing instead of getting on with it. We felt that we had a strong team. It was a cohesive team of regional chairmen and regional chief executives who knew what had to be done, Bob and Tim were trusted and respected by the team. It was as good an option to make progress as we could find at the time.

Nick Timmins: Right. Bob, what went well and what went badly?

Bob Nicholls: Well, I underline that we would have wasted a lot of time (and I think Bernard being a northern regional chairman would have known that) if we'd said, we need an overarching London region, another statutory tier, it would have taken three years to even get that. I entirely support that.



At the time, from the finish of Tomlinson to the publishing of *Making London Better*, I look back, that this was going to go ahead, and thought, they'll never do that.

October to February? Well, the groundwork had been done, by the King's Fund and Tomlinson,

Making London Better did actually name more and disagreed with – 'put back!' is probably better – some of the Tomlinson recommendations. While we did specialty reviews and other additional detailed analysis, but there was a combination; we inherited some of Jonathan's team, so we had people who had been right through it, civil servants who knew how to brief and advise on policy, and then we brought in, seconded people – nurses, Aina's here, doctors, Peter Simpson, people from the service – who also knew, as Virginia has emphasised, that something really had to be done. There is a slight fault in all our memories, in that we only narrowly avoided a judicial review. We managed to argue out the closure of Barts A&E partly because I was temporarily sworn in as a civil servant, because I wasn't one, and I had to vouch for the Secretary of State's sanity of mind when she made the decision to close it. (LAUGHTER) So we got our legal challenges. As Pearl said and Virginia confirmed, there was a lot of concrete pouring, as I call it, including by my friends on the left at Guys – put up another building, that'll slow things down.

The other thing that was mentioned in the first session but I hope Malcolm and Cyril will go back to it, is that the academics got it. The academics knew that education, research and teaching in London was sliding. It had been the world's best; it was no longer, only UCL in the major league. Your very fair question was, why wasn't there a different solution? Physically, geographically, there was no problem at all, I would emphasise. Hang on a minute, this wasn't one market. A shaky internal market had just started for service, but it was not connected with the 'markets' for teaching and research. They weren't connected. Do you need to connect? One would argue, yes, you do, for the education of nurses and doctors for the future you've got to connect the new service model, which was hopefully going to be more based on primary and community care, with where education was done and you need to make sure that research was five-star and not, as it was slipping into being, three-star. So I think that some things we picked up and were equipped to do and the long courtships, as I call them, for merger generally worked better than the shotgun marriages.

Virginia Bottomley: Back to your doughnut point, or the starfish, I was pro-starfish on the basis that it kept the tension up. If London was just enclosed, they would all reinforce each other as a pressure group. That is where the rotations worked a lot on medical education. I wouldn't have died in the ditch over it but that was my view.

Nick Timmins: Cyril and Malcolm, on the point about the academics getting it, my vague memory of this is that when the service mergers happened they were partly driven by the medical schools. It is not the normal power balance you would expect, the medical school driving the service. Is that fair? Helping drive the service anyway.

Cyril Chantler: Yes. It has always seemed to me that rationalisation of hospitals partly depends on the medical schools, although you shouldn't actually design hospitals around what's best for the medical school, it should be about what's right for the patients. But it was clear at UMDS, and my predecessor, Ian Cameron⁴⁸, has a lot of credit here, that we really couldn't sustain it. As he used to put it, how are we going to cope with our

students walking between the anatomy lectures and the physiology lectures, past the new site of life sciences that belongs to King's College near Waterloo Bridge? Because we had anatomy at Guy's and physiology at St Thomas's. So Ian and I decided by '92 that this really couldn't go on and conversations started between him and Arthur Lucas⁴⁹, and his predecessor at King's, John Beynon,⁵⁰ and I continued them with Arthur



when I became principal in 1992. But we also went back to the notion of Flexner,⁵¹ which Geoffrey knows all about, Haldane⁵² and Goodenough⁵³ and Flowers, all saying that you really can't sustain an adequate medical education if you divorce it from the science that should underpin it. To some extent that didn't matter if the only intention of the London Medical School was to train clinicians

⁴⁸ Professor Ian Cameron (b.1956) was Professor of Medicine at St Thomas's Hospital Medical School, then Dean of St Thomas's and later Principal of the United Medical & Dental Schools (UMDS), the joint Guys/Thomas's Medical School.

⁴⁹ Arthur Lucas (b.1941) was Principal of King's College, London, 1993-2003.

⁵⁰ John Beynon (b.1939) was Principal of King's College, London, 1990-1992.

⁵¹ The Flexner Report, published in 1910 and written by Abraham Flexner, led to major reform of medical schools in the United States, and is remembered, inter alia, for urging more thorough training of doctors in basic sciences.

⁵² The Haldane Report of 1918, named after committee chair Viscount Haldane (Richard Haldane) (1856-1928), recommended that public funding for research should be disbursed by specially appointed research councils rather than government departments; one outcome was the foundation of the Medical Research Council in 1913.

⁵³ The Inter-Departmental Committee on Medical Schools (Goodenough Committee) was appointed in 1942 and reported in 1944; it was highly critical of medical training, particularly in London, called for an overhaul of the curriculum and suggested reorganisation to move schools out of central London.

who could go into practice the day they qualified, but if you were going to do research, there was no way of doing it at all without good science facilities.. Of course the academic medical centre designed firstly in Johns Hopkins by Flexner and Osler in the late 19th century had said you've got to bring education, research and high standard clinical practice all together in one place.⁵⁴

When I got on to the staff at Guy's I was told that if I wanted to do research I had to go to Great Ormond Street because Guy's didn't do research; I remember the Dean telling me that. Well, that wasn't a sustainable position by '92 and yet we didn't have a science base. The only hospital that had a science base was at UCL. I accept the point that was made that they weren't that close to each other, but they were pretty near each other and, of course, it is a measure of the success of the changes that King's is now an academic medical centre in its own right. UMDS wouldn't have had a hope; King's wouldn't have had a hope; either if it hadn't actually taken place. So Ian and I were quite clear that that is what had to happen. And I was on the policy board, so I saw Tomlinson as a wonderful opportunity, I thought it was an excellent plan everywhere except in the south of London where it did pose certain difficulties for me. My main aim during that period was to try to keep UMDS together – it was called the United Medical and Dental Schools, so united we had to remain, but it was made slightly different by the different perceptions that everybody had of it.

For instance, my colleagues at Guy's, which is where I come from, were absolutely clear that either Guy's or St Thomas's had to close – there could only be one hospital – and they very particularly wouldn't say which they thought should close, but everybody knew, so that was a huge problem. I didn't believe that at all; I thought there ought to be a two-site option, so that was an example. We can go into what actually happened after that if you're interested, but the fact that the medical school was very clear where its future lay did actually lead, I think, to the rationalisation of clinical services along lines which were actually determined – I don't know about doughnuts or

⁵⁴ Professor Sir William Osler (1849-1919) was one of the founders of Johns Hopkins School of Medicine, and pioneered new approaches to clinical training through hospital residencies.

starfish – by the railway lines. The reality, and it comes from the Second World War, is that referral patterns in London are determined by canals and later, in the 18th century, by railway lines, and it is still the case. The river Lea flows into east London, so where do the patients from Luton come to? You know where they come to – it is the way it works, so I do think that if you are going to rationalise the hospitals, you have to sort out the medical schools, but they were very keen to be sorted and after 100 years I think that was a very positive push.

Malcolm Green: I was Director of the British Postgraduate Medical Federation, which looked after all the postgraduate institutes across London, allied to the postgraduate hospitals, (then called Special Health Authorities), except the RPMS at the Hammersmith. Just while it's in my mind,



Michael, there were two big players; Michael Besser⁵⁵ at Barts and Colin Dollery at the Hammersmith. These two were fighting for the continued independence of their Hospitals. Until Tomlinson the Charing Cross and Chelsea/Westminster

Hospitals were one Trust. Following Tomlinson that link was broken and Charing Cross was joined with the Hammersmith. I suspect it was felt that one of those two sites should be downsized. 20 years later those two hospitals are still active – and again the recent north London review, currently

⁵⁵ Professor Sir Michael Besser (b.1936) was Professor of Endocrinology at St Bartholomew's Hospital, where he was honorary consultant physician 1974-92, director of the Medical Directorate 1990-92, then Professor of Medicine, 1992-2001; he was chief executive of the Barts NHS Group, 1992-95.

out-to-consultation, says that there's one too many sites for a full range of services. So the merger 20 years ago did not resolve that issue of perceived over-capacity.

Bob Nicholls: I caught Graham Hart's eye. The reason that Christopher Bland and Dollery continued to oppose the proposed link with Charing Cross was back to the education thing; it was the hook-up between the jewel in the crown of the Royal Postgraduate Medical School, with the best ratings, I think, at the time of the Peckham review of postgraduate institutes. Imperial, despite already getting Charing Cross medical school, Westminster medical school, St Mary's medical school, was bobbling along – good for mining and engineering, but medicine? It was never going to be an academy of health science. We had to get the Postgraduate Institute in. You're right; there were too many hospitals and we thought, merge and then they'll rationalise sites. Well, Queen Charlotte's did move onto the Du Cane Road site, so I suppose we did something. So the hospitals lagged behind education but thanks to Graham and LIG involving the Department of Education, and, very unusually, using some of the health service's scarce capital money to build a bio-medical science block on the Imperial site, the RPGMI agreed to join Imperial and that was, in the end, quite a feat. So, not the hospitals, but, once again, the academics.

Virginia Bottomley: Let me just say, not only is Graham there, but I can see Robert Creighton at the back, who was my private secretary at the time. He has probably got a much better memory than I have, so anything anyone wants to ask me, ask Robert, he will remember better.

Nick Timmins: I will take Malcolm then Peter Coe and then Robert.

Malcolm Green: I have to say that I opposed the Tomlinson proposals for the BPMF Postgraduate Institutes, in my role as Director of the BPMF. Partly because I thought that small was beautiful and also I was absolutely committed to the same principles as Cyril: namely, that you had to have a combination of very highly specialist medical care with very highly specialist integrated translational research. Looking around London, I concluded that the postgraduate hospitals, including Great Ormond Street, as mentioned by Cyril, and the 6 others (Maudsley, Moorfields, Eastman Dental, Queen Square, Royal Brompton and Royal Marsden Hospitals), with their associated Institutes (Child Health, Psychiatry, Dental, Ophthalmology, Neurology, National Heart and Lung and Cancer Research) were shining beacons in a relatively dimly-lit environment of translational research. And so I argued that



these lights should not be turned out or dimmed. My protestations were unsuccessful and the specialist Institutes, except for Cancer Research, were duly integrated into the multi-faculty colleges. It is my impression that those colleges that took a federated approach to their new Institutes – namely UCL, and King’s – have managed to preserve the special relationship between Postgraduate Institutes and their associated postgraduate hospitals, with highly focused and integrated translational research, better than the one which did not so do, namely Imperial College. Imperial College in the end merged with only one postgraduate institute, the National Heart and Lung Institute, because, at the doorstep of the ceremony the Institute of Cancer Research rejected

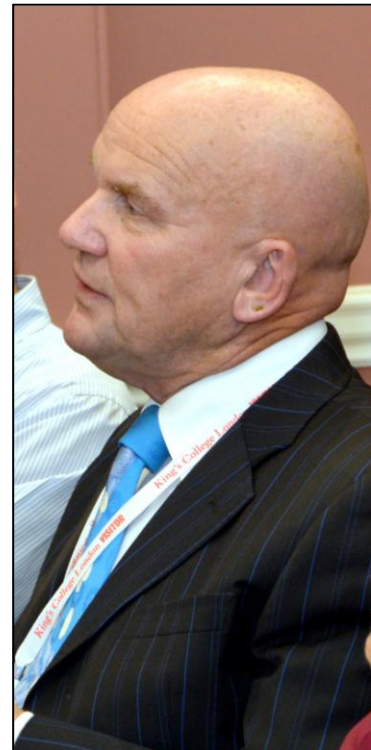
marriage. Despite dire predictions at the time the Institute of Cancer Research appears still to be thriving both scientifically and financially. It may be that the need for closer integration between the ICR and basic medical sciences will increase over the next decade or two, but they may find ways of achieving this which do not involve merger.

Virginia Bottomley: Cancer is often a special case, isn't it?

Malcolm Green: Yes, indeed, cancer may be a special case.

Nick Timmins: We have seven or eight minutes left for this bit; there is loads more to go. Can I just run Peter Coe, Michael and Robert Creighton at the back?

Peter Coe: I shall be very brief. In the '80s the big decision which Colin Dollery pushed first was Northwick Park and the Hammersmith. We lost the clinical research centre at Harrow, which actually determined the Hammersmith as a major investment package in total, but it did enable the Chelsea and Westminster to be created, because Kenneth Clarke⁵⁶ was quite convinced that the ripple effect from that has led to what has now happened, which is that Roehampton has gone and several other hospitals went. So although we are looking at inner London, the impact on outer London was actually



⁵⁶ Kenneth Clarke (b.1940) has been Conservative Member of Parliament for Rushcliffe since 1970; he has held several offices of State, including Home Secretary (1992-93) and Chancellor of the Exchequer (1993-97), and was Secretary of State for Health, 1988-90.

quite significant in the '80s, from the Hammersmith and the Medical Research Council pressure, and constantly, when we went in to talk with Kenneth Clarke, the issue was that Gower Street must remain sacrosanct – it was the big powerhouse in international competition. Of course, when I went to east London and Michael Besser was my unit manager for Barts, he accepted totally that Gower Street was the lead and that whatever he wanted to do for Barts would not be able to upset Gower Street. So, actually, he was quite happy for the merger of the medical school with the London, because there was no alternative for Barts but to grasp that opportunity.

Nick Timmins: But not the hospital.

Peter Coe: Then we had two judicial reviews, one on A&E services and one on closure and we won both.

Nick Timmins: Right. Robert Creighton.

Robert Creighton: I have been set up for this, I think. I can only say two things, really. One is that my memory is defective because I think at the time I was so exhausted by managing the processes in the Department, helping to co-ordinate all this, that I can't describe from one day to the next, the point being that it was an extraordinarily complex set of issues and the scale and number of meetings that we had to hold to get people lined up and to get everybody in the same room together and at least identify where their differences were and then Graham Hart and I would go downstairs and think about what we were going to do. Graham would go off and do something wise and it was

Duncan Nichol and Alan Langlands⁵⁷, at different points in this, who would go off and do something, I won't say what, in the health service and then we'd all come together again. So it was a process of constant iteration, which was really exhaustive and exhausting. From a personal point of view, everything I've heard rings true, everything is as I remember, though I can't say it's crystal clear in my mind at the moment.

Virginia Bottomley: But what is interesting is that there was a great sincerity of purpose.

Nick Timmins: One over there, then we'll break. We are doing the primary care community bit next, but I suspect some of this plays back into it so I think we are going to find an overlap in the next session.



David Noyce: I'm David Noyce and I work for the Higher Education Funding Council for England (HEFCE) and was involved with LIG, with Finlay Scott,⁵⁸ seconded from HEFCE to LIG. I have a couple of comments. One touches on what Cyril was saying – from my point of view the medical school mergers seemed to provide the underlying rationale for the wider change. It seemed like the engine of

⁵⁷ Sir Robert Alan Langlands (b.1952) was General Manager of North West Thames Regional Health Authority, 1991-94, and Chief Executive of the NHS Executive, 1994-2000.

⁵⁸ Finlay Scott (b.1947) was a senior civil servant in the Department for Education who was seconded to the Universities Funding Council and then to HEFCE, as Deputy Chief Executive, 1990-1994. He became Chief Executive of the General Medical Council in 1994.

change, very much; maybe it shouldn't have been like that but it seemed to me that the rationale very much came from that engine of structural change. I think that HEFCE was very supportive of that as a change agenda, so it may be that that helped to smooth a path. The other comment I wanted to make is that, if one thinks about the scale of mergers, it was just extraordinary. I dealt with a number of mergers subsequently in higher education and they are always fairly controversial; they quite often don't go forward, so to imagine the scale of change, it is amazing that it happened in the way that it did. So it is quite surprising that so much change was enabled over such a short period

Virginia Bottomley: Can I leave you with one small comment? When life seemed tough from time to time I remembered a quotation that Dukey Hussey⁵⁹ gave me. He said that running the Marsden and the BBC involved the same issues of passion, rage, loathing of accountants and so forth. He had a wonderful Burke quote: 'Those who would carry on the great public schemes must be proof against the most fatiguing delays, the most mortifying disappointments, the most shocking insults, and worst of all, the presumptuous judgment of the ignorant upon their designs.'

Nick Timmins: One last point: you must have been under huge pressure from a lot of your backbenchers over a lot of this. We have talked a lot about the medical schools in inner London...

Virginia Bottomley: Well, they were 'all bastards', at times weren't they?⁶⁰

⁵⁹ Baron Hussey of North Bradley (Marmaduke ('Dukey') Hussey) (1923-2006) was Chairman of the Board of Governors of the BBC, 1986-96, and Chairman of the Royal Marsden Hospital 1985-98. He chaired the King's Fund Commission responsible for the *London Health Care 2010* report, and also the King's Fund London Commission, which produced the *Transforming Health in London* report, published in 1997.

⁶⁰ On 25 July 1993, John Major was accidentally recorded after a television interview with ITV's Michael Brunson in an off-camera discussion about disloyal Eurosceptic ministers within his Cabinet who were fomenting opposition. Asked by Brunson why he did not simply sack them, he replied: 'We don't want another three bastards out there.' Although the identity of the 'bastards' was not specified, it was thought at the time that he intended either Peter Lilley, Michael

Nick Timmins: But there was an outer London ring of Tory MPs who just loathed some of this stuff.

Bob Nicholls: There were dirty deeds.

Virginia Bottomley: The Prime Minister had a good word for some of his colleagues and I wouldn't disagree.



Nick Timmins: The bastards. Right, let's break there for ten minutes.

Portillo, John Redwood or Michael Howard (Paul Routledge and Simon Hoggart, 'Major hits out at Cabinet', *The Observer*, 25 July 1993; Stephen Castle, 'Major 'says three in Cabinet are bastards'', *Independent*, 25 July 1993.)

Matthew Isom: If I can just say in relation to that, I remember watching one of your last... Sorry, Matthew Isom, Dispensing Doctors' Association, but I also worked for the British Medical Association. I remember Virginia Bottomley giving one of your last Statements as Secretary of State for Health to the Commons on the London review. Not a single one of the backbenchers on the Conservative side spoke up in support of you; they all attacked you, apart from your husband.

(LAUGHTER)

Virginia Bottomley: That is where the stoicism comes in.

Nick Timmins: A cup of tea.

Virginia Bottomley: But on the other hand, I was not political. John Major had said, do you need help? I said, no, no, I'm fine. I'd always said, I'll do the dirty work and when I've done the dirty work, somebody else can take it on and be nice. In politics you have window-breakers and glaziers. I was the glazier in bedding in the NHS reforms that had got noisy for Ken Clarke, but I had to be the window-breaker on London change. Perhaps, I should have been more savvy, talked to the Whips and PPSs more – Robert Creighton never explained that to me!

Nick Timmins: Okay, ten minutes. Thank you.

Part Three

Nick Timmins: Great. Let's get into the primary and community bit. I suspect we should also probably get into some of the debate about outer London. We talked a lot about the medical school/research bit of this, we talked about the inner London institutions; there is a lot more to it than that. Among the implementation bits that came out of Tomlinson was the London Initiative Zone and the attempt to try to do something about primary care. Brian, would you like to start reflecting on that?

Brian Jarman: Okay. There are three things I would say about Tomlinson. First, I don't think enough recognition has been given to the achievement of the integration of the medical schools in ending up with where we are now. Flowers tried – he was the Rector of Imperial – and didn't succeed. I often said to people, that is a part of it that hasn't been recognised. We have got the five main universities and they are world leaders. I had an email from the rector of Imperial the other day saying Imperial is now ranked third in the world. University College is always up there with the top ones. You have achieved what you wanted, it is stable, it is correct and I think there should be an enormous amount of praise. I was saying so at the time.

The second thing is I always felt very sorry for Virginia Bottomley because I had a very unfair advantage with regard to data. I'd been involved in initially contributing to RAWP and then we did the RAWP review and set the formula, which is actually still effectively used now, and we had all the data, with who was going from where to what. If I needed anything I just said to my three people, 'Could you please just analyse that? It is obviously important' and they did. One of the major things was that Tomlinson looked at acute, he did not look at what is now called general and acute, which is actually geriatric and acute services– they do not split them any longer; they are effectively

the same. When you actually look at that and you look at it for the residents, there is a net inflow to London of about 10%, which was not allowed for in Tomlinson because he didn't have the data. The data are very complex because when you set the formula you do the formula to the resident populations, then you allocate it across to the hospitals – it is an iteration process. It is a very complex business; we had all the data so it was easy. We could just look at the things that seem important and do the analysis. There was the question of whether the availability of residential homes is lower in London and all these factors, but my actual first involvement was with the feeling that, as a GP, I was increasingly having to use the EBS, the emergency bed service. I just thought, let's look at it and see, so I thought that was very important.



The third thing I'd like to say is that I believe that that Government – Kenneth Clarke, Virginia – helped to introduce, well, did introduce fundholding. Lesley's review, although they claimed they were getting rid of fundholding, in fact extended it throughout the country. I believe that that has produced the solution for primary care. If you go around – I have just been asked to

chair the assessment panel for the integrated care of north-west London – when you go around looking at it there is a very different situation. When you go around listening to the clinical commissioning groups, they have power, they have the ability to look at quality of care. The thing that was written for Lesley's thing was actually based on the Inner London multifund. The way it worked was that we went around and commissioned. So we had all the funds from the fundholding and we said, okay, we are going to do dermatology services. We did 200 interviews, 20 focus groups, we found the problems, we went out to seven places and so on. That was the model that we thought would work. When you actually look at the wording that was recommended by Lesley's panel, it is almost the same for groups purchasing care for 100,000 people and 70 GPs. It is very similar to clinical commissioning groups, which I believe, for the first time ever for primary care, is the solution. All the other recommendations, the fact that it is almost impossible to purchase premises, for instance, for a GP in London – you cannot, within the GP rules, the costs are so high. So you can say wonderful things about, 'It is necessary', but it's actually difficult. I used to be rather left wing but I have moved nearer right wing, I must admit, because when I look at, for instance, our deprivation score, that was introduced by Margaret Thatcher and got rid of by Tony Blair, who I consider was right of Thatcher, actually. And I believe that the changes that were made by that Government have set up what is now, and I did not think I would ever be able to say this before, the beginnings I think, actually, of a solution. Because these clinical commissioning groups are purchasing care for their resident population. They have the power, they have the resources. I think there are a lot of good things which haven't been recognised about what that Government did and what Tomlinson did. In terms of the review you mentioned, about the data and so on: I would go on and be debating against her and I'd think, 'Oh, don't say that, I know it's wrong, please.' I thought you'd gone, actually, I didn't mean to... I wasn't to know!

Virginia Bottomley: You used to accuse me of using too many statistics.

Brian Jarman: It wasn't fair – I just needed to say, tell me the figures for acute and geriatric, because that's the equivalent thing. Within a day I'd have them. Sometimes, I have to admit, the interviewers would ring me up and say, what questions shall we ask her? I didn't tell them the nasty ones to ask, I must admit. So my feeling is that the Tomlinson report actually did a lot more than people have given it credit for and I believe the Government did a lot more. In fact, it gave, and I didn't think it would ever happen, particularly when you think of AJ Cronin and so on, the solution we've reached.

Virginia Bottomley: Very quickly, on that point, I'm an old Fabian...

Brian Jarman: Right – so you've gone left and I've gone right!

Virginia Bottomley: My view was that my job was to speak for the inarticulate needy rather than the articulate greedy - to speak up for the unfashionable causes and issues because the powerful were powerful enough.

Brian Jarman: If I may say, the thing that took the most of my time ever was writing a social security benefits programme. It was called the Lisson Grove benefits programme and is now run throughout the country but it was the first there was and I wrote the thing because I thought I could do more to help than just to give 20 quid occasionally. There was old Mrs Devonshire who had to have stamps on the top of the thing and there was this group who I knew were collecting benefits, I knew that there were ways and we were spending two and a half times as much on the benefits as we

were on the health service so I wrote this programme and they would run it in the social services office in our health centre and they'd say at the end of the day, 'Could you change this, Brian?' So I'd go home after the surgery, write it through the night and bring it back. We ran 2,000 patients, the programme was used, run by the social services, and 82% of them were getting the wrong benefit. The benefit office admitted that 13% were wrong. I just felt exactly what Virginia is saying: that it is the social factors and the integration of that which takes all the time. I never normally ever mention this because people don't know that I did it, but we did do it in the end and that integration side of things is extremely important.

Nick Timmins: Ainna, during this five-year period between Tomlinson and Turnberg what did it feel like on the ground in terms of improving those sorts of services?



Aina Fawcett-Henry: Listening to Virginia I was saying to myself, did you realise how tough it was for us? This enormous agenda to deliver – we had money but we didn't have time. That was the one big issue for me; not that we didn't love the recommendations, but how can you do so much in two years? I can remember Dr Mawhinney⁶¹ calling me in and berating me for not getting on with the job after another critical headline in the *Evening Standard* about the

closure of London's hospitals– those are the bits you remember. We had a tough time, it was tough,

I remember the Royal College of Nursing, for whom I had worked for eight years and who

⁶¹ Baron Mawhinney (Brian Mawhinney) (b. 1940) was Conservative Member of Parliament for Peterborough, 1979-97, and North West Cambridgeshire, 1997-2005; he served as Minister of State in the Department of Health, 1992-94.

perceived me as one of them. I then became regional director of nursing at South East Thames, and now was actually involved in closing hospitals and nurses were going to lose their jobs. The first report from the Royal College of Nursing prior to Tomlinson said 'London needs all its nurses'. It said, not one job should be lost. You were up against the profession and I remember a meeting at which I was referred to as a traitor, that I was actually colluding with a loss of jobs. Having said all that, we can't look at any of this without putting it in the context of how people were feeling at the time.

My focus within LIG was not to be protectionist about nursing but to focus on healthcare and on what nurses could do to improve the healthcare of Londoners. I had made a film about primary healthcare team in Lisson Grove Health Centre in London some years before and thought PHCTs were the most wonderful development that could ever happen in the health service, but alas PHTs were very few and far between in the early 1990s. Relationships between doctors and nurses in London weren't great; there was a feeling amongst the nursing and health visiting profession that GPs operated in isolation in locked-up premises, they weren't interested and therefore teams couldn't happen. But, having said all that, I think that some of the developments that we witnessed in London, coming from the bottom up, were phenomenal. I remember one afternoon being almost ill from eating onion bhajees, out in Brent and Harrow ; being taken around from one Centre to the next to see where voluntary organizations, nurses and social workers had joined together to address the needs of local people. I think that was what was really special about Tomlinson and the London Implementation Group. I look on LIG, without wanting to sound arrogant, as a transformational leadership organization, we were providing leadership at the top, but actually, we were working with the grass roots. We were asking the people to develop initiatives, prove to us that they would be worthy of funding and that they would address the needs of Londoners.

The other thing we did was to show the acute hospital sector, even if they weren't receptive all the time, that there was an alternative, that if people didn't need medical intervention in a hospital but needed nursing care, there was another way of doing it and that you didn't always need to use acute beds. So for me, in many ways, it was a time of great change in a



positive way. We saw hospital-at-home schemes, we saw intermediate care centres; they happened from the people themselves. Chatting to Pearl Brown, the Nurse Adviser to Tomlinson earlier, many of those important initiatives have now closed down because they were not perceived to be cost effective but, I wonder whether, if they were evaluated on patient satisfaction or quality of life for patients, you would have got a very different outcome. For me, LIG opened the door for primary care developments. In many ways it was like a rich tapestry – all these developments happening in isolation were suddenly being pulled together because of LIG. Players that had never sat around a table together before were now in discussion with each other and there was acceptance. But I don't want to forget about the tough times either. Sorry about that, Virginia, but they were tough.

Virginia Bottomley: I agree. I know they were.

Ainna Fawcett-Henesy: Bob warned me to be careful!

Virginia Bottomley: I was under no illusions about that, about what the demands were.

Ainna Fawcett-Henesy: But for an implementation group to have two years to deliver on that Agenda was overwhelming. Having said that, we did move the agenda on and I think there are many examples as testament to that now. I remember going to Victoria to visit a GP who had set up a service for people with drug problems. He was rehabilitating this group and finding them housing employment etc. It was just so uplifting to see that physicians and others were thinking beyond an acute model. Those people with addiction problems would have been in a mental illness institution but for the efforts of such people as this GP who, from the grass roots up, was making a difference. Is that my five minutes?

Nick Timmins: That is your five minutes, great. Tony, from the BMA's point of view, in a funny way your members were all in the firing line fighting each other, on one level, and then you've got the problem of the very heavy criticism of the standard of general practice.



Tony Stanton: That is always true, of course. A well known saying in the BMA is that consultants will fight to the last dead general practitioner (LAUGHTER) and there is some considerable truth in that. With subsequent reviews, not least Darzi and others, that is still true. Just by way of background, and picking up one or two themes that came up in the earlier

part of today's very interesting discussion, I think it is 53 years and two months ago that I walked into this courtyard to start pre-clinical at King's. Why did I choose King's at that time, when there was a choice? It was very much on a theme that was picked up earlier, that there is a lot to be said for medical education being alongside general university education and I think it is rather a shame that that system no longer applies here.

Cyril Chantler: It does.

Nick Timmins: The academic health science centre has been plugging all this stuff together.

Tony Stanton: I meant in the same building.

Cyril Chantler: As a matter of fact they can spend up to a quarter of their medical course studying humanities in King's.

Tony Stanton: Excellent. Good – I stand corrected. I think that is very positive. Secondly, picking up on something that Brian Jarman referred to earlier, namely that the estate in general practice in London was and to some extent still is a considerable problem. In the mid-'80s I chaired the BMA's practice premises subcommittee at a time when minimum standards for surgery premises were introduced. They included amazing things like that there ought to be a degree of privacy, perhaps a curtain around the couch and a wash basin, et cetera. I was talking to Peter Coe earlier and reminding him that he'd done a surgery inspection in east London and the doctor had proudly pointed out that yes, indeed, he had a wash basin and Peter had to point out that it would be better if there were a water supply connected to it. (LAUGHTER) My first encounters with Geoffrey

Rivett were in the detailed negotiations running up to the 1990 contract and it became quite apparent to me as the junior member of the GPC's negotiating team at that time that we were talking about something that was completely different between London and much of the rest of the country. There were things that the Department wished to achieve which struck me and I think most of my colleagues as absolute common sense but simply didn't apply in much of London. My theory was that that is where civil servants by and large not only worked but lived so they knew these things – it is the point that Baroness Bottomley was making about standards in certain parts of south London at that time leaving much to be desired. That was an important consideration.



The Tomlinson report and the King's Fund report very much shaped the second half of my career because in exactly July '92 I moved into a full-time job in London as secretary of the London group of local medical committees, so this was our number one agenda and I think I first met Virginia when she came to an open event that we called to discuss the King's Fund report - I think that Tomlinson hadn't quite been published at that time. As a result of all that

and, I suppose, blowing my own trumpet, because I was sufficiently senior in the GP committee of the BMA, having been the immediate past deputy chairman, I was able to persuade different people. Just like, I think, the rest of the NHS, GPs outside London hate GPs in London and I think that's probably true of NHS managers in general – it's a generalisation. I was able to persuade people that we did have to take some initiatives and we were able to work with colleagues from NHS

management first of all in bringing in a package of flexibilities designed to make life easier and to introduce incentives for practices and, secondly, to bring in the LIZ educational incentives, which by and large, I think, was a very successful double package which brought considerable benefit, so I think that worked well. We didn't get particularly involved in the hospital reorganisation debate and that is, interestingly, still going on. I retired two years ago but in the last year or so of my time there was a big consultation on the future of hospital services in south London and it is wonderful to read now that the whole thing has collapsed because people are very reluctant to take decisions to do things that are absolutely necessary. With due respect to the previous Secretary of State, I thought she was incredibly brave over what she was wanting to do with Barts, but it is virtually impossible for any politician, it seems to me, to take a decision to close a particular hospital or a particular service because everyone expects there to be a district general hospital in their backyard. There were dreadful promises made by politicians before the last election about the future of various hospitals in north London which were completely undeliverable. That is really all I want to say by way of background.

Nick Timmins: Can I just ask, there was money for this primary care stuff?

Ainna Fawcett-Henesy: Loads of money.

Nick Timmins: And you have talked about how things came from the bottom, but in a sense it was a horizontal programme. How did it fit with the health authorities and the other bits of the system? You made the point that quite a lot of these things happened but haven't lasted, weren't adopted. Is there a process point here about how you get these things to take root and last?

Bob Nicholls: Ainna is right, it was naïve, we were naïve. The concept, the King's Fund concept, I think, and certainly the Tomlinson concept was get some money out of the acute hospitals... with due respect to Brian's analysis of the total number of beds, there were actually four DDHs worth of beds not being utilized across London – already, never mind the future projection about acute beds and whether we had allowed for the elderly and so on. Actually, if you could just rationalise the four then the money would come out, provided you could have capital for redevelopment, then revenue savings



would be made, and that would pick up what was promised and delivered by the Government for improving primary care - £200 million plus, I think it was, for three to four years, a lot of money in those days. Brian is right that perhaps too much went on premises, not enough on the things Tony has mentioned. The real problem was that that was not sustainable. How it was done was actually a bit like I see going on currently, bidding by the new purchasing authorities – Peter is here, he was one of them. A lot of them had very good ideas but needed the access to money and that was fine, we got going, but sustaining it was extremely difficult when you haven't actually delivered the planned rationalisation of acute facilities.

Ainna Fawcett-Henesy: It is also understanding the cultural change that needs to take place: a building is not enough; it doesn't make people work together. Perhaps we didn't put enough focus on that kind of cultural change, the whole change management agenda that I would be very aware of now. It is very easy to be wise after the event.

Nick Timmins: It is the soft stuff that is very hard to measure.

Ainna Fawcett-Henesy: It is, but it did get an energy going; there was an energy in London, an excitement that, my God, they are actually giving us money to do something; they are not just doing another report like Tomlinson, talking about it. They are actually now giving us money, so they must be interested.

Peter Coe: I was just going to comment that money went into departments of general practice to encourage further lecturers actually out there working with GPs, which changed the curriculum for medical schools so that instead of one day a term in general practice, you end up with one day a week and that was a lever for change amongst those primary care practitioners. If you go back to what Geoffrey referred to, the LHPC 1981 document on primary care and look at the age profile of GPs, lots of them were still there in '92 and trying to get them to change was difficult because actually, they were only hanging on because they couldn't afford to retire. The FHSAs had not been geared up either as change management facilitators or, indeed, as capital developers; they just did not have that knowledge and wherewithal. It was the opportunity brought about by the integration of FHSAs and DHAs and the restructuring of so many of those first-wave trusts in London that allowed us, certainly in east London, to look at how we could use community health services'

facilities, expertise and knowledge to come out of hospital development and go and work with GPs on practice development and we achieved an enormous amount.

Nick Timmins: I have forgotten the date when family health service authorities got amalgamated with health authorities.

Martin Gorsky: 1996.

Nick Timmins: 1996. So that's in the middle of this.



Peter Coe: But before that, informally – certainly by the end of '93 I was managing both, informally. If you remember we totally restructured trusts in east London and we used that community; Hilary Scott managed all that community resource for a while.⁶² We just went in to move things, despite the intransigence, as Tony knows, of one or two individuals who did not want to leave their premises. That money from LIG allowed that to happen in the way that hadn't happened before and although some of it was short-term, by having the nursing schools, the medical schools and the GPs on board, what LIG did was buy that change. And it worked. We moved from 7%

⁶² Hilary Scott (b.1954) was Chief Executive, Enfield and Haringey FHSA (1989-93), Project Director, City and East London Family and Community Health Services (1993-95), Chief Executive, Tower Hamlets NHS Healthcare Trust (1995-99), and Deputy Health Service Ombudsman, 1999-2003.

of premises in '92 were acceptable – 93% of primary care premises in '92 were not acceptable – and by '98, 35% were acceptable, which is really quite a major change, fast.

Nick Timmins: Right. Can I move on to the next section? What we have heard quite a lot of in this bit is that lots of good things were going on and yet we are left with the perception that there is still a bloody great crisis and we end up with Leslie Turnberg's review.

Virginia Bottomley: There was another election coming up.

Nick Timmins: Can I swap the panel at this point? Because is there a sense that we've done good things and yet we end up with another review?

Part Four

Nick Timmins: I suppose the bottom-line question is, given what we have just heard, why Turnberg?

Virginia Bottomley: I'm afraid that I was detached. I just thought this was New Labour making mischief as they came in – they needed a way of getting themselves off the hook. Remember, their election slogan was, no hospital closures, no more postcode lottery – which was ridiculous – and no more managers. So if you don't believe in managers, you can't have hospital closures and we're going to save Barts – I just thought this is all pretty cheap and they needed to have an inquiry to get them off the hook. I'm afraid I didn't even read it because I was elsewhere by then; I'd packed and gone.



Nick Timmins: This is very Barts oriented, but there is that famous quote of Frank Dobson's – 'I'm not having a blue plaque on Barts that says, "Founded by Rahere in 1152, closed by Frank Dobson in 1998"'.⁶³ I was in the room when he said it and you thought, Jesus Christ almighty. In a sense the war had been won and he just goes and reopens it.

⁶³ Contemporary reports recorded the quote as: 'I'm not having a blue plaque on Barts that says, 'Founded by Rahere in 1123, closed by Frank Dobson 1997'', see J.Warden, 'St Bartholomew's saved in London plan', *BMJ*, 316, 1998, 496.

Bob Nicholls: Except that there was a similar quote and I remember Virginia saying it. She challenged me to go and find a respectable, prestigious and, most importantly, economical use for Barts. Quote: ‘If I was the Minister for heritage I might want to save it, but as I’m the Secretary of State for Health I’d like to have another use put in it and then we could get out with honour’ and we failed, we backed down on that. But what happened next was the interesting thing to move on to. I did want to put in that there was money not only for primary care pump-priming there was money lined up by the DH – John Bacon is here, Graham Hart is here – and the Treasury for three redevelopments of major hospitals in London. The business cases still had to be finalized but then PFI came in.⁶⁴ My view is that PFI slowed the acute changes and left us with the legacy that Darzi and the London SHA are landed with. South London is the exemplar extraordinaire – why was Woolwich ever built? It was a shady deal between some of Virginia’s backbenchers and Ministers, but I won’t go further into that on the record.

Michael Bond: No – especially as we live in an era of defamation.

Bob Nicholls: Yes – I might be tweeted. But it would be very interesting to say, we got it to a point, things were beginning. Brian absolutely said that there was a steamroller moving on education but we had begun to move on acute service rationalisation. Cyril says we did close some



⁶⁴ The Private Finance Initiative (PFI) has been used since 1992 as a method of funding public infrastructure works. Private sector capital is contracted to deliver new infrastructure, principally in the education, transport, prison and health services; these contracts are not recorded by the Treasury as part of the National Debt, although they bind the Government into long-term repayment arrangements. In London the largest PFI hospital schemes have been those at UCH and Bart’s and London Hospital.

hospitals, but not anything like the amount that would be needed to really put community and primary care where it should be.

Nick Timmins: Right. And the three big builds were UCH...?

Bob Nicholls: St Mary's...

Nick Timmins: St Mary's, of course, which never happened...

Bob Nicholls: And the London. On the assumption that there would be only two PFIs in east London, or I hoped there would be. Originally there wasn't going to be a PFI for The London, it was going to be Treasury capital with lower rates and then suddenly it was going to be a PFI.

Leslie Turnberg: Just on PFIs... I'm the one who saved Barts; I'm sorry to disappoint you.

Virginia Bottomley: They're not grateful to you!

Leslie Turnberg: If you had read the report you would have seen why we saved Barts in the form that we did. Stephen Dorrell had brought PFI in before Labour came in and I was amazed that Labour continued when they came in to power, but I remember Frank Dobson saying, it's the only show in town to build new hospitals and that's why it continued, and we are stuck with it, of course. I don't know what made Frank Dobson decide to have a review; I think he was just starting, he needed something and he chose me because I was from Manchester, so I would presumably not have any particular axe to grind.

Virginia Bottomley: Like Tomlinson – north of Watford.



Leslie Turnberg: Yes. Although I had worked at UCH, rather like Tomlinson. The questions we were being asked was, was London privileged, was it getting too much money relative to the rest of the country, was it having too many beds compared with the rest of the country and the populations. We were fortunate in that we had Brian Jarman on the panel and some other excellent people. Brian, of course, was a mine of information on the numbers of patients, numbers of beds and all that sort of thing,

so we had quite a lot more data than I think Tomlinson had to work on. It was pretty clear that the pressures on beds in London were tremendous. London has a heavy load of homeless people, a heavy load of AIDS patients, a lot of commuters coming in and it seemed that in primary care, despite Tomlinson, the numbers of GPs had gone down by 1% while the numbers of people had gone up by 1%. So there was a mismatch in primary care and, as I will describe in a moment, we found that primary care, although it had improved, was still pretty poor in many areas and we came to some conclusions on that.

Can I just say that I think a lot did happen after Tomlinson, I wouldn't want to denigrate that, and, indeed, quite a lot happened after our report. I am slightly cynical about what happens after reports, because one relies very heavily on people out and about to implement what you are suggesting – that is the difficulty. It is always about implementation and unless you take people with you, implementation becomes almost impossible. We spent a lot of time talking to lots and lots of people and going round to lots of hospitals and primary care places trying to get a feel for what might be feasible, given the task we were given. I have to say that the Barts issue, if you read the

report, was a relatively small part. We focused very heavily on the defects in primary care, community services and mental illness. Interestingly, those are just the areas that we've still got big problems with and we don't seem to have cracked those despite various reports. We still have a long way to go on both of those. We do get distracted by the hospitals and that seems to be the problem.

We did suggest mergers of a number of hospitals, we did suggest the mergers of Middlesex and UCH and Elizabeth Garret Anderson and that one or two other little ones should come together. I was quite pleased to be able to say that, having seen in 1960 the idea about the new hospital on the UCH site and there we have it now. Certainly, we had our ears bent by Mike Besser about what was going to happen in east London. We also had our ears bent by people at the London. I remember going to a meeting which I chaired with members of the panel and two or three hundred irate doctors, nurses and managers at the London, each vying with the others to capture our attention and ensure that we favoured them rather than the others. We had to go away, of course, and think carefully through what was required.

Nick Timmins: That was to favour the London over Barts?



Leslie Turnberg: It was both, because the Barts people were there at the same time.

Virginia Bottomley: That's where the population is.

Leslie Turnberg: That's where the population is and was. One thing we did decide was to close the A&E department at Barts, which didn't create as much fuss as it did the first time around. I think they recognised that they only had 6,000 people living in the area, which didn't merit an A&E department, at the very least. That immediately meant that they couldn't run acute general services any more. The big problem with the London build which was being proposed was that it was huge. I think it had 1,300 beds and there had been no hospital of that size built, costing the amount of money that they were suggesting, ever. We felt that those were the bed numbers that were going to cope with the acute load of a very deprived part of the population of London. To put into that mix the specialist services, cancer and cardiac services, which were at Barts, first of all the number of beds would not be 1,300, eventually it became 900, and secondly, they wouldn't be able to cope with the load of clinical input from the local community and at the same time be able to provide those specialised services which were for the majority of east London and going out to the coast. We recognised that the port of call for east of the City, going right out to the coast was into Barts; that was the first major hospital that it would meet on the transport route. That was why we said we would like to see those particular specialised services kept at Barts.

Virginia Bottomley: Not if you came by car.

Leslie Turnberg: That is another matter. People who come to Barts probably don't come by car. The idea was that they would, at some time, if the Royal London was built and was big enough to

cope with those specialised services, we suggested that they could then move in. So there was quite a lot of hovering around what might happen at Barts, but we were known as the people who saved Barts.

Of the other hospitals we looked at there is one that I am particularly pleased about and that's Queen Mary's Roehampton, which we said should close and become a community hospital, and that is what's happened.

Virginia Bottomley: That's because David Mellor⁶⁵ was no longer there. You must understand the politics. He wouldn't let anybody touch it. The other hospital we haven't mentioned is the Homerton, which was a great success. Sorry, I didn't mean to butt in, but every so often there is someone in a particular role who is particularly impossible. James Goldsmith⁶⁶ effectively closed Roehampton.

Leslie Turnberg: It is a fantastic demonstration of what you can do in the community, because it has got beds for longer-term patients and rehabilitation, it has outpatient facilities, it runs clinics for specialists to come there and general practice. That is the sort of thing we should be aiming at much more around the place.

Nick Timmins: Was Roehampton part of the deal that led to Woolwich? No.

⁶⁵ David Mellor was Conservative Member of Parliament for Putney, 1979-1997.

⁶⁶ Sir James Goldsmith (1933-97) was a Eurosceptic businessman who in 1994 founded the Referendum Party, a single issue party favouring a UK referendum on membership of the European Union. In 1997 Goldsmith stood for election as Referendum Party candidate for Putney, and although he won only a small percentage of the vote this split Conservative support, allowing Labour to defeat the sitting Conservative candidate, David Mellor.

Chris Spry: I am Chris Spry, I was the regional general manager at South West Thames when Tomlinson reported and went on to be regional director of South Thames when the regions merged in '94 and stayed there till '96. Queen Mary's Roehampton is a very interesting little case study. Tomlinson didn't really say very much at all about outer London hospitals. He referred to flows and so on, but he didn't really address the issue about whether they were viable and all that sort of stuff. Certainly, as far as I can recall there was no mention of Queen Mary's Roehampton in Tomlinson itself. What Tomlinson did was to sow some seeds; the work he initiated looking



at specialised services. Queen Mary's Roehampton had plastics and burns, and that was the thread that started to pull at what was intrinsically a non-viable general hospital. I remember vividly a meeting at Virginia's office – we used to have regular meetings around that table in your office and agonise about how this or that was being handled. Brian Mawhinney was there, Virginia was there and it must have been just before the election or something – a by-election or a general election – and I remember Brian Mawhinney insisting that Queen Mary's Roehampton be kicked into the long grass. We at the region had advocated that something needed to be done about it, it wasn't viable, and so on. He was insisting that it be kicked into the long grass, but of course there is an underlying current of change, which you can't really turn back. What really broke the back of the Queen Mary's

issue in the end was that it was a very dilapidated, run-down hospital site with very poor plant, and they had capital aspirations. As a regional health authority we said 'no', we were not going to sanction a capital investment programme, and we started to talk to them about their becoming an ambulatory care hospital. There is a point here about gestation, those conversations had started some few years before, then by the time Leslie comes on the scene, people locally had got the message, and the change was very locally driven, actually. The vision for what to do about it came from local people being confronted with the reality that they weren't going to get a gin palace and therefore had to think of a plan B.

Leslie Turnberg: We realised we were pushing at an open door.

Robert Creighton: Chris makes two separate points, which I was going to see if I could pick up at some point. One is, and I shall be quite careful because this is all being recorded and made public, and I say it because Graham Hart won't want to, one of the things that he and I and, indeed,



Virginia herself had the greatest difficulty with was managing her colleagues in her Department. She had Brian Mawhinney, who was very, very, very intensely political and whose typical Mawhinnian remark was, if there is no political benefit, just forget about it; the blessed Tom Sackville,⁶⁷ who was utterly charming but often quite semi-detached; and Tim Yeo,⁶⁸ who I think kept out of this as much as possible, didn't he? And then there was Julia Cumberlege, who was deeply loyal. Managing that group of people was an occupation that took up a lot of my time and energy and, I should imagine, Graham's too. That is one point. The second one is from a completely different perspective, having later on gone on to become chief executive myself in Ealing. The point Chris makes about there being almost no mention whatsoever of outer London in Tomlinson resonated enormously when I got out there and I realised just how totally unregenerate outer London turned out to be. There was a lot of investment in LIZ in the central part and Peter's point about transforming local primary care in relatively east-End-ry areas, yes, I can see that. When I got to Ealing 40% of the GP practices were still single-handed and in terraced houses. There was no ground on which to build a future there and it still is, unfortunately, pretty unregenerate too. There is one final point that I just wanted to throw in here, mentioning names, because one name hasn't come up here. The most reviled – note the pun - the most reviled name in our fourth floor at the time was Jo Revill, who was the reporter on the *Evening Standard* who, under the auspices of her editor, ran the most excoriating series of articles.⁶⁹

Bob Nicholls: Some of us know why.

⁶⁷ Thomas (Tom) Sackville (b.1950) was Conservative Member of Parliament for Bolton West, 1983-97; he was Joint Parliamentary Under-Secretary of State at the Department of Health 1992-95.

⁶⁸ Timothy (Tim) Yeo (b.1945) has been Conservative Member of Parliament for South Suffolk since 1983; he was a junior minister at the Department of Health, 1992-93.

⁶⁹ Jo Revill (b. 1963) joined the *Evening Standard* in 1987; she was later health editor, then Whitehall editor at the *Observer* (2002-8), then communications adviser to Alan Johnson (2008-10). She worked briefly as media director at GlaxoSmithKline, became Communications Director at London Councils in 2011 and joined the Royal College of Surgeons as Chief Media Communications Officer in 2012.

Robert Creighton: Possibly so. I remember the amount of time we spent in wondering what to do about Jo Revill, who is a perfectly nice person, actually – she is now at London Councils. And a good friend.

Nick Timmins: Right. I will claim one tiny piece of credit here because when Frank brought Barts back on the pitch I had just started at the FT, the City paper, and I remember having a conversation with the editor saying ‘I am not going to campaign to save Barts, I don’t care what these people say to you. The decision has been taken to close it. It doesn’t matter whether it’s right or wrong. It’s part of a bigger picture. You should not go there.’ And to Richard Lambert’s credit he just accepted that.⁷⁰ So at least the FT wasn’t trying to cause too much trouble. I might pick this up a bit later, but if I don’t, remind me. Chris, you were talking about services. I want to come back to that at the end, as opposed to institutions, and whether that has moved on. I suppose we are starting to move to what we might learn from all this and where we have got to now.

Graham Hart: I am Graham Hart. A lot of this discussion, always, in these circles is about the difficulty of making change, and it’s inevitably tied up with politics. I would just like to say about what Virginia said earlier, that ‘I’m not political’, or ‘I wasn’t political over this’. She was political over this in the sense that she was trying to make change in a democratic constitution, and that is a political act. We don’t do our politicians a service if we assume automatically that being political about change in the health service is to obstruct every change that might conceivably have some impact on you or your constituents. Not all politicians behave like that, actually. I believe, if you take a long view of what has happened in the health service in London and in the rest of the country over the last 50 to 60 years, it is nonsense to say that change doesn’t occur; it occurs all the time,

⁷⁰ Sir Richard Lambert (b.1944) was editor of the *Financial Times* from 1991 to 2001.

against the grain sometimes. It is very difficult, there are some no-go issues – okay, that is fair enough – but if you just look at the configuration of services and how they are provided now, compared to even 20 or 30 years ago, they are very different. I think it is very significant that one of the points that struck me in this discussion was that it does seem to have been rather easier – nothing's easy, but rather easier – to make change in the medical school and university world than it was in the NHS world. That might not be unconnected with the fact that, public institutions as they are, the university and the medical school are not directly accountable to Ministers or answerable in Parliament, in quite the same way, at any rate, for what they do. If important people, senior medics and all the rest of it, in the university and the medical school come to a view, it might not be very easy, but if they come to an agreement that they want to change something it may be rather easier for them to do it. They have to raise money and all the rest of it, I understand the difficulties, but it may be rather easier for them than for the health service and they have shown us the way in a way that I think is very instructive.

If I could just come on to how change can be facilitated, it does seem to me that it's getting easier, because although things are becoming, in one sense, more political – there is more debate, there is more exposure in the press, more debate in the media and all the rest of it – which makes things difficult sometimes, it does also help to change public opinion, and public opinion can change. If you explain to people that the reason that if you have a heart attack in Lewisham High Street you are no longer taken to Lewisham Hospital, which has got a big A&E department, you are taken to King's, and why that is so and how the outcomes are going to be a lot better because of the way services are configured, people can see the point. It is wrong to say you can't change opinion. If I can say one last thing – sorry to go on, Nick – we have been saying a lot about teaching hospitals. Because I happen to live in south-east London I've had a bit of involvement with what's been going on there with the South London Trust and all the rest of it and even there, there has

been change. A nonsense has been created, that is true, in that mega-trust which was burdened with these massive PFIs – and they are quite unconscionable, these PFI debts that they have – but there has been change there and there will continue to be change in south-east London, mainly at Queen Mary's Sidcup. The driver for that has simply been that the service there is not safe. The doctors know it, the doctors have explained that and some quite big changes have taken place at that hospital to the benefit, I believe, of the public. So the message to the politicians and to the leaders of the healthcare system, if you like, is that we have to focus, as others have said, on outcomes, on quality, on showing how it can be better and trying to get away from the idea that it is all about cuts.

Nick Timmins: Can I just bung in two thoughts you might want to mull over? I might be completely wrong, but it strikes me that one of the big difference between now and the mid-1990s is that there is much more outcome data, so you can actually begin to say whether a service is safe or not – that absence of data that plagued Tomlinson early on has got much better. Secondly, in reshaping services; people are now talking more about reshaping services rather than closing hospitals. That changes the nature of the discourse somewhat. The classic example is stroke in London, when you say, what we need to do is change the service and that has a knock-on effect, rather than, we have to close Barts, or we have to close ... It is just a passing thought.

Virginia Bottomley: It is about health literacy. With schools, people know that one school delivers better results than another. I might have, or we might have had information available with an indication, but people weren't really ready then for the idea that different service provision produced different outcomes. I think that has been a dramatic change in 20 years; I totally accept that.

Nick Timmins: Geoffrey then Cyril.

Geoffrey Rivett: I am rather scared about the ‘big ideas’. When I came into the Department way back in ’72-73 the big idea was strategic planning. That went down the plughole. Shortly after that the thing which was going to sort everything out was the market, with Kenneth Clarke saying how great it would be handling hospital closures when the hospitals were so awful that everybody wanted them shut and were already going to others. So we moved on to another concept. More recently we had the Darzi concept and there are two angles to that. I won’t talk about Darzi health centres – I’d like to know what people feel about them, but the involvement of clinicians and the clinicians driving things I think has achieved quite a bit. More recently we’re seeing a whole series of huge mergers, not just in London, outside London as well. Already in one case in south London we can show that they don’t deliver what was predicted. The next big idea is outcome-driven reconfiguration – okay, we have these series of ideas, and perhaps there will be another good idea which will solve everything coming over the horizon in two or three years’ time, but I think we ought to be careful not to be carried away by the idea of the time.

Cyril Chantler: I agree with that, but it is the context that matters, not just the idea, because an idea can work in one context and not in another and the context can be temporal as well as geographical. I agree with everything Graham said. I think it is absolutely right and it’s interesting to reflect that since I got interested in health policy, which was 1989, I suppose, 1985, it seems to me that Governments of both parties have tended to move in the same direction, which is, to a greater decentralisation of the organisation of healthcare within the National Health Service and I absolutely approve of that, not least because I have had the experience of being in effect the chief executive of a hospital and dean of a medical school, and while both roles have their interests and challenges, it is easier dealing with the Higher Education Funding Council as a semi-independent organisation than with the political pressure of managing within the National Health Service. I also sat on Ara’s review

Making London Better and the report in 2007. One really good idea that came out of that was for stroke and it just shows that organising things centrally works in some contexts but not in others, so our notion was to localise wherever possible but centralise wherever necessary and I still think that's a reasonable maxim.

Where we failed, and we failed after Tomlinson and Lesley's report, is not actually really concentrating our effort on improving primary care. I have no doubt whatsoever that when we first met as a group of 30-odd clinicians under Ara's leadership for the London review it was quite clear to most of us that the real problem in London was primary care and the solution was primary care and we needed to help primary care skill-up, both in terms of its own skills, in the access of specialists to work with their colleagues in primary care and in the facilities, the kit they get to work with. It is extraordinary what we put up with in this country, that you can go to your GP for a blood test, have to make an appointment for the blood test and then have to wait a fortnight to go and get



the report which says, the blood didn't work, you've got to have another one. I am talking about a recent case study, by the way, and remember, I am a patient these days. So finally, six weeks later you may have the opportunity

to go and talk to the doctor about a result, something which my son in Paris would get done in two or three hours. These are things we've got to put right. Darzi health centres, Boris clinics, polyclinics, call them what you will; I'll call them anything as long as we get the investment to

achieve them and to achieve much better community hospitals in localities in London to promote and to improve healthcare. If we do not reinvent London Implementation Group and support for that we will not actually solve the problems of the poor outcomes for healthcare in London or, indeed, I think, improve the health of Londoners. It is actually crucially important, so I think we need to gird our loins to have another attack on that.

As for the outcome of Tomlinson, in terms of the universities I think it has been very positive. I suspect our medical schools are now too big and they need to be reduced in size to the benefit of undergraduate education but, putting that to one side, I think it has worked well. I think the hospital rationalisations are moving forward in a sensible way. I can talk about where I work at UCL Partners, liver disease is now concentrated at the Royal Free, transplantation is concentrated at the Royal Free, neurosurgery no longer takes place at the Royal Free, it is all at the National, ENT is moving to the Euston Road. We are now involved with Barts and the London, because they are part of UCL Partners, cardiac services will be concentrated, I believe – it is moving in that direction – on the Barts site, the PFI does not open for another 18 months and in the meantime cancer services will be concentrated at UCLH. So these things are all happening. Barts is now responsible for Newham and for Whipps Cross, so that is coming into that fold, and, of course, there are all sorts of hospitals in that part of the world that I never knew when I was a registrar at the Queen Elizabeth on Hackney Road. Six of the hospitals I used to cover in 1967, when I was a registrar, have closed and nobody has worried about that because the population knew they were going to get better care. I remember being the registrar at the women's hospital, the Salvation Hospital on Upper Clapton Road; it was a lovely hospital but one remembered Aneurin Bevan: 'I'd rather survive in the altruism

of a large hospital than expire in a gush of warm sympathy in a small one.⁷¹ So I think this report and its outcomes have been generally positive but there's much more to be done.

Nick Black: I want to pick up Geoffrey's point about serial panaceas. Of course they go back before 1948; they go back 200 years through the history of hospitals and healthcare in London. Geoffrey, I think the one we are now riding on the wave of - the market has, as you say, been forgotten to some extent - is outcomes. We are going to drive it all through outcomes and maybe through the academic health science networks and so on. I'm an optimist and I hope this works. After a lifetime of working in outcome measurement, this is great, this is my time. On the other hand areas in which I think outcomes will be effective, and already have been, is something like stroke services. There, we know that if we create eight hyper-acute units, people having strokes will have better outcomes. Outcome data doesn't necessarily help determine where those units are located. We can see that most vividly at the moment with paediatric cardiac surgery, where we know we should have seven, or whatever it is, units in the country but that hasn't actually solved where they should be. Very interestingly, in all the reviews, the judicial reviews and so on, nobody has looked at the outcomes. In fact, ironically, some of the units to shut actually have better outcomes than the units to stay open. That is a defensible position, because you can move staff, but we have to be careful - if outcome is the new panacea, it may help shape the overall service, but the battles about where, the locations, are inherently political, will continue to be political, will involve politicians, and quite rightly.



⁷¹ Hansard records this quote, from the Third Reading of the NHS Bill, 30th April 1946, as 'I would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one.' 422 H.C.DEB 5 s, col 44.

John Bacon: During the period we are talking about I was a relatively junior artisan, trying to implement a lot of this. As a product of Turnberg I did end up as head of NHS London for a while and was involved with trying to sort some of these things out. Trying to make an assessment of how successful or otherwise this sort of thing is is very difficult because you get a series of events that follow it and you don't know quite what would have happened had *they* not happened. Also the problem is that things aren't sustained. To take general practice as an example, LIZ did some good stuff but it wasn't sustained. I would argue that general practice in London now is not hugely better now than it was when we started; indeed, you could argue whether conventional general practice is the right model for providing primary community care in London at all. Similarly, with a lot of the major changes, what we then got in the late '90s and early 2000s was a massive investment in infrastructure, both in the teaching hospitals and in the peripheral hospitals. I know, because I did most of the PFIs, for my sins. All my fault. So it is very difficult to disaggregate each part of this set of changes over a 20-year period. One thing I would say is that if I was to draw one thing out of this that has been really successful and for which we owe huge gratitude, it is the establishment of the research institutes and the reconfiguration of the teaching pattern, because that bit, I think, has been sustained and a product of that is that we now have two or three of the great biomedical research institutes in the world in London. I don't think we would have had that had we not had this report.

Malcolm Green: A point and a question. My point is, Nick, the outcomes for pediatric cardiology were published this week in that important medical journal *Private Eye*⁷² – I don't know if you read it? My question is on a completely different topic: to what extent is the difficulty in changing general practice due to the fact that each practice is an independent, self-contained, for-profit contractor?

⁷² *Private Eye* is a fortnightly satirical magazine, published in Britain since 1961; its column 'Medicine Balls', written by the GP and comic Phil Hammond under the pseudonym 'M.D.', regularly features critical commentary of the NHS and supports whistleblowers.

Nick Timmins: Which we will reflect on. One back there and then Tony.

Peter Simpson: One or two of the things I think we've skated over when we were talking, for instance, about information is the tremendous effort that goes into misinformation when the chips are down. I hope you won't mind my quoting a couple of examples. Attempts were made in south-west London to say that the specialist hospitals were extremely busy. They counted all the patients who were in the tamoxifen trial that made the place look as though it was all abuzz. If you'd spoken to the radiotherapist who'd moved from them to the Charing Cross, he said, don't look at that, look at the number of people having radiotherapy – you'll find how few there are and that'll give you an idea of how little actual work they're doing. That's what comes, I think, out of personal conversations that actually help you to put the pattern together. In the same way, the personal conversation could lead to interesting opinions from very important colleagues at the Hammersmith about whether Colin Dollery was serving the hospital well. They weren't any too pleased about his turning his back on cardiology; they thought that had been a major mistake and they thought he might do the same in terms of their position in London. They were very worried, because of the fashions that Geoffrey Rivett mentioned, because of the fashions that come and go in terms of individual specialties – just a couple of famous cases and all of a sudden you're at the front of the queue. Also, I must say, the fact that the politicians may only be there for a couple of years and the next person, even of the same party, may have different priorities, meant that when you said, 'Have you thought of moving the Hammersmith? Who wants to be chucked in beside a prison and a railway line?' and they say, yes, we don't want to be here, but how can we believe that someone, if we were going to move, would put ten years of effort into making that a reality? How would they keep to the cause and how would they keep finding the money? And we have to look up the road at Northwick Park and say, dear me, wasn't that a hell of a shame?

Nick Timmins: Someone said that one of the problems was that the investment – the LIZ investment, the LIG investment – in primary care was not sustained. A lot of heads nodded at that. Why not? What prevented that happening? In a sense it comes back to Malcolm's question – why?

Matthew Isom: It's not sexy. Big hospital building is huge for politicians; they can say 'I built that in my constituency'. That's a huge issue. If you say, I'm sure Tony would agree with me, 'We've just built a couple of GP surgeries, we've just put a couple of extensions on', well, who cares? It doesn't make a big splash in the media, it's not a huge issue, I don't think.

Nick Timmins: I fully accept that, but it's much less capital intensive. It doesn't stop you doing it, so to speak, below the radar of the sort of things that people like me write about.

Matthew Isom: Health authorities are totally obsessed with deficits – I'm sure the gentleman sitting in front of me would agree with me – they are obsessed with the deficits that their hospitals create and they often rob the money that is used and identified for primary care to plug those deficits, so you never get the capital investment that you need.

Nick Timmins: Robert Creighton, then Bob Nicholls and Brian Jarman.

Robert Creighton: I'm going to speak from my experience as a PCT chief executive with the answer that, in the first case, there has been massive investment in primary care. The GP contract of whatever year it was, 2002, resulted in a massive influx of finance into primary care, but not necessarily into premises. It went into the existing pattern of primary care, not a changed pattern of primary care. Having spent ten years at a PCT trying to change the pattern of primary care, I feel

hugely relieved that I'm no longer banging my head against that brick wall. It has a range of different issues, one of which is that the levers are incredibly hard to manipulate and the second is that there is a very difficult planning system in this country. We fell foul on several occasions, not anything to do with the health service but planning arrangements. It is very creaky, hugely creaky and incredibly hard to get any kind of 'liquidity'.

Nick Timmins: Can we go to Peter Coe and then to Bob, because the microphone's over that side?

Peter Coe: I'll just make a quick comment, if I may, that having spent the last seven or eight years within the world of optics, opticians actually don't get the benefits that family doctors get, but if you talk to Mary and Doug Perkins⁷³, who developed Specsavers, they will tell you how to create a primary care facility which does repay its capital investment very fast and which allows for the fickle public who can go to whichever optician they want to at any moment. And they are incredibly successful. It is not so totally different: there is a lot to be learned. It is not all to be learned, but we need to learn and there are models in this country from which we can learn, and there are models abroad, but certainly, if we look at pharmacies and opticians we will see a different model which has some advantages.

Bob Nicholls: In the short term, why wasn't it sustained? Because we failed, we all failed to get the money out of the acute. That was the short-term reason for not sustaining it. Longer term, I am interested in Robert's point; he is much more up-to-date than me, but I saw a depressing graph recently that shows nationally – I am sure it is true in London as well – that that graph that shows how much money is going into hospitals and how much is going into primary and community care

⁷³ Dame Mary Perkins (b.1944) and her husband Doug established Specsavers in 1984; this subsequently grew into a large privately owned chain of opticians with outlets in both the UK and overseas.

hasn't really altered. Every generation says, the problem is that we haven't put into primary care, but we don't actually do it. Then someone, I can't remember who it was now – said, I'm not sure that the old model of primary care, we had the thing about property prices – would a GP be able to afford London – is this the right model? I'm glad you mentioned optical, because I'm now pharmaceutical. It is interesting that Leslie thought that GP fundholding, maybe clinical commissioning groups, might have the key to making...

Leslie Turnberg: Might.

Bob Nicholls: Might. My worry is that there is a conflict of interest, clearly, so you have to keep the primary care contract with a national commissioning board. Hang on a minute – you have to keep the pharmacy contract with a national commissioning board. Where is all this happening? Locally. If you believe in local and you believe in clinical commissioning groups you would actually say, you have the money, there must be Chinese walls about conflicts of interest, but then you might start changing how services are provided because the customers, if you believe in markets, would go to the optician, would go to the pharmacy in the high street and might not, for many things, bother with the GP. That would be a cultural shift. My last point while I've got the mic, and I think Ainna made it very well, is that I suspect, and Lesley, I think, hinted, reports don't change hearts and minds and even though there were top-of-the-office, academics, good clinicians – with one or two exceptions that seem to have been mentioned a lot this afternoon – generally in agreement with King's Fund and with Tomlinson, actually that didn't convince the punters and therefore the *Evening Standard* and therefore the politicians. There is a sequence. Darzi, I thought, was beginning to crack it, but then it was held up, as Tony said, by politicians anxious to win the next election. Generally,

we are not good at explaining and educating the public understanding. Actually it should be better with real outcome measures – I’m reasonably cheered that that might happen.

Nick Timmins: If I could just come in, I find it remarkable that when we rebuild general practice we just replicate it. If you go anywhere else in the world it looks different. They rebuilt my surgery relatively recently: it is just a replication of the old one in nicer premises. There’s no bloods, there’s no ultrasound – if you walk into anywhere in the States that is all on the doorstep.

Brian Jarman: I want to take up that point, which is serious. We have an adjusted death rate which we measure. I have done it in ten countries around the world and the effect, there is a double adjusted HSMR between some countries and others. Countries which have the high levels, and the highest is England and some of the lowest are places like France and Singapore, the ones where you don’t have to go to the GP first, where you can do as Cyril was saying, you can go straight and get your blood tests done. You need to put the money in and perhaps competition is the way to do it. You should be able to walk to the GP, have your ears syringed and your bloods done the same day and the mechanism for doing it is there and someone needs to do it. Simple. The other point I want to make is about what Malcolm and Nick said – why do pediatric cardiac surgery outcomes have to be published in *Private Eye*? At the Bristol inquiry, when they were published, they dropped from 29% to 3.5% within three years. The data to do it has been better since then; why do they have to go to *Private Eye*? That is measuring outcomes. Really, I think they actually relate to these things, you do have to actually set incentives. You say, this practice has got to deliver these things. I’m thinking of the Bristol inquiry, and I gather the Mid-Staffs⁷⁴ inquiry which I’ve been involved in a bit, the only

⁷⁴ In 2010, the Secretary of State for Health Andrew Lansley announced a public inquiry into Mid Staffordshire NHS Foundation Trust following serious failings in emergency care; the report was published as *The Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC*, in February 2013.

thing that has really driven that and improved it are patient groups – in fact, Julie Bailey and Cure The NHS.⁷⁵ What has the medical profession done to improve care? Nothing. You tell me anything. What did the Royal College of Surgeons do in Bristol back then? We need to develop outcomes...

Nick Timmins: Well, cardiac surgeons published their death rates, their outcomes, and that's what drove ...

Brian Jarman: They don't publish adjusted outcomes and they don't publish pediatric cardiac surgery outcomes for units. At all. They were published for Bristol; now, for units, they've been done in *Private Eye*.

Nick Timmins: Martin, we're drawing towards the end, is there anything I've not drawn out that you desperately want out of this?

Martin Gorsky: One of the things that interests me, comparing not just Turnberg but also the later King's Fund report is that public opinion and responsiveness to localism has become a much bigger issue. One of the things we haven't quite got to is whether that turning point occurred within this phase, in thinking about the public reaction to Barts and all that issue and so on. It's much clearer in those two reports, there's a much greater focus on that, and then, of course, going forward into the early Blair period there's a much greater interest in some new forms of patient/public involvement. I wonder whether that is something that we could also locate in this period?

⁷⁵ In 2007 Julie Bailey established a campaign group, Cure the NHS, to lobby for a public enquiry into care at the Stafford Hospital, following the death there of her mother Mrs Bella Bailey (1921-2007).

Virginia Bottomley: I make the small point that you'd never see an MP or parliamentary candidate have a newsletter or leaflet which didn't talk about the health service. That's the price, the penalty, the privilege of the health service. It's inconceivable that they would not discuss the health service and their local hospital: that's just a burden you have to accept. But I do think there is a growing sophistication. One of the great things about Governments changing is that when you're in charge you've got to do something about problems. There's quite a lot to be said for a bit of changing about on these things. I also think that the people are becoming more sophisticated about how they regard health. The whole Blair thing was about the focus group. It was much more sophisticated. I remember, Graham, I don't know if you remember, but I wanted to use MORI and have some leaflets delivered about London and you said I couldn't.

Graham Hart: Yes, I remember.

Virginia Bottomley: I went to Robin Butler⁷⁶ and said, 'Look, like anybody else trying to achieve a great change, I should have a budget for educating people on what these changes are about'. That was vetoed because it was 'party political'. Robin said, 'Well Virginia, the things you don't like in Government are the things you'll most appreciate in Opposition'. Now I'd say to him, 'Ha-ha'. It's part of the same story: there are now more resources for the health service to explain their



⁷⁶ Baron Butler of Brockwell (Robin Butler) (b. 1938) was Cabinet Secretary and Head of the Home Civil Service from 1988 to 1998.

story, almost certainly, and people are becoming more educated about what's required. I think lessons have been learned. It's never going to be easy. I'm sure the story about Mawhinney and Putney must have been just before that close election when Mellor lost his seat. If you run the Royal Mail, the people involved need to understand – don't announce 100 post office closures in the run-up to an election. It is the same with railways. The health service loves special pleading, saying, we uniquely suffer in this regard, but I suspect that there many utilities and government-regulated animals that have to abide by similar conventions.

Tony Stanton: I would like to make a plea for a touch of reality here. I take the point about the uneven pattern of delivery of primary care still, but I would say that in the 20 years that I was, not because I was, in office, I observed a general improvement of standards and I think there are many practices which are totally transformed and where the services that Cyril mentioned would be readily available on the day. The question one really has to ask is, why can I not get those tests? Often it is because of decisions taken by NHS management in general, rather than the specific practice. I think you have to be honest about that. The second is that there are still grave difficulties in dealing with serious faults. When I was first in post I discovered that the then Secretary of State, who is with us, was about to open a surgery extension in a part of London and I took the trouble to ring her private office and said, this is a very dodgy doctor and if I were you ...

Virginia Bottomley: Was this in Dulwich?

Tony Stanton: It was, yes.

Virginia Bottomley: It was.

Tony Stanton: I would not allow your Secretary of State to be photographed too closely ...

Virginia Bottomley: I knew the moment I got there. Very close relationships with the pharmacists, dodgy. I was completely traduced and beaten up by the local MP when I was there, who should have known better. It was shocking. I remember the whole thing.

Tony Stanton: It does take a long time to deal with those sorts of problems. I think it took 14 years before the GMC⁷⁷ finally dealt with him. I would have applied Stanton's test, which is, would you go there a second time if you were a patient? Would you go back again? And the answer was frequently, no. But I think there has been improvement and I don't think we should forget that.

Nick Timmins: Chris Spry, we had a brief conversation in the break. You've seen London, you've seen Newcastle, you've seen Glasgow; you've been involved in these big changes in three different places.

Chris Spry: Throughout the whole of this I have been reflecting on the similarities and differences between London and some other big cities. You mentioned that Bernard Tomlinson had been in Newcastle, and so on. It is worth bearing in mind that both Bob and I had experience of Newcastle. If you go to Newcastle now the new, rebuilt RVI has just completed and Newcastle General Hospital closed last year or the year before, I can't remember which, but the gestation period! Bob had grappled with the three hospital configuration way back in 1979.

Bob Nicholls: Unsuccessfully.

⁷⁷ GMC: General Medical Council.

Chris Spry: Unsuccessfully. I have to say, I had no greater success, but the gestation of change - in years - to get complete reconfiguration on the ground and open, you're talking about 30 years. Glasgow is the other city I've got experience of. Glasgow had six big acute hospitals for a population of a million and only needed three. There'd been two previous big attempts to sort it out, both had crashed into the buffers; a third go was then had in the mid- to late-1990s which got political approval in 2000 and the reconfiguration will be complete in 2015, I think it is, in terms of bricks and mortar on the ground. So, there is a place that, in a way, had everything going for it; didn't have all the organizational complexity; it was a single health board with a single focus; all the conversations could be conducted in quite a tight way, et cetera – none of the complexities you see here, yet even there that process of change took 30 years. With Tomlinson, we have been talking this afternoon about a window of four years between Tomlinson and Turnberg. I think the point has been made before, the three great achievements of Tomlinson in that window of four years were to give accelerant to the academic and research side, which has been of tremendous benefit; secondly, to set the hare running on looking at specialization, and we are still seeing the reverberations of that; and thirdly, he did succeed in injecting some energy into the primary care situation. Now, you can argue about whether that ran out of steam, and why, but the fact of the matter is that did happen and it did result in some improvements. So I think that is worth reflecting.

My final thought is that in both Newcastle and Glasgow there was quite a long gestation period before the thing went political. That gestation period was about managers and clinicians, *local* politicians and sundry others – the RHA and so on – having conversations about 'what are the options, how do we do it?' They weren't secret conversations, they were relatively open, but somehow or other they never got into the political stratosphere. The difference in London is that all your gestation is done in the stratosphere – so right from the outset you've got all that big-p Politics

hitting you at the time when you're still gathering your thoughts, testing opinions and so on. I think that's a massive difference. We haven't got time, but the other interesting comparison, which I don't know enough about, but Leslie will, is with Greater Manchester, where you don't have the singularity of focus, the single driver, in a way, that Newcastle and Glasgow did, where you've got a lot of hospitals, an inner and outer and so on, but that is perhaps a story for another day.

Leslie Turnberg: The first three hospitals I worked in have all closed down!

Nick Timmins: One comment and one question and we will wind up. My comment on that is if you take Tomlinson as the jumping-off point, London has done quite well – it is only 20 years on and we have had some progress. Does anyone violently disagree with what Chris has just said? If not, that may be the moment ...

Virginia Bottomley: Quit while you're winning.

Peter Simpson: It doesn't necessarily take 20 years; so much depends on a significant figure locally. If anyone had been in Liverpool with Sir Donald,⁷⁸ they knew what impulsion could mean. A month of the medics' meeting in August and he was closing seven hospitals by December.

Virginia Bottomley: The interesting point in the commercial world is that they just get on and do it. They plan it all and they execute it fast. They give a bonus to the guy who did the horrible job and give him a nice job next. I don't know what the answer is but in the public sector the guys who lead

⁷⁸ Sir Donald Wilson (1922-2001) was chairman of Mersey and North West Regional Health Authorities from 1982 to 1995.

these changes go through hell and back. Sometimes they get cut off, or the rope gets cut on them as though it was never the Minister's fault anyway ...

Nick Timmins: Tesco is not democratically accountable. Can I just say thank you very much indeed to you all for coming. I hope you enjoyed it.