Conflict & Change

SPECIALIST CARE IN LONDON

Christine Farrell

A report of six meetings arranged to discuss the London Specialty Review reports

KING'S FUND

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

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FOREWORD

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This report is based on public discussions of the six specialty Reviews for London that were set up by the Secretary of State earlier this year. In the King's Fund we have argued consistently that Londoners should have a strong say in the pattern of their health services – they cannot have a responsible say unless they understand the issues.

Throughout the debates on London, we have been impressed by how the main commentators have sought to understand the complexity of the problems, and hence how high the level of debate has generally been. It would be easy simply to resist change, because NHS money is being switched from London to other parts of the country, and because many inner London hospitals are in danger.

Change is needed in London not simply to minimise the damage brought about by current financial policies, but to create a strong base for future development. The specialist Reviews all argued for a consolidation of specialist services on fewer main sites. Many of the members of the Review Groups (virtually all of whom came from outside London) will say that they were often saddened by what they found in London – not only that morale is disintegrating under uncertainty, but also that the London centres have, for a considerable time, been losing ground relative to the best elsewhere.

The public discussions which are summarised in this report enabled the conclusions of the Review Groups to be tested in an open forum. Naturally enough, attendance tended to be stronger from institutions that stand to lose from the Review Groups' recommendations than from those that do not appear to be threatened. So the comment was often hostile. There certainly are legitimate points for disagreement about particular institutions. Nevertheless the broad direction of change, and the models of care that we should seek to create, linking specialist centres with secondary and primary care in a 'hub and spoke' pattern, commanded general support.

Organising these public discussions at very short notice was a difficult task. I am grateful to Christine Farrell and Pat Tawn for undertaking it, and to the London Implementation Group and the leaders of the Review Groups for co-operating fully. A detailed list of acknowledgements follows. I believe that the resulting report is timely and will be useful.

Current events underline just how quickly the situation in London hospitals is spiralling downwards and could spin out of control. Many of the difficult issues that require decisions are now as clear as they are going to be in the short term. It is urgent that the Secretary of State announces as quickly as possible her decisions, which will not necessarily be the solutions recommended by the Review Groups, trust boards, health authorities, etc., but must address these same issues. The decisions must include how London is to move forward from here, including the financial and human implications. It is not merely a matter of finding intellectual answers to a complicated set of interlocking puzzles, but of ensuring that these answers can be implemented in the real world.

Robert J Maxwell
Secretary/Chief Executive Officer
The King's Fund

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The meetings and this report represent the culmination of effort by a team of people called together at short notice to design, organise and execute a difficult task. The assessors: Michaela Benzeval, Heather Bond, David Perry, Chris Smaje, Richard Smith, Albert Weale, Caroline Woodroffe; and, in particular: Clare Dover, Annabelle Ferriman and Richard Woodman, whose job it was to record each meeting and to draft a report. The small-group facilitators: Priscilla Alderson, Naaz Coker, Adam Darkins, Martin Fischer, Pat Gordon, Naomi Honigsbaum, Gordon McClenahan, Julia Neuberger, Gordon Peters and Angela Towle, who helped to make the afternoon group sessions so productive. Sean Boyle and Diane Plamping who contributed to the design of the days. Robert Maxwell and Jo Ivey Boufford who chaired three meetings each so effectively and contributed to the final report. Pat Tawn, without whom the meetings would never have got off the ground within the very short time scale. Hilary Sampson-Barry and Tracy Dighton from the London Implementation Group who helped in a variety of ways. The Review chairmen: Mr Thomas A Hide, Professor Sir David Hull, Professor Netar Mallick, Dr Christopher H Paine, Professor Geoffrey H Smith, Mr Phillip J Sykes and some members of their groups, whose excellent presentations provided a stimulating beginning to the days. The participants who presented their points of view and suggestions for ways forward.

The King's Fund acknowledges all these contributions with thanks.

INTRODUCTION

The King's Fund arranged six meetings to encourage public debate about the outcomes of the independent Reviews of specialty services in London. These Reviews were carried out following the inquiry into London's health care chaired by Sir Bernard Tomlinson. The Government's response, *Making London Better* (HMSO 1993), announced the setting-up of six independent inquiries into specialty services. The reports of these Review Groups – on renal, children's, cancer, plastic surgery and burns, neurosciences, and cardiac services – were published at the end of June 1993. The public meetings were organised by the King's Fund Centre and held there during the second half of July. The purpose of the meetings was threefold:

- to inform interest groups about the outcomes of the specialty Reviews;
- to allow interest groups to contribute to the debate about the outcomes;
- to allow interest groups to contribute ideas and observations to the process of implementing future change.

The report which follows contains a summary of each of the six days' proceedings together with an assessment of the balance of opinion expressed. In this way, we hope to inform the public, patient groups, health professionals and managers living and working in London; and to make available to the decision-making process an account of their views. Participants were invited from the following groups: clinicians (doctors, nurses and therapists) in each specialty; consumer groups and patient associations; purchasers and providers (managers); general practitioners; and the deans of medical schools. Invitations were sent to named individuals, primarily in the four Thames Regions but with a small proportion selected from other English Regions. Inevitably, within the time constraints, there were cases where the invitations did not always go to the right people, or reached them too late. We apologise to them for that. We did the best we could.

Between 60 and 80 people attended each of the six meetings. The balance between these groups – clinicians, managers and consumers – was almost equal on most occasions. There were few general practitioners and no deans. Each day had the same format, beginning with a presentation from the chair of the Review Group. This was followed by a brief question-and-answer session. Participants had been invited to make short presentations expressing their views of the Review which they did during the second half of the morning. Discussion and debate occurred between and after each presentation. In the afternoon, small groupwork focused on specific issues arising from each Review and these groups reported back to a final plenary session.

Because the meetings took place so soon after the Review reports were published, they provided the first opportunity for people to express their views in public. It was inevitable to some degree that representatives from the institutions that felt themselves most threatened, would outnumber representatives from hospitals which the Review had recommended for development as specialist centres and hence, those who attended, would be more critical and would present the case for their own institutions. The design of the days took account of this and the morning sessions allowed these views to be expressed. The small groupwork in the afternoon was designed to encourage participants to contribute ideas to the future planning and organisation of specialist services. This part of the day was particularly successful and produced many constructive suggestions.

The process of producing the reports which follow and the assessment of the balance of opinion expressed during the meetings was achieved with the help of three independent assessors who listened to the proceedings throughout the day. They met at the end of each day with the chair and organiser of the meeting, to identify areas of agreement and disagreement. These independent assessments have been incorporated into the reports and used to guide the conclusions and recommendations.

1
RENAL REVIEW

KEY ASSUMPTIONS UNDERLYING THE REVIEW

The aims and the thinking behind the Review Group's recommendations were presented to the meeting by its chairman, Professor Netar Mallick, Professor of Renal Medicine in Manchester.

The recommendations for the reorganisation of renal services in London were based on the need to plan for the long-to-medium-term future. Resource considerations and the principle of equity had directed the Review Group's thinking. Is it right that one third of the national resources for renal services is allocated to the Thames Regions which contain only one quarter of the population?

The epidemiological evidence indicates that there will be a substantial increase in the incidence of end-stage renal failure and reversible or acute renal failure in the Thames Regions. The current pattern of provision is not well placed to offer a cost-effective, high-quality service in the places where patients need it. There is good patient care at the centre, but uneven outreach services. A proliferation of transplantation services is not the most economic or effective use of resources and there is spare capacity in most dialysis units.

To overcome these problems, the Review Group proposed a concentration of transplantation, academic and expert nephrology services in five centres in central London together with the creation of five centres providing all renal services, except transplantation, in the shire counties. A network of satellite dialysis units attached to these ten centres should also be developed to provide services closer to patients' homes, with a middle ring of district general hospital (DGH) based services providing dialysis.

To achieve the best outcomes in terms of access for patients and concentration of expertise, the Review Group proposed that the five transplantation centres in London should be based on existing units at Guy's/St Thomas's, Charing Cross and Hammersmith jointly, University College/Middlesex Hospitals, St George's and the Royal London/Bart's Hospitals. All these units are closely associated with colleges of London University, an essential requirement for the development of basic scientific knowledge and research. The five non-transplantation tertiary units would be at three existing units in Brighton, Canterbury and Stevenage, and at two other sites. These units should have close service and academic links with the five university units in central London.

CHALLENGES TO THE ASSUMPTIONS AND PROPOSALS

Objections to the Review Group's findings came under four main headings:

- the merger or transfer of existing units and subsequent loss of experienced teams and good quality services;
- a reduction of services and purchaser choice, and a threat to competition which is the basis of the NHS reforms and the internal market;
- a loss of choice for new patients and stress for existing patients where their units have been identified for closure or transfer;
- the lack of data on outcomes, quality and cost to underpin the Review's recommendations for the designation of tertiary university centres.

Professor Rees, Professor of Nephrology at the Hammersmith Hospital, said that the Review Group had been extraordinarily successful in meeting its overall objectives. He believed, however, that the report probably underestimated the future prevalence of chronic renal failure. The data collected by the Group provided a unique resource which could be used for calculating the population demand for services for renal failure in and around London. Professor Rees felt that these data demonstrated the paucity of dialysis facilities for London. He agreed with the Review Group's recommendations to concentrate transplantation services in tertiary referral centres and with the dispersal of dialysis, investigation and treatment of less complex problems to sub-regional units sited in teaching hospitals, and DGHs and satellite units. He agreed also with the Group's recommendation that tertiary referral centres should be located in or close to institutions with a strong scientific resource base.

Dr Taube, Clinical Director at St Mary's NHS Trust, said that the report was flawed because comparative data on quality, cost and outcomes had not been provided. He also believed that its proposals would increase the cost of London's renal services without necessarily improving their quality. St Mary's was disappointed that it had not been designated a tertiary centre. The Review had ignored the fact that St Mary's has the largest renal unit in the North-West sector, performs the most renal transplants and looks after the most cases of acute renal failure in London. 'The creation of small numbers of large renal and transplant units will restrict competition and reduce purchaser's choice and power. The increased costs will inevitably be passed on to purchasers and may reduce services for patients.'

Dr Phillips, from Charing Cross Hospital, welcomed the report but said that it had underestimated workloads and could have defined the roles of the 'losing' hospital more carefully.

John Powell, Chairman of the National Kidney Association, said that all renal patients were concerned about what would happen to their services. This concern inevitably caused stress and worry. He felt that the Review Group's recommendations had been made on academic grounds rather than quality of service, and that patients' views of the service has not been taken into account. To support this belief he mentioned the specific case of the recommendation that the renal unit at St Helier's Hospital be relocated at St George's. 'This recommendation is farcical when St Helier's is the second largest unit after King's College Hospital, offers excellent services and has room to expand to meet the increased demand.'

David Poulter, from St Mary's Hospital Kidney Patients' Association, said that on 23 June the Secretary of State said that patients' needs should be paramount. He said the Tomlinson Report's recommendations had not been as widely accepted as the Government

had made out and that, during National Transplant Week at the end of July, there had been two demonstrations against the Renal Review Group's recommendations. He went on to say that the recommendation that St Mary's transplant unit should move to the Hammersmith Hospital was 'outrageous, totally against the interests of the patients and cannot be justified on grounds of cost or efficiency'.

Jacqueline Dowding, Vice-Chair of the Save Bart's Patients' Campaign, said the outcome of the Renal Review was biased and misleading. She mentioned the fact that Bart's had been targeted for closure and felt that this had influenced the Review Group's proposals. The report had not mentioned patients' care or choice, and had omitted to note two of St Bartholomew's Hospital satellite units. Other omissions in the report included the importance of nursing care and patient choice, community care, rotation of all staff and urea-kinetic modelling.

Rozanne Lord, Consultant Surgeon and Senior Lecturer in Transplant Surgery, emphasised the importance of listening to what patients had to say. Their need to get to and from dialysis quickly meant that transplantation could not be provided in as many centres as are necessary for dialysis. She referred to a point made earlier by Professor Mallick that surgeons working in small, hard-pressed units are on call around the clock. Apart from the poor quality of life this offered, it was no role-model for young doctors in training and would not attract the best doctors to the specialty.

Professor Raine, St Bartholomew's Hospital, said the service at Bart's met most of the criteria identified by the Review Group for a tertiary centre and offered a high-quality service. Nevertheless, staff at St Bartholomew's are in discussion with colleagues at the Royal London about the provision of a joint service. He made a plea for civilised local planning and resolution of problems to avoid distress to patients and loss of expertise. 'Some patients,' he said, 'have already had letters from purchasers saying they should transfer to the Royal London.'

Professor Moorhead, from the Nephrology and Transplant Unit at the Royal Free Hospital, said that the Specialty Reviews had had a destabilising effect on London services. They were poorly researched and lacked important financial and outcome data. The estimates of demand for the future were underestimates of the numbers of patients needing treatment. In respect of the recommendation to site the North-Central tertiary university centre at the UCH/Middlesex complex and the subsequent loss of transplantation work at the Royal Free, Professor Moorhead pointed to a number of problems including uncertainty and distress for patients and their relatives; the consequences for other transplantation programmes (i.e. bone marrow, heart, liver) and the substantial research programme already in existence at the Royal Free.

In response to these points, Professor Mallick replied that the Review Group *had* put patients first but because their terms of reference were to look to the long-to-medium-term future, they had made recommendations based on the consideration of the best model of care for future patients. The future may bear only a passing resemblance to the present. 'You must think into the middle distance ... there is bound to be tension about what we recommend and what people in their own parish face.' He referred to the epidemiological evidence in the report and emphasised that this indicated a growth in the need for transplantation and dialysis services. Some centres would lose transplantation services but would remain very busy centres. Outcome data are not often available and this is something which should be rectified.

Professor Mallick then asked Mr Graham Shipp, an independent consultant who had provided financial assistance to the Review Group, to speak about the information available to the Group. Mr Shipp described the nature of the requests for financial information which had been made to all the units involved and said that the returns they had received had provided inadequate data. There appeared to be little correlation between cost and tariff, and it had been impossible to come up with any reliable comparative cost data in London. The Review Group did, however, look to the provinces where good

information was available. The London Implementation Group (LIG) had been asked to take the costing exercise further.

Areas of consensus and disagreement

At the end of the meeting, there were some areas of general agreement among participants. They included:

- agreement that it is right to look 10-15 years ahead; that change would have to happen and that the five-sector analysis of London was correct. There was much less agreement about specific institutional recommendations within each of the five sectors;
- agreement that the epidemiological data in the report are useful for predicting future need and that the model should be used within the sectors for more detailed service planning;
- agreement with the model of care proposed that university-based transplantation tertiary centres in London should be linked to peripheral centres and an increased number of satellite dialysis centres, giving greater access to patients;
- agreement that outreach from London centres is poor and that it should be improved;
- agreement that outcome data and cost data are poor and should be improved, and that a greater number of staff would be needed to achieve this;
- agreement that research and teaching are essential to service development and future human resources and should be attached to tertiary centres, but uncertainty about whether it is feasible for all five centres to carry out research and whether undergraduates should be taught renal medicine in detail;
- agreement that the evidence for better outcomes from larger centres is poor or non-existent; (Note: This statement is correct in relation to central London but not so internationally)
- agreement that equity of access to donor kidneys is not achieved (London uses more than it harvests), and that co-ordination between units should be introduced alongside the development of better criteria for access to donor kidneys.

The future

A considerable amount of concern was expressed about the way in which the Review Group's recommendations would be used and the timescale within which decisions would be taken. A strong case was made for decisions to be taken quickly to avoid planning blight, the disintegration of expert teams and distress to existing patients. To some extent this conflicted with the majority view that decisions should be based on better quality information about relative costs and quality, both of existing units and the proposed larger, tertiary centres. There was considerable anxiety about fragmentation of services and loss of quality if decisions are delayed and the disposition of services is left to local purchasers.

2

CHILDREN'S SERVICES REVIEW

KEY ASSUMPTIONS UNDERLYING THE REVIEW

The aims and thinking behind the Review Group's recommendations were presented to the meeting by its chairman, Sir David Hull, Professor of Child Health in Nottingham. Children's services had been overlooked in the Tomlinson Report, but the Review Group had sought to rectify this omission.

Sir David said parents and professionals recognised that current hospital provision is inappropriately deployed, with too many hospitals in the inner London area. A 'model' tertiary centre for children's services in the future should offer highly specialised care for children with very rare or complex conditions. These centres should be based in hospitals where a full range of skills, knowledge and equipment can be drawn together with associated specialties. Sir David emphasised that services provided by these centres must reach out to the whole population.

Resource considerations had influenced the Group's thinking because it was clear that purchasers would receive lower budgets under the new capitation regime. Plans should facilitate the easier uptake of hospital services by those who need them most, but with the aim of admitting the child to hospital only when there is no other alternative. Areas of deprivation were of particular concern. At every stage it should be recognised that children are part of the family and dependent on their parents and all services should be provided as close to their homes as possible. With shared care, district general hospitals could provide out-patient and day care for many of the children's specialty services. This would avoid the children and their families making long, tiring and expensive journeys into the centre of London.

Tertiary services should be based at hospitals providing a full range of child health services for their local populations, including: accident and emergency service with a separate admission space for children; a paediatric medical service; a paediatric surgical service; maternity services with neonatal intensive care; paediatric intensive care; children's support services (teachers, therapists); a home nursing service; and a parent care approach. Links with a medical school, academic and clinical research are vital.

To achieve the best outcome in terms of access for patients and concentration of expertise, and given the size of the child population in South-East England, the Review Group recommended that cardiac services for children should have two or three specialist centres, but not including Harefield where children would no longer be admitted. Neurosciences should have two or three centres, nephrology two centres, oncology two centres and plastic surgery two centres.

The Hospital for Sick Children, Great Ormond Street, already offering the widest range, is proposed as one of the centres for each specialty. Guy's or St Thomas's Hospitals, depending on the site chosen, could become the second major centre with a full range of tertiary services. The committee had been very impressed by King's College Hospital and its

work with the local population, but Guy's/St Thomas's Hospitals were better placed for easy access from the south. Appropriate links should be forged between the tertiary centre and its associated hospitals, and the populations served.

CHALLENGES TO THE ASSUMPTIONS AND RECOMMENDATIONS

Challenges and concerns about the Review Group's assumptions and recommendations came under seven main headings:

- the destruction of existing units leading to loss of experienced teams;
- concern that the transfer of small specialist units will cause stress to families who fear their children will suffer;
- concern that the brief should have been wider, addressing a greater range of children's ailments;
- concern that more prominence should have been given to children's accident and emergency services at secondary centres, where children are still often being seen in corners of adult accident and emergency departments;
- concern at the absence of psychiatric and mental health services from the Review Group's remit;
- concern that viewing children as aged 0–14 left the picture unclear for older adolescents;
- concern that reorganisation should not be used as a smoke-screen to obscure the basic problem of cash shortages.

Professor Martin Barratt, Director of Clinical Services, The Hospital for Sick Children, Great Ormond Street, welcomed the Review, particularly for its insistence on standards of care for children. Taking stock of the issues which arise for Great Ormond Street, he said he had been 'saddened' by the recommendation that the Queen Elizabeth Hospital, Hackney, should be separated from Great Ormond Street. Accepting the severance, he strongly endorsed the recommendation that the Queen Elizabeth Hospital should be moved to the Royal London Hospital. He welcomed the forging of stronger links between Great Ormond Street and University College Hospital. The two would undoubtedly grow closer because of the need to link neonatal services, and the treatment of adolescents. 'Whether we will remain the same hospital remains to be seen.' He stressed the importance of monitoring the effects of changes as they took place.

Philippa Russell, Director of the Council for Disabled Children, expressed her 'enormous concern' over the impossibly short timescale for the changes and stressed the importance of getting the infrastructure up and running. 'Our key message is that we need to look at children's needs in the context of primary care. We need a comprehensive child health strategy.' Inner London had more disadvantaged children and children from black populations than any other part of the country. Planning must reflect the changing health care needs of children who would not have survived years ago but are now surviving, often with handicaps. The importance of continuity of consultant care was also stressed by her.

Edward Hurst, representative of parents of children treated at St Bartholomew's Hospital, emphasised their great satisfaction with the quality of care. He expressed fears that an excellent service would disappear, and that the quality of service for children currently treated at St Bartholomew's would decline during the transitional period. He asked for assurances that all current and future children suffering from cancer in London

would be treated in specialist units by teams of doctors with the same expertise as the consultants at St Bartholomew's; that as good a range of in-patient facilities for children and their parents be made available; that every effort be made to keep clinical teams intact and that the ward at St Bartholomew's would not be disbanded before an equally good facility was operational.

Dr Judith Kingston, Consultant Paediatric Oncologist at St Bartholomew's Hospital, said she thought it was good that children's services at St Bartholomew's and the Royal London Hospitals should be under a single clinical director. 'What we thoroughly disagree with is that there should be no tertiary paediatric services in the North-East sector. It is already a deprived area and this is wrong.' She registered objections to the Review Group's recommendations that the St Bartholomew's Retinoblastoma Unit should go to Great Ormond Street. 'Cancer of the back of the eye requires ophthalmology, paediatric oncology and paediatric radiology; St Bartholomew's is the only place in London with the three services on the one site. St Bartholomew's has a long tradition of treating ocular tumours in children and adults. We feel that the links with the adult oncology service are very important.' Definite improvements in survival rates had been achieved through experience. 'At Great Ormond Street clinicians have always referred their complex patients to us. Great Ormond Street does not have radiotherapy, and the Middlesex Hospital does not have state-of-the-art radiation.' Fragmenting services did not seem in the best interest of the children or their eyesight. Parents and parent representatives echoed Dr Kingston's concerns. Libby Halford, Regional Co-ordinator of the Retinoblastoma Society, said that retinoblastoma was a very rare illness. 'People who know about it are very few and far between, and are working at St Bartholomew's.'

Dr Carlos de Souza, Consultant Paediatric Neurologist with St George's Health Care Trust, said he had no argument with the majority of the recommendations, but there were some concerns for the future of children's neurosciences, particularly within the South-West Thames Region. These were currently provided in a tertiary surgical service at Atkinson Morley's Hospital which the Review Group had recommended stop admitting children once a neurosciences centre had been established at Guy's/St Thomas's Hospitals. Non-surgical neurology at St George's provides an exemplary outreach service to 11 or 12 hospitals in the Regions. Head injury cases would be sent to Guy's/St Thomas's or Southampton, creating a vacuum at St George's. It was preferable for Atkinson Morley's to relocate at the St George's site to become a regional neurosurgery centre.

John Price, the Care Group Director, King's College Hospital, emphasised the problems for paediatric services in South-East London and the need for specialties other than the five adult specialties covered by the Reviews, to be considered. He raised the question of whether clinical directorates should be responsible for both hospital and community paediatric services. Sir David Hull said that the British Paediatric Association and the Minister for Health supported this combined approach.

Mr Patrick Duffy, Paediatric Urologist at Great Ormond Street, described the report as 'a good one', but pointed out that changes in children's services would require additional resources. 'I would like to know where the money is coming from.'

Dr Michael Rigby, Consultant Paediatric Cardiologist at the Royal Brompton, spoke in favour of larger units. Outcome was likely to be mediocre in units handling fewer than 200 cases of paediatric cardiology. 'Tremendous differences in outcome have not been addressed.' Sir David Hull said that the Review Group had considered this.

Bill Alexander, Assistant Director of Planning, Croydon Health Authority, speaking as a purchaser, said, 'Pressure is increasing because there are more and more children who need home support services.' He was very concerned that the current purchasing situation was making purchasing more difficult. If block contracts were introduced, there should be no difficulty, and if not, an extra contractual referral should be raised.

Mark Whiting, Secretary of the Paediatric Home Care Nurse Forum, Royal College of Nursing, told how he had recently had an enquiry asking if it was possible to provide

outreach care for a terminally ill child. 'It was not possible and very sad.' He made a plea for family doctors to have access to expertise unrestricted by hospital boundaries. He said also that he was concerned that the lack of reference to paediatric community nursing and medical services in the Review report would be taken as an indication that all was well in this area. Unfortunately, this was not the case.

Dr Clare Goodheart, representing general practitioners from east London, expressed anxieties about the relocation of tertiary services from St Bartholomew's Hospital to the London Hospital, and dismay at losing the Queen Elizabeth Hospital from Hackney. This hospital serves a deprived area where only 40 per cent of the people have access to private transport. The proposed changes would decrease access for children and parents. The limitations of the Great Ormond Street site for development of accident and emergency services and extended services for the local population were mentioned. Fears were expressed that the pendulum in paediatrics was swinging towards centralisation.

During the discussion which followed concerns were expressed about the situation of small centres and the possibility of deterioration if their situation became eroded by uncertainty. As long as the future of small specialist teams is in doubt, there would be the risk of erosion by blight. Parents described children's cancer treatment at Bart's as a model of what the health service should be. Parents would expect any replacement to be as good. Concern was expressed about the risk of notes getting lost in the move and care suffering during the transition period. There were fears that an impressive network of services which had taken a century to build up, could break down during the process of change.

Attention was drawn to a number of other issues raised by the Review Group's report and recommendations, including:

- the difficulties for purchasers in placing contracts for packages of care which ensured continuity from home to tertiary services and between tertiary services;
- the difficulties of access to specialist services for deprived populations;
- the need for child health strategies which included all forms of care;
- the absence of psychiatric and psychological services from the Review Group's remit;
- the lack of information about the relationship between volume and outcomes.

Peter Simpson, Project Director of the London Implementation Group (LIG), responded to complaints that child psychiatry had not been considered by assuring the meeting that LIG would be advising ministers on what the next tranche of Reviews ought to contain. Mental health services would be included. He assured the meeting that primary care and mental health services were of considerable importance to LIG at this time.

Areas of consensus and disagreement

At the end of the meeting, there were some areas of general agreement among participants. They included:

- agreement that it is right to look ahead and that change is needed, but much less agreement about specific institutional recommendations, and whether there should be a wider overview crossing sector boundaries;
- agreement that tertiary care should not be taken out of the context of a holistic approach to the child;
- agreement that children need special attention, advocacy and to be represented in service planning;

- agreement on the model of care which extends from homes to tertiary centres, and includes secondary centres, primary care and outreach. There was less agreement on whether the model should be designed outwards from the centre or built up inwards from the periphery. This was based on the agreement that outreach care is poor and should be improved. The report's institutional recommendations did not always meet these principles;
- agreement that good teams should not be lost, that the transition process should be carefully planned and managed;
- agreement that purchasing strategies need to be developed and that the problems of referral between tertiary hospitals and from secondary to tertiary care need attention;
- agreement that access to care and links between health and social care are vital and should be carefully planned and developed;
- agreement that transitional arrangements for finance are urgent;
- agreement that areas of deprivation need extra resources.

THE FUTURE

There was considerable concern about the way the Review Group's recommendations would be used and whether it was possible to influence decisions on the relocation of some units and hospitals. A strong case was made for decisions to be made rapidly to avoid planning blight and distress to existing patients and their families. However, conflicting fears were expressed that acting too swiftly could cause added problems if the infrastructure and outreach services were not in place. There was also concern that children's services might not get the prominence they deserved in the context of other changes which would be taking place at the same time. It was felt that clinicians should have greater involvement in the planning process. The problem of purchasing care packages for children needed to be addressed and purchasing planned locally.

3
CANCER REVIEW

KEY ASSUMPTIONS UNDERLYING THE REVIEW

The aims and thinking behind the Review Group's recommendations were presented to the meeting by its chairman, Oxford cancer specialist, Dr Christopher Paine, and members of the Review Group. The Group's recommendations sought to achieve a more rational disposition of cancer services in London, to gain advantages of scale and to provide a stronger service and academic base for the future. The development of services on the periphery of London would enable more patients to be treated at local units.

The Review Group had looked at the range of cancer services including care in the patient's home, in district general hospitals, secondary care and specialist tertiary care. The challenge of the task had been to provide a co-ordinated framework for the whole range of services. Increased liaison, especially with primary care services, was seen as vital to earlier identification, treatment and improved outcome. The importance of good communication was stressed.

Existing cancer centres in London are small and the quality of care is variable. A 'critical mass' of at least 3,000 new non-surgical patients per year was considered to be the minimum in order to achieve effective treatment and care. The Review Group was not convinced about the merits of creating very large centres in London like the Christie Hospital in Manchester, where 10,000 patients are seen each year. In London, this would result in services being concentrated in two or three centres.

Purchasers should aim to set minimum standards for the quality of care. As much care as possible should be provided locally, but this implied careful planning and adequate resources. From the purchasers' point of view, there were poor data on performance and outcomes by providers, highlighting the need for improved data collection.

For cancer centres to be based in multidisciplinary hospitals was seen as the ideal, so as to avoid sick patients being shunted from one hospital to another and to achieve economies of scale. Specialisation would provide the best outcomes for patients, and there was a strong need to develop cancer sub-specialties. Comprehensive psychological and social support services were necessary to support patients. No single centre in South-East England is at present offering everything the Group believed could be reasonably expected from the NHS in the future and within present funding limits.

To achieve the best outcomes in terms of access for patients and concentration of expertise, the Review Group proposed that the major cancer centres should be the Royal London, Guy's, Charing Cross and the Middlesex/UCH Hospitals. The Hammersmith Hospital seemed just viable and undertook good research. The Hammersmith's future would depend on how the balance of purchasing patterns worked out, especially in relation to Charing Cross Hospital. A new unit should be created in Essex to avoid inappropriate redevelopments at Oldchurch and Colchester. It is envisaged that the Royal Marsden,

Sutton Branch, would be expanded to absorb some services from the Royal Marsden, Fulham Road. Other patients, now treated at Fulham Road, would be treated at Charing Cross. Mount Vernon would continue at about its present size. The North Middlesex could be expanded, or, if not, the possibility of a UCH rebuild or an extension of the Royal Free Hospital facilities should be re-examined. These centres should have close service and academic links with university departments.

Professor Mansel, Professor of Surgery in Cardiff and member of the Review Group, outlined the thinking behind the recommendations for surgical services. Ideally, treatment of common cancers should be carried out by local (DGH) surgical teams. These teams should have sufficient numbers to allow some sub-specialisation, back-up and regular on-site consultation with oncology specialists from the nearest cancer centre. Rare conditions should be treated in tertiary centres specialising in the relevant cancer. Close collaboration between cancer specialists and local centres is essential.

Loretta Tinckham of the Cancer Relief Macmillan Fund, who headed a sub-group reporting to the Review Group, stressed the importance of charting the cancer journey from a consumer perspective, so that each patient should have a 'map' of what to expect. There were excellent examples of patient support from voluntary and statutory services, but no single centre that had been visited provided the comprehensive range of support which was felt should be available to patients and their families.

Dr Elizabeth Murray, a GP, said, 'As the trend towards early discharge continues, patients will need more care in the community. Communication between different health professionals is needed. This is not happening.' The GP often had no idea what had been done or said in hospital, and the discharge letter would arrive weeks later. She suggested the use of electronic mailing and fax machines. Care in the community should not be seen as a cheap option. Use of minicabs or a hospital car service should be explored, to make it easier to travel to hospital for clinics.

Becky Miles, a cancer patient who had finished treatment two years previously, and who had served on Loretta Tinchkham's sub-group, said cancer patients should have a larger voice in planning services. She felt consumers should have had proper representation on the main Review Group. 'Because our service is so fragmented, there is a frequent breakdown of continuity and lack of care. It is so often the detail or the seemingly trivial thing that can break the spirit of patients and their carers ... A civilised service costs money, effort and co-operation, which seem to be in short supply these days. My own experience was not a picnic.'

Mike Bellamy, Chief Executive, Ealing, Hammersmith and Hounslow Health Agency and Co-ordinator of the Review Group, said that the main concern of the Group had been to ensure that cancer services are improved. One in three people will experience cancer at some point in their lives, but cancer services currently have less than 5 per cent of service spend. Care patterns are complex and co-ordination is essential. Much better data and information were required. The quality and extent of current services are variable and there was a need for a toolbox to help health authorities find out about quality of care. He went on to identify five priorities for health authorities' strategies for cancer care:

- prevention;
- information and education for GPs to keep them up to date;
- wider access to good practice which exists in many places but which is not shared;
- evaluation of cancer care in DGHs;
- the develoment of specialist units with links with a number of secondary hospitals.

CHALLENGES TO THE ASSUMPTIONS AND PROPOSALS

Challenges and questions about the Review Group's assumptions and recommendations came under seven main headings:

- the number of closures and, indeed, whether any closures at all were warranted;
- the destruction of existing units leading to loss of experienced teams;
- speed of change, resulting in little time for establishing arrangements for information and support of patients, palliative care and the organisation of volunteers;
- a loss of choice for patients and stress for existing patients whose units have been identified for closure or transfer;
- insufficient attention to nursing and cancer nurse training;
- the assumption that the balance between radiotherapy and chemotherapy will not change over the next 15 years;
- whether it was wise to use radiotherapy as the baseline in planning tertiary care, rather than an oncological strategy which combines surgical, chemotherapeutic and radiotherapeutic approaches to treatment and care.

Professor Michael Baum of the Royal Marsden said, 'How saddened I am by the whole process which is really akin to divide and rule.' It was the Royal Marsden's misfortune to be geographically in the North-West Thames Region. A health authority for London was needed. It was a false premise that cancer care was based on linear machines and that cancer was better treated in a general hospital than in a comprehensive cancer centre. The Royal Marsden should have been a role-model for future specialist centres.

Professor Begent, from the Royal Free Hospital School of Medicine, said that working with the Middlesex Hospital, as recommended by the Review Group, would be beneficial in terms of the quality and cost-effectiveness of oncology care. Some preliminary work had already been done by the two units to develop a plan which would allow oncology services to continue on both sites. These proposals included new approaches to the relationship between cancer-related specialties and primary and secondary care. Research will continue on both sites but existing collaboration would be strengthened and developed.

W F Hendry, a genito-urinary surgeon at St Bartholomew's and the Royal Marsden, said, 'You will get more cures if you go to a cancer centre.' In general hospitals, cancer patients competed for beds against other specialties. 'I have seen two of my colleagues nearly come to blows as to whether an endocrine patient or a cancer patient should have the bed.' He had travelled the world and seen the creation of cancer centres. 'What are we doing? Closing them down!'

Dr Jessica Corner of the Royal Marsden Hospital said that, as a nurse, she had been disappointed with the report which lacked a coherent plan for nurse education and research, and had failed to consider the importance of research into cancer patient *care* as opposed to *treatment*. The proposals would seriously undermine the nation's most important resource for the training of cancer nurses.

Jeannette Webber, Chief Nurse Adviser of the Cancer Relief Macmillan Fund, told of the wealth of evidence showing that the role of nursing in relation to the care of patients and their ability to cope is critical. She was 'desperately disappointed' that the report did not reflect the achievements of nursing and was 'staggered' to note that there was absolutely no reference to the role of the Royal Marsden in the development of cancer nursing. She was concerned about the future for innovative work in cancer nursing and its dissemination throughout the country.

Dr J A Bullimore of the Royal College of Radiologists said that leaving the available spread of expertise among 13 radiotherapy units would be a drain on human and economic resources. 'There must be a reduction in the number of centres and, in so doing, I would hope you would create large centres where expertise can be focused ... I do not think we should get stuck in a dinosaur mentality.' She expressed concern that if the Institute of Cancer Research were to move to Imperial College and become divorced from the Royal Marsden, there would be a threat to academic radiotherapy. She urged that decisions should be made quickly to avoid blight.

Lesley Parkinson, Chief Psychologist, Riverside Mental Health Trust, spoke of the need for psychological support to engender fighting spirit and coping styles to help patients overcome their feelings of helplessness and hopelessness. She argued that clinical psychologists should be seen as core specialists, outlined the nature of their contribution and emphasised the importance of their services to patient care.

Professor James Malpas of St Bartholomew's Hospital said it was illogical to destroy St Bartholomew's and the Royal Marsden at Fulham which were highly rated for their expertise and research, and had taken years to build up. 'I think this is a money-driven scheme based on inequities.' Doctor had been set against doctor, unit against unit, hospital against hospital, 'by government that looks as though it needs terminal care itself'. He warned that it was unlikely that teams would be kept together. 'Personally, I do not believe that London has too many cancer centres.' He warned that the £43 million estimated in the report to bring about the changes would be 'totally inadequate', and he called for the setting-up of a pan-Thames organisation.

Ros Levenson, Director of the Greater London Association of Community Health Councils, told of how local authorities are under pressure with community care. 'We really must sort out the divide between health care and social care before any more changes can take place. If you cannot get a bath, how can you look at the delivery of more complicated services?' She emphasised the difficulties patients experienced in transport to hospitals. At local level, funding of voluntary organisations was going down. It was important for new services to be in place before the old were swept away, and also to start monitoring the changes as they occurred.

Dr Paine, in responding to these contributions, emphasised that his Review Group's objective was to propose a system that cared for patients better in the future than now. The smaller number of larger centres would encourage the benefits of sub-specialisation and improve outreach to general hospitals and the community. This would improve, not reduce, the prospects for training and research.

Areas of consensus and disagreement

At the end of the meeting, there were some areas of general agreement. They included:

- agreement that the concept of specialist cancer centres is right, provided that the principle of interlinking them with primary care services and district general hospitals remains central and is not lost during the reorganisation;
- agreement on the principle of a network extending from primary through to tertiary care and back, with information support and training support, and points of entry from anywhere in the network;
- agreement that numbers of cancer patients will increase and that care for them must be properly resourced;
- agreement that not all patients are currently getting the treatment which would offer them the best hope of remission or cure, that the quality of existing services is variable and that work must be done to improve the quality of care;

- agreement that patients with rare cancers are best treated at cancer centres;
- agreement that outcome and cost data are poor and should be improved;
- agreement that research and teaching are essential to service development and future human resources and should be attached to tertiary centres;
- agreement on the damaging effects of blight during the period of transition.

THE FUTURE

A considerable amount of concern was expressed about the way in which the Review Group's recommendations would be used and the timescale within which decisions would be made. A strong case was made for decisions to be taken quickly to avoid planning blight, the disintegration of expert teams and distress to existing patients. To some extent, this conflicted with the desire to establish the new infrastructure before dismantling the old. Considerable concern was also expressed about whether the number of existing cancer centres should be reduced, and, if so, to how many. Some difficult issues need to be addressed quickly if improvements are to be achieved. These include:

- how to begin co-ordination and integration of cancer services from prevention and primary care through to specialist centres;
- what planning mechanisms would help to improve quality and reduce variation;
- what kind of information about services should be available to patients and who should provide it;
- the case for a national cancer registry and a national case-mix office;
- how to involve patients in quality audit and service planning;
- how to ensure collaboration between professionals and purchasers;
- the need for a Cancer Patients' Charter.

4

PLASTIC SURGERY AND BURNS REVIEW

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KEY ASSUMPTIONS UNDERLYING THE REVIEW

The aims of the report were outlined at the meeting by its chairman, Philip Sykes, Consultant Plastic Surgeon at St Lawrence Hospital, Chepstow, Gwent, who regarded the proposals as a blueprint for the future.

The Review Group considered that plastic surgery services in London required reorganisation because they were underprovided and unevenly distributed. The Group's aims were to improve access for patients, strengthen services and build up the specialty's academic base.

Plastic surgery and burns services initially developed in response to wartime needs. Servicemen and servicewomen were treated outside London, with the result that several large departments developed at hospitals in the Home Counties. Since World War II, services developed in a piecemeal fashion. In central London, some teaching hospitals established services, but many of these departments remained small. Consequently, the existing pattern of services consists of a small number of hospitals on the periphery of London which have many consultant staff and large caseloads (such as St Andrew's Hospital, Billericay and Queen Victoria Hospital, East Grinstead), and a large number of hospitals in central London which have small departments with few consultant staff, when translated into whole-time equivalents (WTEs), and limited caseloads.

Some parts of London are poorly served and residents have to travel a considerable way for treatment. Residents of Enfield, for example, have to travel 10-30 miles for in-patient services, while Bromley and Bexley in the South-East are also a long way from any centre. Hospitalisation rates vary considerably between different districts, depending to some extent on their proximity to centres. Greenwich has a hospitalisation rate of only 1.0 per 1,000, compared with Hillingdon, which has a rate of 5.1 per 1,000.

Because surgeons have traditionally worked both in the periphery and in central London, it is common for consultants to have split contracts and work at several hospitals, most having contracts with two or more. Consequently, many surgeons waste many hours a week driving between sites. Many plastic surgeons in the capital do not work whole time for the NHS, the 26 surgeons working in London translating into 17 WTEs. They were responsible in 1991/2 for 16,000 in-patient finished consultant episodes (FCEs) and 31,700 out-patient episodes. The Review Group considered that 17 WTEs was too low for the needs of 7 million Londoners.

In order to meet current and future needs, the Review Group considered there should be three levels of plastic surgery and burns services: primary services in primary care

settings (which would take an increasing proportion of out-patient work in future) and accident and emergency (A & E) departments; secondary services in out-patient, day surgery and in-patient settings; and tertiary services, which would be at supra-regional centres.

To rationalise services, the group proposed a 'hub and spoke' model of care. This was seen as building on the strengths of an existing model. 'Hubs' would be hospitals offering comprehensive (i.e. in-patient, day case and out-patient) plastic surgery and burns services at the secondary level. 'Spokes' would be hospitals providing day case and out-patient services also at the secondary level, linked to 'hubs' with in-patient facilities and served by the same consultant plastic surgeons.

To achieve the best outcomes, the Review Group considered that 'hubs' should be based in acute hospitals which housed A & E services and other major specialties with which plastic surgeons worked; which treated a minimum of 2,000 patients needing plastic surgery and burns services; and where there was a minimum of three WTE consultant staff and there were opportunities for undergraduate, postgraduate and continuing medical and nursing education and research.

In its recommendations, the Review Group proposed developing five 'hubs' in central London, at the Royal London, Royal Free, Charing Cross, St George's and Guy's/St Thomas's Hospitals, and recommended retaining Mount Vernon Hospital, North-West London, as a 'hub' for the time being. It also proposed transferring some plastic surgery and burns services from University College/Middlesex Hospitals to the Royal Free Hospital; from St Bartholomew's Hospital to the Royal London; from King's College Hospital to Guy's/St Thomas's Hospitals and from Queen Mary's University Hospital, Roehampton, to St George's Hospital and possibly to the Royal Surrey County Hospital, Guildford.

It suggested that proposals to relocate plastic surgery and burns services from St Andrew's Hospital, Billericay, to an acute hospital site closer to London should be re-examined in the light of proposals to expand services at the Royal London Hospital, and serious consideration be given to relocating services from Queen Victoria Hospital, East Grinstead, to two acute hospital sites in the South-East. The Review Group considered that the four burns units serving London at St Andrew's, Mount Vernon, Queen Mary's University and Queen Victoria Hospitals, should remain associated with plastic surgery departments, but that their futures should ultimately be decided after studies on the incidence and distribution of burns were completed.

In discussing how many consultant posts and associated resources should be allocated to plastic surgery, Mr Sykes said that in 1976 the British Association of Plastic Surgeons had an agreement with the Department of Health that a reasonable ratio was 1:250,000. More recently, however, this ratio had been improved, and it is currently felt that it should be 1:125,000. This latest figure is supported by the Royal College of Surgeons. The present ratio in South-East England is 1:350,000.

He said that discussions to agree the way forward should be started as quickly as possible, to minimise 'planning blight' and uncertainty among staff. While the Review Group recognised that the implementation of its proposals would require both capital and revenue investment, it was not in a position to put a figure on costs.

CHALLENGES TO THE ASSUMPTIONS AND PROPOSALS

Challenges to the proposals came under three main headings. Participants claimed that:

- transferring departments from one hospital to another often led to the break-up of experienced teams, loss of expertise and poorer services to patients;

- transferring departments was expensive both in capital and revenue terms, and there was no evidence that purchasers were willing to spend more on buying either plastic surgery or burns services;
- several of the hospitals chosen to be 'hubs' had relatively small plastic surgery departments and only limited services. Consequently, it was perverse to choose them to pioneer the services of the future.

Lorraine Clifton, Unit General Manager of the Queen Victoria Hospital, East Grinstead, said that her hospital offered outstanding quality care to its burns and plastic surgery patients, at competitive prices. It was one of the few hospital units in the UK large enough to operate on the 'hub and spoke' model, providing, as it did, a consultant-based service on the periphery and a consultant-led service in the centre. Because of its size, it was able to achieve economies of scale, which would be lost if the department was split in two and transferred to two district general hospitals. The capital costs of doing so has been estimated at £25m, but the increase in revenue costs would be even more serious. 'To provide a service which matches the outcomes achieved by the QVH will increase the total costs of the provision of burns and plastic surgery for the population we cover. However, there is no evidence that commissioners have any desire to increase the proportion of their budget used to purchase these services.'

Simon Stevens, Business Manager at Guy's/St Thomas's Hospital, welcomed the Group's recommendations and thought that, of all the Reviews, changes in plastic surgery would be the easiest to implement.

James Harvey Kemble, Head of the Department of Plastic and Reconstructive Surgery at St Bartholomew's Hospital, said that the Review Group's report contained some excellent passages and some flaws. They had been told to make their proposals without regard to financial consequences and as if no hospitals already existed. If unlimited money were available, it would be better spent on developing plastic surgery services in most district general/teaching hospitals, with just one or two major plastic surgery and burns centres. A full plastic surgery service was necessary at St Bartholomew's to provide input to its other specialties, such as ENT surgery, orthopaedic surgery, and oral surgery. St Bartholomew's new £10m operating theatre suite and £1.5m day surgery unit were providing excellent services for patients. Any monies available for plastic surgery would be better spent on employing more staff, rather than rebuilding Bart's facilities on the Royal London Hospital site.

Professor Angus McGrouther, of the Department of Surgery, University College London Medical School, welcomed the report and the 'hub and spoke' principle, but expressed the view that each 'hub' should be developed to an adequate size to cope not only with service commitments but also teaching and research. The future of the service to the people of London would stand or fall on the strength and adequate resourcing of these units. 'Each London unit should be large enough to allow sub-specialisation and the combined management of patients with other specialists.'

John Clarke, Consultant Plastic Surgeon at Queen Mary's University Hospital, Roehampton, questioned the necessity, suggested by the report, to move the burns unit from his hospital to two other sites in South-West London and the Home Counties. 'If you tried to transfer the burns unit to somewhere else, you would lose half the people.' Mr Clarke was convinced that his department could stay where it was and attract enough contracts to survive in the market-place.

Mrs Anita Convey, the mother of 15-year-old Mark, a burns out-patient at Queen Mary's, said, 'If we had to go to different hospitals for all the different things that Mark needs, it would put an intolerable strain on us. No-one thinks of the mental stress that patients and their families suffer. I would prefer to travel long distances for excellence, than to go locally to a diluted service.'

AREAS OF CONSENSUS AND DISAGREEMENT

Participants seemed in general agreement that there were too few plastic surgeons to serve the needs of Londoners adequately and that their number should be increased. There was little consensus, however, on what work could only be done by plastic surgeons and what could be done by other specialists, such as ENT surgeons, orthopaedic surgeons, dermatologists or oral surgeons. Some purchasers wanted the information to help them in their purchasing decisions, but surgeons said that there was no simple answer.

Participants also wanted plastic surgeons to develop some outcome measures by which their work could be evaluated. The Review Group had concentrated, in its recommendations, on improving access, rather than quality, because it had felt that outcomes were hard to measure. There were no easy yardsticks, such as mortality statistics, by which to assess the work of different departments. This situation was considered unsatisfactory. Participants felt that plastic surgeons could not simultaneously claim that certain work could only be performed, or was best performed, by them, if they could not prove it with the necessary evidence. Participants were also disappointed that there was not enough data on need. What was the real need for services and had the lack of resources depressed the apparent need?, they asked.

There was some feeling in the conference that the Review Group had put too much emphasis on the importance of access to services. Several participants thought it was important that patients did not have to travel far for some of the simpler procedures, such as basal cell carcinoma, but it was generally felt that for the more complex work, such as cleft palate repair, people were prepared to travel to find quality. The main problem of access would occur if high-level rehabilitation services were located only at the hub. The Review Group had done more detailed work on travelling times but this had not been included in its report.

The 'hub and spoke' model was generally accepted as a satisfactory way of organising services, but there was some disagreement about how many surgeons were needed at the 'hub'. Three surgeons, recommended as the minimal number in the report, was generally considered to be too few. Many thought that at least four WTEs were necessary. Six 'hubs' and 30 'spokes' was recommended as a sensible number to provide the service. A total of 30 WTEs plastic surgeons was considered necessary to service them. Most participants agreed that there was a real need to define what a hub is. Two possibilities were discussed:

- a centre with a wide range of interdisciplinary services, especially geared for acute care, rehabilitation, recovery and counselling; or
- a centre with sub-specialty centres of excellence such as in breast, burns or cleft palate work, with very technical specialisms either clustered in the hub or located on a population basis in different centres.

The importance of outreach links to general practitioners and primary care, particularly in relation to day cases, was emphasised by several participants.

There was disagreement over two further issues: the provision of services for children and the place of plastic surgery in the undergraduate curriculum. Some plastic surgeons felt that they had had a long and successful history of providing services for children, and that services could be provided in hospitals where there was no paediatric specialist available, but others hotly contested that view. Similarly, some surgeons felt that it was essential that the techniques of plastic surgery were included in the undergraduate curriculum, while other participants felt that the specialty was essentially a subject for postgraduate education.

THE FUTURE

Participants were not clear how the changes were going to be implemented. How far could a blueprint be imposed on London, when the health service was now subject to market forces? If a hospital chose to challenge the plan and 'go it alone', convinced that it could survive in the market-place, as at least one hospital did, could the Government prevent it? The audience did not accept that the case had been made for moving certain departments. It was felt that the Review Group had not appreciated quite how destructive breaking up teams could be. There was no real clarity about the future of the burns services and, although the British Burns Association is to publish recommendations soon, more thought should be given to the disposition of these services.

Three more problems were raised. If the report was predicated on the assumption that the number of plastic surgeons would expand, and that did not happen, how would the picture look if the reorganisation went ahead with present numbers? If some of the large departments were closed and services moved to departments which at present only had small consultant teams, would the services ultimately be worse and patient care damaged? Finally, if the 'hubs' were to provide a high-quality, well-resourced service, how easy would it be to persuade purchasers to buy from these centres, when their prices were bound to be high and purchasers were anxious to cut costs?

If these questions were not addressed, any reorganisation was likely to fail.

5
NEUROSCIENCES REVIEW

KEY ASSUMPTIONS UNDERLYING THE REVIEW

The chairman of the Review Group, Rab Hide, Consultant Neurosurgeon at Southern General Hospital, Glasgow, presented the Group's findings to the meeting. The Review Group believed services could be improved by organisational change. Many existing facilities were too small, inappropriately located and somewhat fragmented. There was duplication, an inefficient use of scarce resources and, in some instances, a dangerously inadequate level of care. Because of this pattern of provision, the Group thought that patients requiring emergency neurosurgery after a road traffic accident were likely to get a better level of treatment in several other British cities than in London.

While specialist (tertiary) centres needed to be rationalised and reduced in number (from the existing 11), local services simultaneously needed to be strengthened. The Review Group felt that many neurology services, particularly for chronic conditions, needed to be delivered close to the patient's home. Consequently, the Group recommended that regional clinical neuroscience services should be organised on the 'hub and spoke' model. This model would put all clinical neuroscientists at a regional neuroscience centre, with neurologists also holding sessions at district general hospitals. It was felt that there was no place for neurosurgery at district level, nor for a neurologist who did not work both at district and tertiary levels. Tertiary units needed to achieve a critical mass: they needed a large throughput of patients to maintain and develop clinical skills and to concentrate financial resources. In order to achieve that, they needed to cover a population of 2–2.5 million. Links with strong university departments of biological science, psychology and social science would also be advantageous.

Finally, the Group considered that, ideally, a regional centre should be based in a multi-specialty hospital (offering, among other specialties, accident and emergency services, general and orthopaedic surgery), not a single-specialty one. The Review Group also agreed that a sensible working solution might require its vision to be compromised for pragmatic reasons of cost.

The Group looked at five sectors in London and the South-East: North-Central, North-East, South-East, South-West and West. It recommended a total of six tertiary centres based at: the National Hospital for Neurology and Neurosurgery and Great Ormond Street; the Royal London Hospital; Guy's Hospital; Royal Sussex County Hospital, Brighton; Atkinson Morley's Hospital (temporarily); and Charing Cross Hospital. These centres would serve a population of 14 million people.

The Group proposed that neurosurgery at the Royal Free should be relocated so that the North-Central sector neurosurgical service should be provided at the National Hospital for Neurology and Neurosurgery. It felt that if the Government's existing funding arrangements continued, the National Hospital would not survive competition with the Royal Free. It was thought too expensive to move the National Hospital to another site;

and that if the National Hospital was cut back to a minimum research capability, it might well close. This would do lasting damage to the nation's research base and investment in clinical neuroscience.

In the North-East sector, the Group recommended that the tertiary centre be based at the Royal London Hospital, taking in the work from Oldchurch Hospital and St Bartholomew's. It decided against siting the centre at St Bartholomew's because that hospital had severe financial difficulties, its income base was insecure and it was not as well placed geographically as the Royal London.

In the South-East sector, the Group decided that the neurosciences work of the Maudsley and King's College Hospitals and the Brook Hospital should be located at Guy's/St Thomas's Hospitals on the Guy's site, because of good rail communications with North and East Kent. Hurstwood Park Hospital should move to the Royal Sussex County Hospital at Brighton.

In the South-West, the Group recommended that Atkinson Morley's Hospital should remain where it was for three years, and a decision about its future taken then. The unit had no long-term future at its present site, because it was not a multi-specialty hospital and would dilute the market for Charing Cross Hospital. The group thought consideration should be given to merging it with the Royal Surrey Hospital, Guildford. Some of the patients from South-West London would, in future, go to Charing Cross Hospital.

In the West, it was decided that services should be concentrated on the Charing Cross Hospital site, which currently provided a good service for patients. The future of this hospital depended on the outcome of other specialty Reviews; a possible second choice, however, was the Hammersmith Special Health Authority.

CHALLENGES TO THE ASSUMPTIONS AND PROPOSALS

Objections to the proposals came under three main headings:

- The final recommendations were thought to be inconsistent with the principles behind the report. The Review Group had said that tertiary centres should be sited in multi-specialist hospitals, yet had chosen to save the National Hospital, Queen Square – a research centre of international standing, but one not based on a multi-specialty site. It had said that a strong research base was important to tertiary centres but was proposing to move the psychiatric neurosciences from the Maudsley Hospital, which had a strong research base, to Guy's Hospital, which did not have such a strong base in that subject area.

- The Review proposed siting most of the tertiary centres in or near central London, which was contrary to the spirit of the Tomlinson Report, which had said that, because of population movements out of the capital, hospitals should be resited nearer the periphery.

- The proposals flouted some of the pressures of the internal market, by siting tertiary centres at expensive central sites, instead of at some of the cheaper sites further out.

Dr John Wade, Clinical Director, Neurosciences, Charing Cross Hospital, said that the Review contradicted its own recommendation that neurosciences should be based on a general hospital site by recommending that the National Hospital should be the tertiary centre for the North-Central quadrant. He expressed concern that the decision to maintain and expand the National Hospital would severely reduce the catchment area for the Charing Cross neuroscience department. The effect of this would be to prevent the development of critical mass and volume of activity required for the best standards of care.

Dr Lionel Ginsberg, Senior Lecturer in the Department of Neuroscience, Royal Free

Hospital, said that neither the Royal Free nor the National Hospital had a big enough catchment population to survive on their own. However, both hospitals had important strengths and both could be said to be providing excellent regional and supra-regional services. Clinicians at the Royal Free and the National generally agreed that the Royal Free should continue to provide a regional neuroscience service, particularly for acute disorders and trauma. 'We would propose a combined department on two sites.'

Celia Davies, Secretary of the Greenwich Health Authority, said that the Review Group should have considered moving the services at the Brook Hospital, Greenwich, to the Queen Elizabeth Military Hospital, Woolwich, which was closing and would have offered a superb site. All community health councils in the South-East Thames Regional Health Authority supported Greenwich CHC in its plea to keep neurosciences in Greenwich. The plan to move these services into inner London was contrary to the spirit of Tomlinson.

Tom Cumberland, General Manager, Neurosciences, Cardiothoracic and Diagnostic Services, St George's Hospital, objected to the claim in the report that 'Atkinson Morley's strength lies in the weakness of other units'. He added that the idea that the hospital should remain where it was for the next three years was incompatible with the claim elsewhere in the report that it should open on a new site by 1998. 'We need to make a decision sooner rather than later.' He added that the reason why Atkinson Morley's Hospital had developed the way it had was because it was ideally situated to serve the population of the South-West Thames Region. It was true that it would provide competition to Guy's and Charing Cross Hospitals, if it remained where it was, but that was a good thing. If the hospital went to Guildford, it would not get enough referrals.

Professor Nigel Leigh, Professor of Neurology at the Maudsley and King's College Hospitals, said that the collaboration between neuroscience and psychiatry at these hospitals was unique. Their research into mental illness would not be able to continue if the neuroscience department was moved to Guy's. He could not understand why the Review Group had a very positive approach to the National Hospital and its research base, but not to the unique service at the Maudsley. Mental illness was going through rapid change. Changes in neuroscience were going to be applied to mental illness. If neuroscience were removed from the Maudsley, research and development in social and community psychiatry was going to be divorced from developments in biological psychiatry. 'We want to see these integrated in a hospital that is unique in Britain.'

Peter Hamlyn, Consultant Neurosurgeon from St Bartholomew's, said that there was significant under-resourcing of neurosciences in London, both in terms of beds and human resources. People claimed that London used about one quarter of the country's resources; that was incorrect, it was nearer to one fifth. Ninety per cent of stroke patients never saw a neurologist. The level of provision in London was significantly worse than in the rest of the country and should not be reduced further.

Mr Hide responded to some of the points raised by the presenters with regard to the siting of tertiary centres. The predominant requirement for neurosurgery and uncommon neurology was a critical mass of patients. This could only be achieved by a degree of centralisation as proposed in the Review Group's report because of access routes. The main thrust of the report had been to supply common requirements for neurological diagnosis, care and rehabilitation outside the central London centres. The conflict between the need for a critical mass to give high-quality patient care in neurosurgery and uncommon neurology, and the pressing requirement to improve the care and rehabilitation for the very many patients suffering from common neurological disorders, was difficult to resolve.

He did not accept that the development of the North-Central sector tertiary centre at the National Hospital would reduce the catchment area for the Charing Cross Hospital as long as the other recommendations of the Group were implemented. Nor did he accept that the Maudsley Hospital's clinical and research base was critically dependent on the small neurosciences unit supplying pure neurology and neurosurgery. There were cogent reasons based on patient accessibility and care which led the Group to propose Guy's Hospital as a

site for the tertiary unit in this area. He agreed that there was inconsistency between the principle of siting tertiary centres in multidisciplinary hospitals and the recommendation of the National Hospital, but the Group had felt that most of the difficulties could be obviated because of the National Hospital's close geographical relationship to hospitals with major acute services, as long as clearly defined channels of communication and care were developed.

Areas of consensus and disagreement

There was general agreement that a successful tertiary centre required a large catchment population of the order of 2–2.5 million, as suggested in the report. Most participants also accepted the 'hub and spoke' principle, but worries were expressed about the possible isolation of neurologists in district general hospitals. Would the departments be too small, underfunded and with too few junior staff?

Some members of the audience suggested that very few neurology patients would need to be treated at the tertiary level and asked whether that level could be confined to neurosurgery work. Others hotly disputed that suggestion. General concern about neurophysiology – which is currently located in a high number of small, rather isolated, centres not linked to particular centres of excellence – was expressed. This situation is more predominant in the areas south of the river and had not been dealt with in the report.

There was a consensus that purchasers needed more education and information to enable them to make decisions. Some participants suggested that it was so hard for purchasers to know which neurosurgical procedures to buy, that these services should be purchased by neurologists at the district general hospital. Others said that such an arrangement would provide a disincentive to neurologists to refer their patients for tertiary care, when they might need it. There was agreement, however, that neurologists and interdisciplinary team members involved in surgery, neurology and rehabilitation, should be involved in setting professional standards for tertiary care as a guide for purchasers. Because of fears that purchasers would be unwilling to purchase expensive tertiary care, some audience members suggested that central government funding should be provided for tertiary centres.

The importance of links between psychiatry and neurology, especially in clinical work and research, was recognised by most participants. There was agreement that more resources should be provided for rehabilitation. A spokesperson from the Alzheimer's Disease Society said it would be wrong to think that the voluntary sector could pick up most of the burden. There was some disagreement about the relative importance of tertiary rehabilitation services, compared with services based at district hospital or community level.

The future

The report contained very little about future clinical trends. Considering how dramatically such developments as imaging had changed the specialty over the last ten years, this was considered an omission. In what ways was the specialty likely to develop over the next twenty years? Were the recommendations of the Review Group also bucking the market? All tertiary care was expensive and it was not clear whether purchasers were going to be willing to buy these services. How could purchasers be persuaded to buy high-quality care for rare but complex cases?

How could planners ensure better rehabilitation services in future? Rehabilitation services were seen to be seriously lacking and getting worse, yet purchasers were reluctant to buy such services and had little idea of quality. Many neurology patients spent a relatively short time in hospital and were then discharged to very little care at all. Any reorganisation of the neurosciences must strengthen rehabilitation services.

6
CARDIAC REVIEW

KEY ASSUMPTIONS UNDERLYING THE REVIEW

The aims of the Review were outlined at the meeting by the chairman, Professor Geoffrey Smith, Chair of Cardiac Surgery, University of Sheffield. The Review Group's key objective was to ensure cardiac services in London are organised in such a way that all patients with heart disease are provided with the highest possible specialist care in the most cost-effective manner. Equally important, the structure of services should ensure continued high-quality teaching and professional development for all staff, and safeguard London's international reputation for high-quality medical research.

The team believed the best way to achieve this objective was to concentrate resources and expertise in fewer, larger centres and recommended that the number of centres in London should be reduced from 14 to nine. The case for larger units rested on four arguments:

- the positive correlation between better outcomes and the volume of work;
- the economies to be achieved by creating fewer, larger units;
- the organisational advantages of larger units, particularly with regard to medical and technical human resources;
- the advantages of larger units for research.

The Review Group concluded that none of London's 14 centres met all their criteria for model cardiac centres and many fell a long way short. There was therefore a 'clear case for rationalisation to create fewer, larger and stronger centres'.

To assess the need for cardiac services and the best method of providing them, the Group reviewed the literature, set up focus groups to gather views on contentious issues, sent out questionnaires to obtain an accurate profile of each unit, organised site visits and examined the data available in UK registers and in theatre records. To assess demand for cardiac services, the Group assessed health purchasers' intentions.

The findings showed clear signs that the existing centres were overstretched. The major area where patients' needs were not being met was the diagnosis and treatment of ischaemic heart disease. The team judged that London should plan for 450 coronary artery bypass grafts per million population by 1998, compared with the average of 370 per million actually performed in the Thames Regions in 1991/2.

In drawing up its recommendations, the Review Group assumed that each cardiac centre should serve a population of 1.8–2 million people, carry out 2,000–2,500 invasive investigations each year and 1,200–1,500 open-heart operations each year. Each centre should be staffed by 4–6 consultant cardiac surgeons, 6–8 consultant cardiologists, 4–6 WTE anaesthetists and a critical mass of junior staff. In terms of facilities each centre

should have two operating theatres and access to a third, two or three catheter/angiography rooms, ten dedicated intensive-care beds plus adequate recovery, and a facility for day case investigations.

Another planning assumption was that demand for services from regions outside London would fall as new tertiary centres were developed outside the South-East and as the Special Health Authorities entered the internal market. As a result, the Group believed the loss of the non-Thames work could exceed the growth of local demand over the next five years.

In terms of geography and tertiary cardiac patient flows, the Review Group decided that London divided naturally into five sectors: North-East, North-Central, North-West, South-West and South-East. The Group's detailed recommendations included two tertiary cardiac centres in the North-East at the Royal London and London Chest Hospitals; one centre at the Middlesex/UCH for the North-Central sector; two centres at the Royal Brompton and the Central Middlesex Hospital in the North-West sector; one centre at St George's Hospital for the South-West sector; and two centres in the South-East, based at Guy's/St Thomas's and at King's College Hospitals.

Challenges to the assumptions and proposals

Challenges to the proposals were raised under five main headings:

- the report underestimated the need to expand cardiac diagnostic and treatment services;
- the division of central London into five sectors was inappropriate;
- the proposed changes would not shorten waiting times for operations, or improve services for elderly patients and women;
- the appropriateness of the specific units chosen for closure/expansion into future tertiary centres was questioned;
- the case for multidisciplinary hospitals providing a better model of care than single-specialty hospitals was not proven.

Dr Roger Boyle, from the British Cardiac Society (BCS), agreed that the number of cardiac centres in London should be reduced, but criticised the Review Group for 'making no attempt' to determine the facilities needed to meet current or future demand for services. He said the Review findings assumed a very low level of service. Instead of 450 coronary artery bypass operations per million population, there should be planning for between 500 and 600. Ten centres might be needed rather than the nine suggested. Dr Boyle also cast doubt on the assumption that London was better provided for than other parts of the UK. Yorkshire, he said, had relatively more cardiologists and operating theatres than the capital. He added that the Review Group's proposals would be disruptive to established teams, particularly at Harefield. The recommendations about institutional moves and mergers would increase, in the short term, the amount of cardiac facilities provided away from district general hospitals, contrary to BCS recommendations.

Professor James Scott, Director of the Department of Medicine at Hammersmith Hospital, said the loss of academic cardiology from the Hammersmith site would significantly undermine the unique importance of the Institute in training academics, while the loss of the training base in academic cardiology would seriously undermine the research strategy of the Institute. Without an adequate flow of patients, research would 'completely dry up so that the whole future of the Hammersmith could be challenged'. The

Hammersmith was a multidisciplinary institute, and the cardiology unit was essential to other research in the Department of Medicine. Vascular research was crucial for rheumatic disorders, inflammatory renal diseases and systemic vasculitis. Professor Scott also challenged the view that the Hammersmith was on a 'poky site', adding that it was within his power to expand the cardiology centre. He said the Medical Research Council, British Heart Foundation and the Wellcome Trust fully supported the Hammersmith's views.

Lewisham and North Southwark CHC said that as all the Specialty Reviews had identified Guy's/St Thomas's as the preferred site in the South-East sector, there was a question about the status of the other hospitals in the sector. Would they all become DGHs? The CHC also objected to the transfer of paediatrics and neonatal surgery from Lewisham and neurosciences from the Brook to Guy's. These decisions favoured a central London site, which owed more to the convenience of doctors than the interests of patients.

Dave Shields, representing Greenwich CHC, expressed concern about the proposal to transfer services from the Brook to Guy's/St Thomas's and/or King's. While the Brook was 'past its sell-by date', a better alternative to moving to central London would be to move to the Ministry of Defence. Queen Elizabeth Military Hospital in Greenwich which had 'superb facilities'. Criticising the Review Group for concentrating facilities in central London, he added: 'Do not write off the services which you have paid tribute to in Greenwich on the basis of a building. There is a real opportunity to transfer them to a much more modern hospital (still within Greenwich).'

The College of Health questioned whether the proposed changes would do anything to shorten waiting times of up to one and a half years to see a consultant and another year for an operation. 'Do patients die on these waiting lists?', the College's representative asked. She added that she was particularly disappointed by the proposal to close the cardiac unit at the Brook where the waiting time was only two to three months.

Objecting to the proposal to transfer facilities at Harefield to Northwick Park, Harefield's Chief Executive, John Hunt, said that if it were left to market forces, he believed Harefield would not only survive but expand to meet extra demand. It was sad to think of losing the Harefield team when so much hard work had gone into building it up. Mr Hunt added, however, that he was only present at the meeting as an observer since the recent comments by the Secretary of State meant Harefield's position was now secure.

Areas of consensus and disagreement

At the end of the meeting there was broad agreement on a number of issues. They included the following:

- tertiary cardiac services should be rationalised to create fewer, larger and stronger centres (despite some concern that big was not necessarily best);
- the broad model of care – the 'hub and spoke' principle;
- the needs of patients suffering with valvular and congenital heart disease appeared to be met by present services; the availability of transplantation was limited by the supply of donor organs; and services for patients with ischaemic heart disease should be expanded;
- the need to modernise facilities at some centres, notably King's College Hospital;
- that the 'prevention versus treatment' argument was based on a false premise. Prevention would not have any impact on rates of heart disease for a generation, and, in the meantime, patients would continue to need treatment;
- delay was not an option because it would cause planning blight and demoralise staff;

- speedy education of health purchasers was essential so that they could develop a proper purchasing strategy.

Areas of concern included:

- a feeling that too many services would still be concentrated in inner London, and that the needs of patients had not been given enough attention;
- the issue of long waiting lists for diagnosis and treatment of heart disease had not been addressed by the Review Group;
- the case of single-specialty hospitals versus multidisciplinary hospitals had not been properly addressed, nor the cost of losing all the resources invested in existing single-specialty hospitals;
- the difficulties faced by purchasers in identifying and buying appropriate packages of specialist care.

THE FUTURE

Participants said it was difficult to forecast the future, not knowing exactly what the Government meant by the concept of a 'managed market'. To what extent would market forces be given free rein and to what extent would there be central planning?

Another major difficulty in planning for the future was that London would lose resources as a result of the changes to the capitation payment system. How could spending on cardiac services be increased when the loss on capitation was going to be substantial? Would purchasers switch contracts away from central London hospitals in favour of 'cheaper' care outside London, and should they be allowed to?

Members taking part in the small group sessions also warned of the danger that the proposals would be shelved because of their cost and because of opposition from those centres with a vested interest in preserving the status quo. They recommended that a timescale for implementation should be set once the Secretary of State had decided what was going to happen.

CONCLUSIONS

All six meetings demonstrated that clinicians, managers and patient groups agreed that reorganisation of specialist services in London is essential. There was also overwhelming support for the basic models of care proposed: the 'hub and spoke' concept with tertiary centres linked to district general hospitals through to primary and community care services. The principle that care should be provided as close to people's homes as possible, was also positively endorsed.

The nature of the evidence on which the recommendations had been made was heavily criticised. Where epidemiological data had been available and used in the reports (e.g. renal, cardiac), participants claimed that it had underestimated future need in London. The most serious criticism was levelled at the absence, in all the reports, of cost and outcome data to justify the recommendations about specific institutional closures and mergers.

Clinicians were strongly in favour of specialist centres being located close to academic research and teaching institutions. One or two participants questioned the importance of this requirement, but the arguments in favour of cross-fertilisation of scientific knowledge and research with service provision and development convinced most of the sceptics. A slightly different, though related, issue is whether all specialties should be in the same centre (i.e. five or six mega centres for London) or whether they could be more widely shared.

Views on the division of central London into five sectors differed with the specialty. The renal meeting positively supported this arrangement; the cancer meeting expressed some concern about whether it was sensible, given the disposition of the identified centres; the cardiac meeting was not in favour of the arrangement. (The issue was not discussed in the children's, neurosciences and plastic surgery meetings.)

There was widespread concern about the difficulties faced by purchasers in relation to buying specialist care from the tertiary centres. These worries included:

- whether they would be able to afford the cost of this kind of care;
- whether they would have the knowledge and information they would need to buy the right kind of care;
- how packages of care which required primary care, secondary care and episodes of tertiary care, would be purchased.

Participants pointed to the considerable tension between the role of the internal market and planned approaches to tertiary care service provision – the question of the cost of research and teaching, for example, and whether purchasers would be willing or able to afford to buy these elements if they were added to the price of specialist care. Another problem was how the 'hub and spoke' model, which implies a commitment to certain organised networks of linked providers, could be reconciled with provider competition and purchasers looking for best-value contracts. The role of GP fundholders caused concern; particularly in relation to the small size of their budgets and the question of their ability to purchase tertiary care effectively.

Some Review Group reports made an estimate of the capital costs involved in achieving the changes they recommended. Participants at the meeting emphasised the need for adequate resources to be made available to support change. If these resources were not made available, it would be impossible to create a system able to provide the quantity and quality of care required.

There was a strong feeling that issues of quality and standards should be given more attention – particularly in the light of some Review Group findings that the standard of provision was variable and occasionally poor. Clinicians from all disciplines working in the specialty should be involved in setting criteria for standards of tertiary care. These criteria could serve as a guide to purchasers and government, and might be linked to an ongoing process of data provision and analysis, secured by government.

The role of patients and patient empowerment were discussed repeatedly. The cancer meeting, for example, agreed that a Cancer Patients' Charter should be produced. Patient and carer involvement, at both purchaser and provider levels, was felt to be important, especially in regard to a role for them in planning resource allocations and styles for clinical services and tertiary care specialties.

Other serious concerns expressed throughout the meetings included:

- how the Government would use the recommendations contained in each report;
- what the timescale would be for implementation of the recommendations;
- the danger of losing expertise and experience through institutional closures or mergers;
- the stress and anxiety caused to current patients in existing units faced with closure.

What is now needed is not simply an intellectual solution to the 'London Problem'. Money and skilled management will be needed to make the transition possible. The latter task cannot be overestimated.

ISSUES ARISING FROM THE LONDON SPECIALTY REVIEWS

RESOURCES

The proposals to reduce capitation rates in London will clearly affect the amount and type of care to be purchased. In addition, the Specialty Review Groups' reports are based on the premise that tertiary care should be developed in outer London and the home counties to allow people to be treated as close to their own homes as possible. These two factors – fewer patients referred into central London and lower capitation rates – make the case for rationalisation of existing services in inner London compelling. In spite of this, considerable sums of money will be needed to achieve the proposed rationalisation and to raise the quality of care to an acceptable standard. It is unrealistic, therefore, to take the line that change is acceptable only if standards of service rise. It is most likely that, during the next five to ten years, the most that will be possible will be damage limitation while a sound basis for the future is being created.

A substantial number of the recommendations require large capital sums before the changes can be made. There is no indication of whether this money will be forthcoming, or, indeed, exactly how much money will be needed. The recent NHS reforms have made it possible for trusts to borrow money on the open market, within clearly defined limits. This is one way of increasing available funds, but it is also likely to increase costs. A more attractive alternative would be to create a development fund for borrowing and repayment within the NHS. There is also a strong case to be made for ensuring that funds released through efficiency savings and mergers are reinvested into the same specialty.

STRUCTURE AND ORGANISATION

When all the Reviews' recommendations are considered together, five centres emerge, one in each of the five sectors of inner London, which would contain most, if not all, of the six specialties under review. The implications of creating five mega centres in central London need to be thought through. What will be the effects of locating the majority of specialist services, research and teaching in these five centres? What will happen to the specialties not based in these five hospitals? What will be the impact on hospitals that lose all their most prestigious units? Who will be responsible for ensuring that all these specialty links with secondary and primary care are co-ordinated and organised effectively? All these issues should be addressed before final decisions are made.

Since the selection of these five institutions was determined by the concept of five segments, which in turn appears to have been based on an adaptation of the existing regional structure and the populations contained within them, what happens if these structures and populations change? The arguments for a single London health authority have always been persuasive and the internal market might well be better served by such an organisation. The current purchaser boundaries do not fit easily within the proposed segmentation. If, as some participants at the meetings suggested, the segmentation and choice of specialist centres has been determined by the sites of the colleges of London

University, is this academic principle the most appropriate one for reorganisation of services?

The issue of single-specialty hospitals was most hotly debated in the Cardiac Review meeting, but also raised its head in Children's Services and Neurosciences. Although most clinicians agreed that, ideally, patients should be treated in multidisciplinary hospitals, many of them could not see the sense of closing single-specialty hospitals or moving expert teams to other sites, in a situation where capital sums to achieve these transfers were not assured. In addition there is an argument that specialist services do not necessarily fare as well in multidisciplinary hospitals, because of competition for resources and the need to balance priorities. There is, however, general support from clinicians that (other things being equal) specialty services offer better-quality care when they are sited in multidisciplinary hospitals.

When the final decisions about specialist centres are made, institutions will have right of appeal. Some people think that these centres should have the right to appeal against the recommendations of the Review Groups before the final decisions are made. On the other hand, the need to reach decisions quickly was emphasised by all the meetings, and it would almost certainly be better to create a positive climate for change than to delay decisions. This must be done by encouraging teams to move to attractive new sites, by giving them some control over their futures, and by offering attractive redundancy packages.

Planning versus the market

The large number of specialist centres in London allows a competitive market for health care to develop. Concerns raised at all the meetings indicated that the majority of professionals and customers are not happy that this 'free market' should be allowed to determine totally the extent and nature of health care provision in the capital. One or two representatives from centres recommended for closure or transfer claimed that their units would continue to be active in the market irrespective of any decisions made to close them down. There are signs too that hospitals are forming consortia which may enable these centres to continue to exist. What is the right balance between planning and market forces? What happens to institutions which try to maintain tertiary services in the teeth of the Review recommendations and government decisions?

There was a considerable amount of support from managers, clinicians and institutions threatened by the Reviews, for a system which would allow purchasers and providers to reach local agreements about the nature of specialist care within policy guidelines. On the one hand, this approach might guarantee better solutions because it offers opportunities for greater commitment from those involved to reach effective solutions. On the other hand, it would allow those with the greatest bargaining power to undermine the most important principles contained in the Review reports, i.e. those of rationalisation and high-quality care at lower cost provided through a model which reaches out to patients in their own communities. We see no easy resolution of this dilemma. Possibly a way forward is for ministers to lay down the guidelines and for local purchasers and providers to recommend solutions or options, subject to regional (or central) acceptance or rejection. Some central planning and guidance is clearly necessary to overcome the genuine problems of reorganising specialty services. Without such planning and guidance the scope for uneven and inequitable developments leaves the future open to loss of quality and waste of resources.

A major determining factor in the location of certain specialties is an accident and emergency (A & E) department. The recommendations of the Specialty Review Groups and subsequent decisions about tertiary centres will be influenced by this. The fact that a review of A & E services will take place after decisions have been made about the specialty services, could be dysfunctional. Alternatively, recommendations from a review of A & E

services might be unduly influenced by the decisions made about the sites for specialty services. The implications of both sets of recommendations for the other need to be carefully thought through.

Lack of evidence on quality and outcomes

A major criticism of the Reviews is that they did not contain sufficient data to uphold their assertions that large tertiary centres necessarily provide more effective treatment than smaller units; or that the institutions chosen for development as major centres provide better outcomes than the ones chosen for merger or closure. Although this lack was due to the fact that the information for such evaluations was not available, it does mean that some of the recommendations are questionable. Is it right to go forward on the basis of such limited evidence and, if not, how quickly could the data be provided? The majority opinion at the meetings was for a decision to be taken quickly and it would certainly be better to create a positive climate for change than to delay decisions. Moreover, the problems of inadequate data will need to be resolved if future monitoring and planning are to be effective. A strong case can be made for systematic data collection and analysis of tertiary care provision to be secured by government. This information could form the basis of a Resource Centre for Purchasers and would be a positive source of material and guidance for purchasers, providers and the public.

Conclusions

The recommendations of the Specialty Review Groups represent one source of advice to the Government. If they are accepted, in whole or in part, the changes which result will be part of a much wider pattern of change to London's health services. The uncertainty created by these changes for the public and the health care providers will be difficult to bear without some tangible sign that health services will be better once the changes have been made. A vision of the future, however attractive, offers little compensation to people who lose their jobs or their local hospital and see nothing to take its place. Careful, skilled management of the changes is essential, and this in turn will rely on well-planned and properly resourced strategies. Communication of these plans to Londoners and the people who work in the NHS, together with genuine consultation, should be a continuous part of the process of change. This report and the meetings themselves show that there is a willingness to work for change. Decision-makers should grasp this opportunity and reciprocate by involving professionals and patients in the process of change.

APPENDIX
WRITTEN COMMENTS RECEIVED BUT NOT PRESENTED AT THE MEETINGS

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RENAL SERVICES

Gillian Farnsworth, Consultant Anaesthetist, St George's Hospital

St George's welcomed the challenge from the London Specialty Review to look strategically at the renal services in the South-West quadrant. We will set up a steering group of both hospital and medical school members to plan how recommendations can be achieved.

As the London Specialty Reviews are only advisory, there may be some difficulty securing financial arrangements for their recommendations.

CHILDREN'S SERVICES

The Women's and Children's Clinical Directorate, Riverside Hospital

The Directorate welcomed the Review Group's report and described key features of its own children's services. These include: provision of comprehensive and integrated care to families, women and children in West-Central London; commitment to child-centred care, combining hospital- and community-based resources, and to the concept of shared care between adult-based specialties and paediatricians.

King's College Hospital

King's College Hospital welcomed the Review Group's recognition of the expertise within the Variety Club Children's Hospital at King's, and its proposal for a full review of children's services within South-East London. The current provision at King's College Hospital fits the Review Group's stated preference for a dedicated children's hospital linked to a general paediatric service. Further development of neonatal surgery at King's will be complementary to those of other providers in the area and will ensure a comprehensive, high-quality children's service in South-East London.

Guy's and St Thomas's NHS Trust

The Trust welcomes many of the Review Group's recommendations and in particular that Guy's and St Thomas's should be one of two sites providing children's specialist services. In relation to the Review's recommendations about paediatric cardiac services, the Trust points out that the alternative suggestion that these services should be transferred to the Royal Brompton Hospital, is at odds with one of the main recommendations that specialist services should be located in a multispecialty hospital. The report also ignores the importance of fetal cardiology which needs to be on the same site as both paediatric cardiac services and obstetrics.

Evelyn H Dykes, Consultant Paediatric Surgeon, The Children's Hospital, Lewisham

Due to a clash of dates between the King's Fund Centre meeting and the annual meeting of the British Association of Paediatric Surgeons (BAPS), it was not possible for any representative of BAPS to participate. The important contribution of paediatric surgeons is thus missing from the debate.

Child Growth Foundation

The Foundation expressed disappointment with the Review report because it failed to deal, in a thorough way, with paediatric endocrinology. The report also fails to refer to the establishment of a tertiary growth clinic at King's College Hospital. The Foundation is critical of the fact that the Review report mentions secondary endocrinology services at Guy's Hospital and the Royal London Hospital which, by the Foundation's definition, are not offering a proper tertiary endocrinology service.

Irene Sclare, Chair, Special Interest Group, Children and Young People

Support was expressed for many of the concepts contained in the Review Group's report. The notion of careful co-ordination of services is important but frameworks for this co-ordination are not in place in most DHAs. Clinical psychological services are essential at both secondary and tertiary care levels; and particular attention needs to be paid to the psychological needs of adolescents with chronic or life-threatening illnesses. Existing provision does not meet current needs. Care must be taken to inform children and their parents about any future changes to hospitals in which they are being treated.

CANCER SERVICES

All written comments were presented during the meeting.

PLASTIC SURGERY AND BURNS

Philip Sykes, Review Group Chairman
(Comments following the meeting)

1. There was a question from the audience about the discrepancy in the number of males treated at both ends of the age spectrum. There was a hint that somehow or other plastic surgeons favoured men! I am sure this is not the case and one would not expect it to be so, but unfortunately the data available do not give any answers as to this difference and one would have to speculate. I have been speculating!

In early years little boys are more adventurous than little girls and certainly in some papers on accidents males exceed females. I was responsible for some work in conjunction with the Child Accident Prevention Trust in the 1970s and was impressed, when looking at burns in children, that there was a predominance of little boys. There is also one other very obvious answer. Deformities of the male genitalia (hypospadias) treated by plastic surgeons are far more common that deformities of female genitalia and these in fact tend to be treated after puberty.

At the other end of the scale, despite women living longer, there are more men treated. There are certain conditions again occurring in later life which are more common in men than women, for example Dupuytren's contracture, and I suspect, although this is not my field, that cancer of the head and neck also has a higher incidence in men. You might say this would be offset by women with rheumatoid hand conditions being treated in plastic surgery units, but not all of us take on this commitment and a lot of the work is done by orthopaedic surgeons.

2. There was a question about research in plastic surgery units. The Review Group did look at the research done in plastic surgery units and found there was a considerable amount of clinic-based work done from within these units but that few had access to good laboratory-based research. The three exceptions to this, which were highlighted by Professor McGrouther later in the day, are the University College Hospital (Phoenix Appeal funded research), Mount Vernon Hospital (RAFT research work), and East Grinstead in association with Northwick Park and now co-ordinated by Dr Colin Green (Blond McIndoe research).

3. In the afternoon, tertiary centres were still referred to regularly and I think there is some confusion which needs correcting. The Review Group took the view that tertiary work was that which was referred from one consultant to another and certainly this takes place in plastic surgery but much less commonly than within the other specialties which were reviewed. It is wrong to think of hub units as purely tertiary centres. More tertiary work takes place at hub units than at spoke units but indeed quite frequently plastic surgeons operate in collaboration with other surgeons in spoke units. Also a good deal of very basic 'secondary' plastic surgery work takes place at hub units, and I would say that in most units throughout the country this is the majority of the work carried out. I think it would be far better for the future to think of plastic surgery departments in large DGHs as the hub units rather than looking on them as highly specialised tertiary centres.

4. This leads on to accessibility, which was the subject of a discussion in Group A. In many ways the term has led people to think purely of travelling times. We did do isochronal studies which were organised by the London Implementation Group as part of the Review: these were interesting and did highlight some areas where patients had difficulty in getting to see a plastic surgeon. I think now that availability would have been a far better term to have used.

The point that came out of Group A was that many patients did not mind travelling long distances to have treatment for relatively rare conditions by experts, i.e. to hub units, but for the more common 'bread and butter' plastic surgery conditions accessibility or availability of spoke units was highly desirable. It must also be remembered that units themselves provide some of the 'spoke work' for the surrounding community.

Patients' travelling time is obviously highly important but travelling of surgeons is also critical, and it is obvious that they should not have to spend too much time on the road. The spokes should therefore not be too long on both counts as in the case of Queen Mary's, Roehampton.

Save Bart's Campaign

Four comments on the Review as it affects St Bartholomew's Hospital:

- *Accident and emergency at Bart's* – There appears to be an assumption that the A & E Department at Bart's is certain to close. While this proposal has been put forward to the Secretary of State for Health, there is much local opposition to it (over 40,000 objections) and it remains to be seen whether the proposal will in fact be implemented. (There is now an initiative by leading City figures, supported by the Corporation, to explore all possible options for emergency medical facilities at Smithfield.) It is unclear whether the Review's advice – to transfer plastic surgery services from Bart's to the Royal London – still applies if full A & E services at Bart's are retained.
- *Access* – Bart's public transport links are described only as reasonable, while those of the Royal London Hospital are described as good. We would challenge this. While both are good, we would argue that Bart's links are better.
- *Data* – We understand that when the Specialty Review Group visited Bart's, the department was not up to its full staffing complement and that this error is reflected in the data.
- *Time* – We believe that because the Reviews have taken place in such a tight timescale, full and proper consideration of all the options and arguments has not been possible. We understand that the Plastic Surgery Review Group spent only a couple of hours at the hospital, which we find, frankly, incredible. How a fair view could be made after such a short exposure to the department seems unrealistic.

While the Save Bart's Campaign does not oppose change *per se*, it does believe that much more needs to be done by way of research – including seeking patients' views (e.g. on access) in line with the *Patients' Charter*: 'Always putting the patient first, providing services that meet clearly defined national and local standards, in ways responsive to people's views and needs'.

Neurosciences services

All written comments were presented during the meeting.

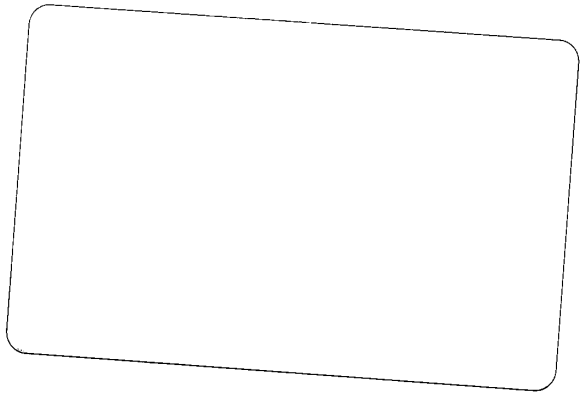
Cardiac Services

King's College Hospital

King's welcomed the recommendations to develop cardiac services at King's College Hospital. It hopes to become the main cardiac centre in South-East London in the longer-term future, when provincial cardiac centres have been further developed. King's also plans to expand its role as an A & E provider to South-East London, and the continuance of specialist cardiac services will support this.

Lesley Parkinson (and Derek W Johnston), Chief Psychologist, Riverside Mental Health Trust/ Representative, British Psychological Society

Points to the importance of clinical psychologists at all levels of cardiac provision. At the primary prevention level, clinical psychologists work with people with primary hypertension to change attitudes and behaviour. At the tertiary level, there is a role for psychologists to help with the psychological consequences of heart attacks and improve patients' quality of life.

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Conflict & Change

SPECIALIST CARE IN LONDON

In July 1993 the King's Fund arranged six meetings to encourage public debate about the outcomes of the independent reviews of specialty services in London. These reviews of six specialty services – renal, children's, cancer, plastic surgery and burns, neurosciences and cardiac – made recommendations for changes to the structure and organisation of tertiary care in London.

This report records the debates and contributions from all those involved; it also comments on the difficulties which need to be overcome during the process of moving towards more accessible and better-quality specialist care in London. It will be valuable reading for clinicians, providers, purchasers, patient groups and representatives. The debates and the emerging issues will also be of interest to health care professionals and the public in other cities in the United Kingdom where the same pressures are at work.

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