THE KING'S FUND WORKING PARTY ON PAEDIATRIC SURGERY IN THE GREATER LONDON PORTION OF THE THAMES REGIONS

Chairman: Professor Ian McColl
December 1987

King Edward's Hospital Fund for London

FOREWORD

The Paediatric Surgery Working Party

In June 1987, the King's Fund convened the first meeting of a working party on the future shape of paediatric surgery in the four Thames regions, with special reference to Greater London. The working party was chaired by Professor Ian McColl (himself a general surgeon) and was primarily composed of paediatric surgeons. This is the working party's report.

I can readily envisage a number of critical questions about why the Fund ventured on this topic at this time in this way, so I will respond to some of them in advance.

1. *What executive authority has the King's Fund in this field?* The answer is 'none' and that is clearly reflected in the working party's terms of reference, which specify that its role is advisory and that the report will be sent to the relevant health authorities for them to consider. Naturally we took soundings in advance as to whether advice at this time would be welcome or unwelcome. Inevitably the response was mixed, but overall it was sufficiently positive for the Fund to decide that this was a venture worth its support – and, more important, worth the time that the working party members have voluntarily given to it.

2. *Why now?* The crucial point is that paediatric surgery in London has grown up in a higgledy-piggledy way, with too few people spread over too many hospitals. Following the classical paradigm of how medical specialties develop, paediatric surgery has split off from general surgery. At first it made over-ambitious bids for its place in the order of things – *all* surgery on *all* children. Now its proper role is becoming clearer, though still evolving into new sub-specialties, such as paediatric urology. London is at an important crossroads in relation to patterns of paediatric surgery, because the founding fathers of the specialty are nearing retirement. Typically their appointments have been split among too many hospitals, with a few sessions here and a few sessions there, and they have been spread much too thin. If there is ever going to be a more rational, more effective pattern of paediatric surgery in London then the nettle must be grasped when new consultants are appointed, including replacements upon retirement. One key retirement has just happened and

another will happen in 1991, apart from the establishment of new posts. So now is a good moment.

3. *Why was the working party mainly made up of surgeons, and paediatric surgeons at that?* Shaw took the view that 'All professions are conspiracies against the laity', so why should this be any different? The initiative for setting up the working party came from the paediatric surgeons themselves, who had tried to grapple with the special problems of London within the British Association of Paediatric Surgeons. We judged their concern to be genuine, and felt the advantage lay with letting the surgeons themselves say what *they* thought the best solutions to be. We took a few elementary steps to keep them honest by including paediatric surgeons from outside London, and two consultant paediatricians. There are other arenas in which people can judge whether the paediatric surgeons have overstated their case or failed adequately to tackle inter-institutional rivalries. But at least this report gives us one good starting point for discussion – what the paediatric surgeons themselves would like to see happen.

4. *How objective is the report?* This is for others to judge, after discussion in many forums. I myself am reasonably confident about the validity of the short-term proposals. The bids for longer-term expansion of consultant numbers in this specialty do not seem to me immoderate, though they will have to be judged by the regional health authorities against other priorities. If I have doubts, they are whether the proposed centres are too many, judged against the working party's own criteria, and whether enough has been made of the opportunities for intra-regional and inter-regional cooperation within the specialty. The ideal arrangement (I think) would at this stage be one main centre for paediatric surgery in each of the four quadrants of Greater London, with strong and effective links from each regional centre to Great Ormond Street (GOS). All consultant contracts (except GOS) would be regional, in the sense that consultants would have to accept further rationalisation within their region and a consequent movement to another hospital, if that was where the main paediatric unit was to be based. Inter-regional links would include training arrangements and a sharing of data across all the centres on workload, case-mix and

the quality and effectiveness of care. The working party's report is not quite that bold, although it represents a long step in that direction.

It only remains for me to thank all the members of the working party, most of all Professor Ian McColl as chairman, and to commend the report to the health authorities and to the DHSS for their consideration and for action.

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

Introduction

The present state of disorganisation of paediatric surgery in London is probably due to the usual shuffling form of evolution which has moulded many other parts of the NHS. Those responsible have tended to organise their affairs incrementally and locally, without reference to the needs of the London population as a whole. As a result some paediatric surgeons have to visit several hospitals miles apart and could aptly be described as 'rally drivers with an interest in paediatric surgery.' The picture was originally more complicated still because some paediatric surgeons were even more general than general surgeons in that they carried out the full gamut of surgery from orthopaedics and plastics through abdominal, urological to thoracic surgery and perhaps neurosurgery. Increasing specialisation is leading to separate entities for abdominal, urological and cardiothoracic work. Musculoskeletal disorders now lie almost entirely in the province of orthopaedic surgeons. For practical purposes paediatric surgery can for the moment be defined as the general surgery of children including urological surgery, with special emphasis on neonatal and developmental abnormalities. It should however be emphasised that paediatric urology is developing into a separate speciality which will in due course need two full time consultants per five million of the population and its own accreditation arrangements.

As the success of prenatal diagnoses increases so will the scope of neonatal surgery. Not only will the amount of investigation and treatment increase but so will the need for much more accurate planning of the birth of the affected children. The mother may need to be admitted to the appropriate unit for delivery, to obviate the requirement for the newborn child to be transferred to another centre. In some instances postnatal travel can be lethal. The best incubator is the mother's womb. Each region should have a well equipped intensive neonatal unit as a sweeper for the region, but also every district general hospital with a maternity unit dealing with over 2,000 deliveries a year needs its own special care facilities for appropriate children.

The picture is further complicated by the fact that much of the less complex general surgery of children is performed by general surgeons in district hospitals. Although this report deals principally with the distribution of specialist paediatric surgeons, who

are usually attached to teaching hospitals, the requirement for some general surgeons to have experience of paediatric surgery must also be recognised. The aim should therefore be that district hospitals with four or more general surgeons should ensure that one of these surgeons has paediatric training.

With consultant retirements imminent and an increasing awareness that it is unwise to plan services in isolation, a working party was convened by the King's Fund in June 1987 to review the present position in the Thames regions and to make recommendations. Its terms of reference and membership are in the appendix to this report. The working party decided to suggest plans for the immediate future and also to consider the ideal arrangement for the long term.

Criteria for achieving a solution

In order to achieve a reasonable solution to the present problems, the staff should ideally work in one main centre in each of the four regions where there is a paediatric department with all the appropriate back up facilities in terms of paediatric anaesthesia, expert nursing, intensive care, radiological and pathological services. However superb the actual operations may be, the result will obviously be in jeopardy if these essential services are missing. Paediatric surgeons working in these regional centres should also have links professionally with the postgraduate paediatric hospital at GOS and where appropriate the Institute of Urology. In terms of total numbers, there ought to be one paediatric surgeon for every 750,000 people, meaning four or five for each of the Thames regions.

Training In future only those with accreditation or the equivalent in paediatric surgery should be appointed to consultant posts in the specialty.

The present position of general paediatric surgery

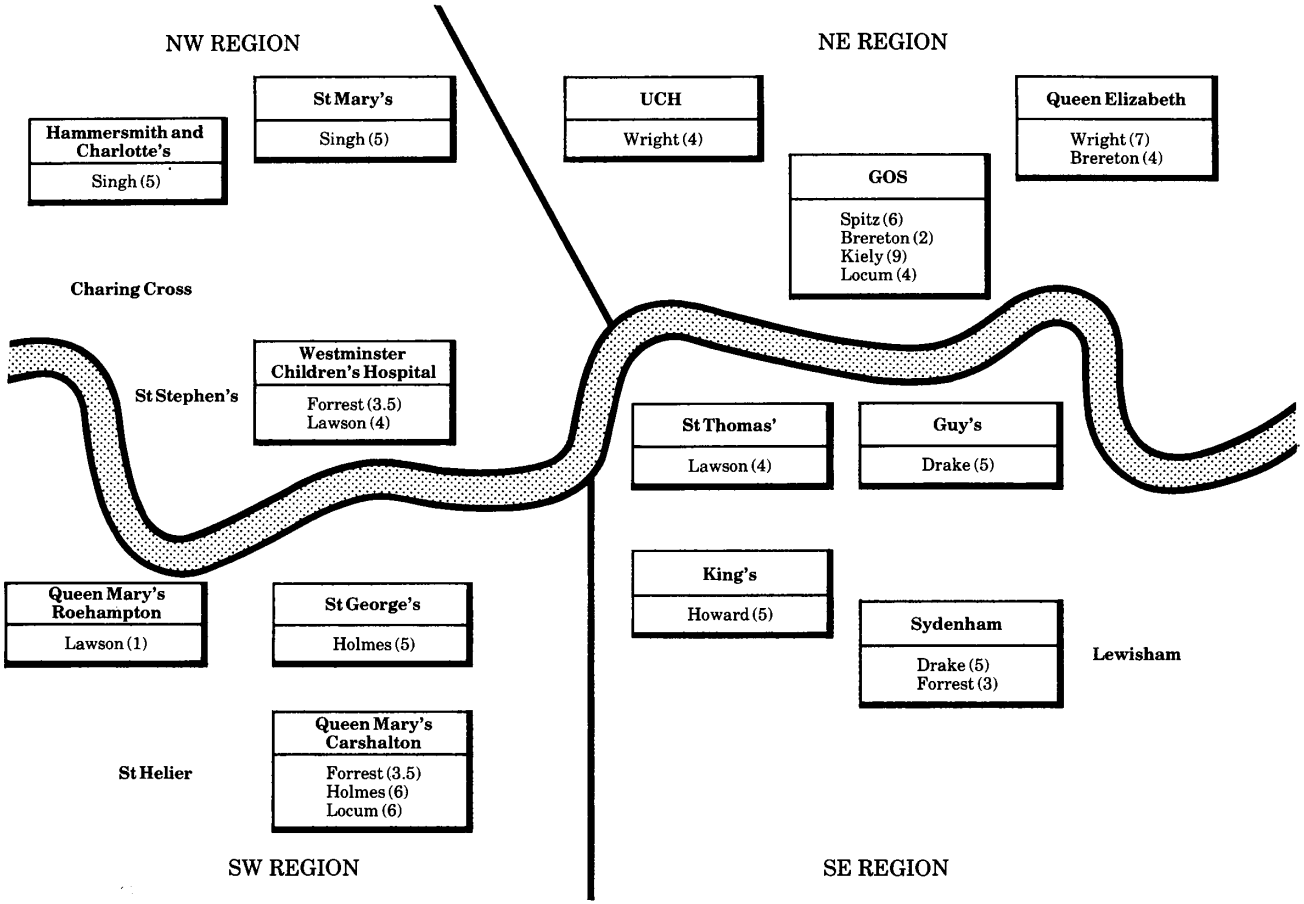
The present position is depicted in Table 1 and Figure 1. In addition, there are two paediatric surgeons in Brighton, serving both the southern part of the South East and the adjacent part of the South West Thames Regions. This Sussex unit is self-contained

Table 1 Present position December 1987

Region	*Hospital*	*Consultant*	*Sessions*	
NW	Westminster Children's	Forrest	3.5	
		Lawson	4	17.5
	Hammersmith Queen Charlotte's St, Mary's	Singh	10	
NE	Great Ormond Street	Spitz	6	
		Brereton	2	
		Kiely	9	21
		(Eckstein locum)	4	
	Queen Elizabeth	Wright	7	
		Brereton	4	15
	University College	Wright	4	
SW	St. George's	Holmes	5	
	Queen Mary's, Carshalton	Forrest	3.5	
		Holmes	6	21.5
		(Eckstein locum)	6	
	Queen Mary's, Roehampton	Lawson	1	
SE	Children's Hospital, Sydenham, (to be rebuilt at Lewisham)	Forrest	3	
		Drake	5	
	Guy's	Drake	5	22
	King's	Howard	5	
	St Thomas'	Lawson	4	

and not in practice accessible to London children. It is not therefore considered further in this report. It should be noted that Mr Forrest and Mr Lawson both work in *three* regions. Mr Forrest retires this month and Mr Lawson in 1991.

Figure 1 Present position (December 1987)



Proposals for 1987 for general paediatric surgery in 1988

North West Region Mr Forrest's retirement will release 3.5 sessions at the Westminster Children's Hospital, which is currently covered by a locum consultant. There is a strong case for the appointment of a nine or ten session consultant as soon as possible to work at Westminster Children's Hospital and Charing Cross Hospital, with close liaison with the Royal Postgraduate Hospital at Hammersmith (RPMS)

North East Region There is an immediate need for six additional sessions to add to the four sessions of the late Mr Eckstein to produce a new NHS consultant post shared by Queen Elizabeth Hospital and GOS. The senior lecturer at GOS will then be able to reduce his clinical commitment in order to fulfil the academic component of his work.

South West Region The 3.5 sessions to be vacated by Mr Forrest on his retirement this month, together with the six sessions of the late Mr Eckstein, should be used to appoint a nine or ten session general paediatric surgeon as soon as possible to work at Queen Mary's Carshalton and St George's Hospitals.

South East Region The regional health authority has agreed to the appointment of a locum surgeon in lieu of Mr Forrest's three sessions at the Sydenham Children's Hospital. This locum will have five sessions at Sydenham and five at King's College Hospital. Apparently King's are very keen to appoint a liver surgeon. It is by no means certain how this will work out for the future. Perhaps it would be wise to re-assess this post after one year to see how well it serves general paediatric surgery.

Future developments

Bearing in mind the government's plans to reduce the number of junior staff and to increase the number of consultants, we ought to be aiming at three paediatric surgeons for each of the four regions in the greater London area. This team of three would work closely together, preferably in not more than two paediatric units.

North West Region When the Westminster Children's Hospital is relocated at St Stephen's Hospital, Fulham, the unit at the Hammersmith (RPMS) will be strengthened. Mr Lawson's retirement in 1991 will release four sessions and another six sessions should be found, making a second ten session consultant post to work at Westminster Children's Hospital and RPMS.

North East Region The region will require in the next five years another consultant at GOS and another senior lecturer to work at University College Hospital and Queen Elizabeth Hospital.

South East Region A careful review will be required to gauge the success of the joint appointment at Sydenham and King's after it has been working for six to nine months. If the locum is a liver transplant surgeon, ordinary paediatric surgery may suffer. The regional plan is for Sydenham Children's Hospital to be rebuilt at Lewisham Hospital, which would become the main paediatric surgical unit with three surgeons, each also working at one of the three teaching hospitals (Guy's, King's and St Thomas'). Upon the retirement of Mr Lawson in 1991 a surgeon should be appointed to work at St Thomas' and Lewisham Hospitals. In addition Mr Howard would continue with his five sessions at King's. The medical and dental schools of Guy's and the medical school of St Thomas's have been amalgamated to form the United Medical and Dental Schools, so hastening closer liaison all round. As previously noted, the Brighton unit, with two paediatric surgeons, is additional to the units discussed in this report.

South West Region It is likely that the Children's Hospital at Carshalton will be relocated at St Helier's Hospital. The region ought to appoint another general paediatric surgeon, thus providing three surgeons at the new centre, who would have links with other appropriate hospitals in the region.

Paediatric urology in the short and long term

If general paediatric surgery requires to be in a well staffed paediatric environment, then even more so does paediatric urology. High technology developments make it increasingly difficult for this speciality to survive in geographical isolation. It ought not only to form part of a good paediatric unit but also to have a

close working relationship with nephrologists and radiologists. The present position is outlined in Table 2.

Table 2 Paediatric urology: the present position

Region	*Hospital*	*Consultant*	*Sessions*
NW	Westminster Children's	Lawson	2
NE	Great Ormond Street St Peter's Queen Elizabeth Hospital	Ransley	10
	Great Ormond Street Institute of Urology	Duffy	10
SE	Guy's	Mundy Joyce	6
	Guy's Sydenham	Drake	3
SW	St George's	Gordon	3
	Carshalton	locum	3

The pattern in London is that most paediatric urology is carried out by those who were trained predominantly in urology but this is by no means the situation elsewhere. On the basis of the ratio of two paediatric urologists per five million of the population, another consultant will be needed to work in London.

Overall summary

The immediate need is to establish four main centres in Greater London, labelled A to D in Table 3. This requires a total addition of 18 sessions (equivalent to two consultant posts) shared across the four regions. For the longer term, the consultant expansion required is considerably greater, as shown in Table 4 and Figure 2, but we would want to preserve the idea of four regional teams, all with links to Great Ormond Street. Inevitably each regional team may have to work at more than one hospital, and this is reflected in Figure 2. The links between the hospitals will be vital, with shared rotas, staffing, training and audit.

Table 3 Summary of proposals for consultant appointments in 1988

	Consultant posts		*Funding of sessions*
A	Westminster Children's	(3.5)	From Forrest (3.5)
	Charing Cross	(5.5)	additional (5.5)
B	Great Ormond Street	(4)	Eckstein (4)
	Queen Elizabeth	(6)	additional (6)
C	Queen Mary's Carshalton	(5)	Forrest (3.5)
	St George's	(5)	Eckstein (6)
D	Sydenham	(5)	Forrest (3)
	King's	(5)	additional (7)

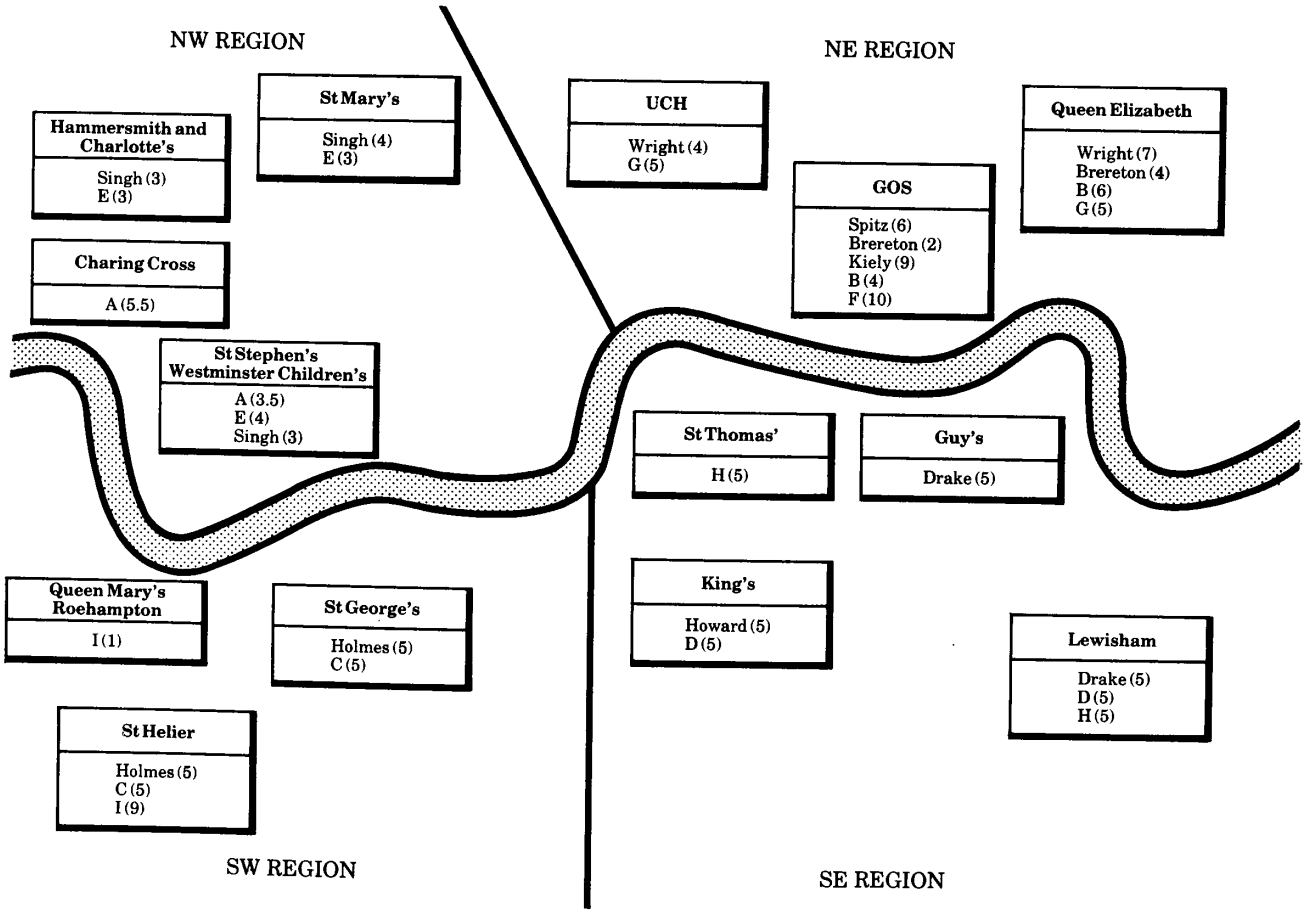
Table 4 Future proposals (see Figure 2)

	Consultant posts		*Funding of sessions*
E	Westminster Children's	(4)	Lawson (4)
	Hammersmith and Queen Charlotte's	(3)	additional (6)
	St Mary's	(3)	
F	Great Ormond Street		additional (10)
G	UCH	(5)	additional (10)
	Queen Elizabeth	(5)	
H	Lewisham	(5)	additional (6)
	St Thomas'	(5)	Lawson (4)
I	Queen Mary's Roehampton	(1)	Lawson (1)
	St Helier's	(5)	additional (9)
	St George's	(4)	

Paediatric urology

Another paediatric urologist will be needed to work in London.

Figure 2 Future proposals



APPENDIX

Terms of reference

To examine the present arrangements for paediatric surgery in the four Thames regions and at Great Ormond Street and to make recommendations for the future.

In carrying out its task, the working party will take account of current appointments at consultant level, the historical reasons for these, and the pattern of retirements. It will suggest what clinical and other criteria should influence the number and location of centres for paediatric surgery and will report accordingly.

The emphasis will be on developing appropriate policy guidelines which the relevant health authorities can consider and take into account in their strategies and operational plans. The working party is established by the King's Fund under the chairmanship of Professor Ian McColl. Its role is advisory and copies of its report will be sent to the four Thames Regional Health Authorities and the Special Health Authority, The Hospitals for Sick Children at Great Ormond Street.

Membership

**Professor Ian McColl, Director of Surgery, Guy's Hospital

Dr Martin Brueton, consultant paediatrician, Westminster Children's Hospital

Mr David Drake, consultant paediatric surgeon, Guy's and Sydenham

Mr Peter Gornall, consultant paediatric surgeon, Birmingham

Mr Malcolm Gough, consultant surgeon, Oxford

*Mr Robert Maxwell, Secretary/Chief Executive Officer, the King's Fund

Mr Philip Ransley, consultant paediatric urologist, Great Ormond Street and St Peter's

Dr Graeme Snodgrass, consultant paediatrician, The London Hospital

Professor Lewis Spitz, Nuffield Professor (paediatric surgery), Institute of Child Health and hon. consultant, Great Ormond Street

Miss Vanessa Wright, consultant surgeon (paediatrics), Queen Elizabeth Hospital, Hackney

** Chairman
* Secretary

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