CENTERING EXCELLENCE?

National and regional health services in London

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Christine Hogg

for the King's Fund Commission
on the Future of Acute Services in London

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Contents

BOXES, FIGURES AND MAPS

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Christine Hogg
January 1992

Executive summary

This working paper concentrates on London's role as the principal national centre for specialist health services. The capital retains this function because of its concentration of undergraduate and post-graduate teaching hospitals. However, the shift of population away from the city's centre over the past century has created problems of access which remain pertinent today. The development of expertise in other parts of the country has also raised questions about the capital's position as a national referral centre.

Centering Excellence? summarises the history of specialist services in the capital. It concludes that their development has been largely unplanned. Moreover, although an estimated £470 million a year is made available to support specialist services in London, the paper finds that their management and funding remains fragmented. Both problems result in inequities of access to specialist services, as well as a lack of integration with local care.

The paper makes a detailed examination of changes in the pattern of specialist services since the London Health Planning Consortium recommended rationalisation and dispersion from the city centre in the early 1980s. In practice, it concludes that a further expansion and concentration of most specialist services has taken place in inner London between 1980 and 1990.

However, *Centering Excellence?* argues that the changes brought about as a result of the NHS and Community Care Act 1990 may result in changes to traditional care patterns. In particular, referrals to high-cost inner-London specialist providers are likely to fall dramatically. Given that this situation will involve major alterations to the capital's health care, the paper argues for a strategic approach to the management of change.

ABBREVIATIONS

CABG	coronary artery bypass graft
CIPA	Chartered Institute of Public Finance and Accounts
DHA	district health authority
CHC	community health council
ENT	ear, nose and throat
GP	general practitioner
LHPC	London Health Planning Consortium
RAWP	Resource Allocation Working Party
RHA	regional health authority
SIFTR	Service Increment for Teaching and Research
SHA	special health authority
UFC	Universities Funding Council

CHAPTER 1

"Rationalising" London's acute services

The problems of London's hospitals have been recognised for over a hundred years. The development of railways in the mid-nineteenth century meant that people could work in London and live elsewhere. The suburbs sprang up and spread. At that time it was already clear that the big voluntary hospitals were not necessarily in the "right places". People were moving out of central London but the main hospitals remained in the centre. There have been a number of attempts to tackle this problem. In 1897, the King's Fund was established to receive and distribute contributions and public grants to voluntary hospitals. It was hoped that the King's Fund would be able to assist in the amalgamation and relocation of these hospitals as a condition of the grants. The 1990 King's Fund Acute Services Initiative is the latest in a long and worthy tradition, and there is still much to be done.

By the 1970s government policies were highlighting the importance of a more equitable distribution of health services, both between regions, and between hospital and community services. London was considered to have too many hospitals and more than its share of health services resources. The formula developed by the Resource Allocation Working Party (RAWP) was used to redistribute resources. Since then the strategic plans of the four Thames regional health authorities (RHAs) have required a shift in resources from inner London to outer London, and from other Thames regions to other regions in the country.

A concentration of undergraduate and postgraduate teaching led to London becoming the principal national centre for specialist services (see Box 1.1). By the 1970s, however, it was recognised that London's health services did not effectively address the particular health problems of the capital, associated with: the high "non-resident" population of homeless people, tourists, and commuters; the deprivation of inner-city areas; loneliness and isolation (London Health Planning Consortium, 1981). In general, primary and community services are weak, a factor which distorts the role of the hospitals. This in turn makes it more difficult to develop adequate primary care.

By the late 1970s, the problems of London were no longer susceptible to gradual adjustment and could not be ignored. The London Health Planning Consortium (LHPC) was set up by the Department of Health in 1977 to look into how services might meet the needs both of Londoners and of the medical schools. Its members came from the University of London, the Universities Grants Committee, the Thames RHAs and the Department of Health.

The LHPC recognised the tensions in London's hospitals and its

Box 1.1

WHAT ARE SPECIALIST SERVICES?

Specialist acute services are generally concentrated in relatively few centres. This may be because they are still new and experimental, because they are very sophisticated and expensive, because their volume is relatively small, or for a combination of these reasons.

The following are examples: cardiothoracic surgery, bone marrow transplantation, neonatal intensive care, neurosciences, plastic surgery and burns, radiotherapy and nephrology (renal services).

Some acute specialist services are funded directly by the Department of Health (supra regional specialties and the special health authorities for postgraduate teaching hospitals), by regional health authorities, (regional specialties), and by hospitals out of teaching, research and general service budgets.

There are problems in defining specialist services, as described below.

Changes over time

Some new treatments will prove their benefit and will gradually extend to all districts. Hip replacement is an example of a specialist technique which is now routine. The technique of knee replacements is following a similar path.

Some specialties, such as those centred on infectious diseases, are declining as services are incorporated into general hospitals. (It is not yet clear what will happen about AIDS: it seems likely that specialist centres will remain, even if services exist in most districts.) Neurosciences are relatively established and stable. Cardiothoracic surgery, on the other hand, has developed rapidly in the last ten years as new techniques have been introduced.

"Hidden" as local services

Specialties are evolving from within general surgery, orthopaedics, general medicine and other specialties all the time.

Specialist services may operate without special funding and they are not always easy to identify among local acute services. A consultant may offer a particular treatment as a part of the general service and (if successful) will attract referrals from outside the catchment area.

"Hidden" in the statistics

The way information is collected means that specialist activities are not easy to identify. For example, the specialty of bone marrow transplantation may be categorised as medical oncology, radiotherapy, or haematology, depending on the department in which it developed.

Hidden specialties are unlikely to remain "hidden" with the introduction of contracts which means that activities will be individually costed. General surgery, for example, is likely to reduce sharply, yielding to a whole range of new surgical specialties.

report was appropriately called *Towards a Balance* (LHPC, 1980b). The balances to be achieved were between:

- the needs of Londoners and those of the medical schools;
- acute services and services for elderly, mentally ill and disabled people;
- inner and outer London.

The LHPC put forward a framework for planning acute services in London and made detailed proposals for the development of cardiac services, radiotherapy and neurosciences, including amalgamations and closures. Few of its recommendations have been implemented (see Box 1.2).

Over the last ten years there has been a decline in the number of general medical beds in the Thames regions, especially in inner London. There have been fewer changes in the distribution and number of beds in specialist acute services since 1980 (see Box 1.3).

Box 1.2

THE LONDON HEALTH PLANNING CONSORTIUM

The London Health Planning Consortium (LHPC) was set up in 1977 to:

identify planning issues relating to health services and clinical teaching in London as a whole; to decide how, by whom and with what priority they should be studied; to evaluate planning options and make recommendations to other bodies as appropriate; and to recommend means of coordinating planning by health an academic authorities in London.

(LHPC, 1980b)

RADIOTHERAPY

What the LHPC proposed
There were sixteen radiotherapy units in London in 1980. The LHPC proposed that one unit, Oldchurch, should close; another, Mount Vernon, be transferred to Luton; and twelve other units should merge to become joint units with radiotherapy on one site. The proposed units were:

- **Hammersmith/Charing Cross Hospitals**
- **London/St Bartholomew's Hospitals**
- **Middlesex/St Mary's/University College Hospitals**
- **St Thomas'/Westminster Hospitals**
- **North Middlesex/Royal Free Hospitals**
- **Guy's and King's College Hospitals**

What happened
The units in the Middlesex and University College Hospitals merged and the unit at St Mary's Hospital closed.

CARDIOLOGY AND CARDIOTHORACIC SURGERY

What the LHPC proposed
In 1978 there were seventeen centres, excluding postgraduate hospitals. Some, such as Northwick Park, undertook major cardiac investigations only. It recommended the closure of units at Harefield, St Mary's, Westminster and Brook Green Hospitals. They also recommended the closure of the London Chest Hospital (a part of the National Heart and Chest Hospitals Special Health Authority (SHA) and transfer of the service to the Royal Free Hospital, which was then a small unit.

What happened
Units in Northwick Park, North Middlesex and Westminster Hospitals closed.

NEUROSCIENCES

What the LHPC proposed
Neurosurgery was provided in eleven centres, excluding postgraduate hospitals. Neurology was also provided in nine other centres, six of which were in inner London, three in outer London.

The LHPC supported the policy that both neurologists and neurosurgeons should work from specialist centres, serving a population of 1.5 million. It recommended that Westminster, King's College, Central Middlesex and Oldchurch Hospitals stop undertaking neurosurgery.

What happened
Units in Central Middlesex and Westminster Hospitals closed. The unit at King's College Hospital was transferred to a joint unit with Guy's Hospital at the Maudsley and Royal Bethlem SHA. There has been little change in the number of centres providing neurology without neurosurgery.

(*Sources:* LHPC, 1979, 1980a, 1980c)

Some services provision has expanded in the last ten years as new techniques have developed (see Box 1.4).

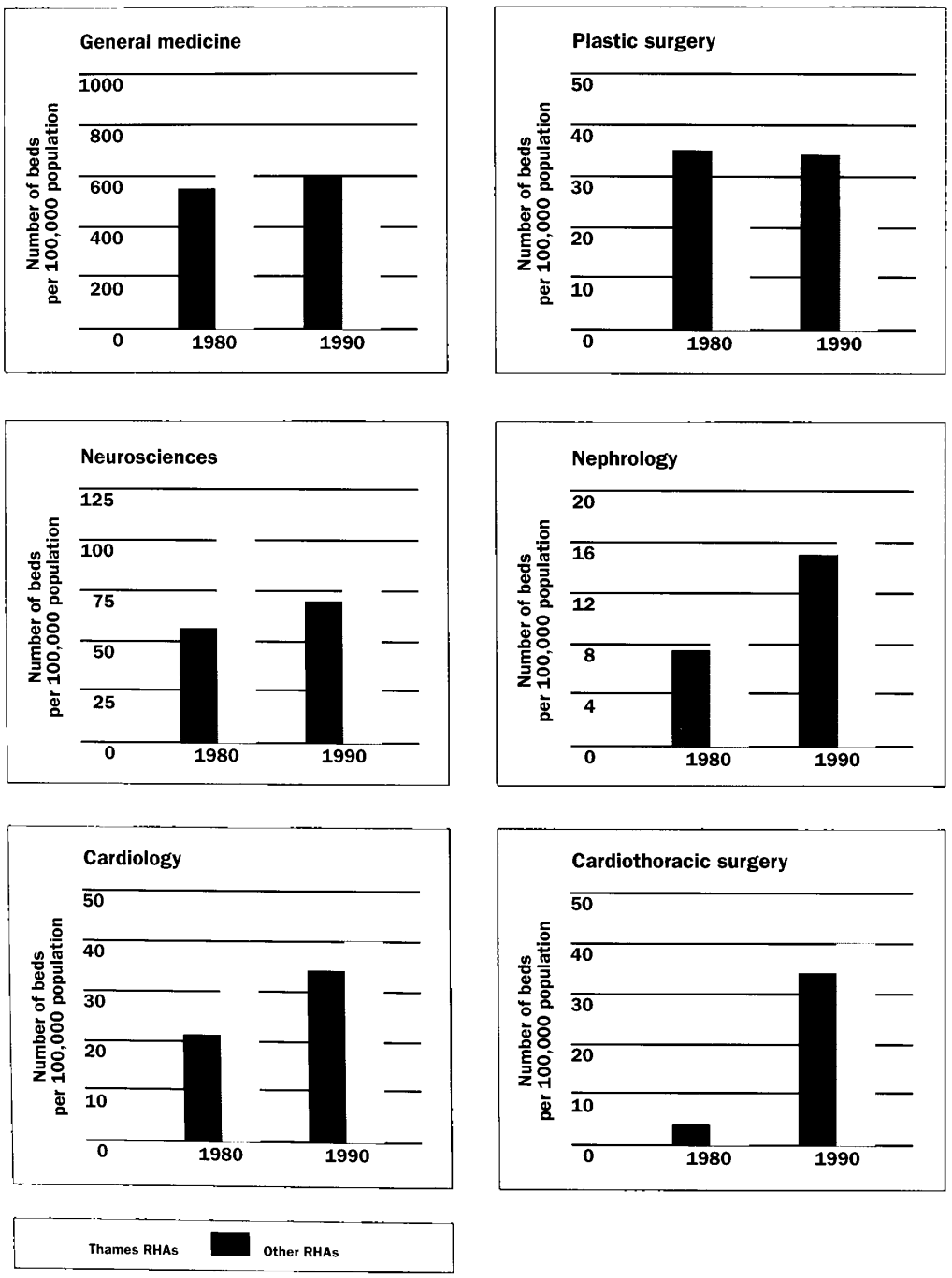
The changes introduced by the NHS and Community Care Act 1990 are having dramatic effects on London. Each district health authority (DHA) receives funds according to the number of its residents. These funds are used to purchase services as considered appropriate by the DHA. The previously established patterns of referral and resource allocation have been broken, and the balance of power in the health service has dramatically shifted. There are many possible future scenarios, two of which have been selected as illustrations.

In one scenario, new specialties will be developed and marketed as a way of generating income. New techniques and treatments will

Box 1.3

AVAILABLE BEDS IN THE THAMES RHAs AND OTHER RHAs, 1980 AND 1990

(Available beds per 100,000 population)



Box 1.4

THE DEVELOPMENT OF NEW TECHNIQUES

Research leads to new diagnostic tests and treatment becoming available. This presents a problem in planning specialist services. Since 1980 new treatments and techniques have been developed, so more treatments can be offered to more people, particularly in cardiothoracic surgery and nephology.

CORONARY ARTERY BY-PASS GRAFTS

In 1979 the LHPC suggested a target of 150 coronary artery bypass grafts (CABGs) per million residents and recommended a rationalisation of cardiac units on this assumption. However, in 1984 the Department of Health recommended that RHAs give priority to CABGs and that they should plan for 300 CABGs per million residents a year. The British rate is still at the low end of the distribution for the developed world, but future trends in heart disease (which has dropped sharply in some countries), and in patterns of treatment, may limit further growth.

END STAGE RENAL FAILURE

There has also been a rapid expansion of services for end stage renal failure and in the number of people taken on for treatment who are "high risk", that is elderly people or those with other diseases. The Department of Health guidance is that services should be available for forty new cases per million residents each year in England (fifty per million in Wales). This was seen as a interim target and has now been achieved. A more appropriate level is now thought to be seventy to eighty new cases per million population for people aged under eighty (Feest *et al.*, 1990). The expansion of services is illustrated in the table.

ACCEPTANCES OF NEW PATIENTS WITH END STAGE RENAL FAILURE (PER MILLION POPULATION)

	Target	All new patients	
		1979	1988
NW Thames	45	21.1	49.7
NE Thames	73	26.5	61.1
SE Thames*	40	43.3	76.1
SW Thames*	50	7.2	23.3
England	40	33.8	46.5

Source: European Dialysis and Transplant Association

*This refers to the number of patients treated in each region, not the number of residents of that region treated. Many SW Thames residents are treated in SE Thames RHA.

attract patients and bring referrals from a wide area if there is little competition. In NHS hospital trusts, specialist services, if they are more lucrative, may replace local acute services. In the long term this may further distort the balance of services between specialist, local acute, and community services in London.

In another scenario, DHAs, as purchasers of services for their residents, may change the traditional referral patterns of their communities.

- DHAs will prefer contracts which send patients to less expensive hospitals, which are in outer London or outside London, rather than the London teaching hospitals.
- Patients will be referred for less expensive therapies when there is a choice of treatment.
- District general hospitals and private hospitals providing NHS services under contract may be more reluctant to make referrals on to specialist centres in future, if these tertiary referrals have to be paid for by the referring hospital rather than the DHA where the patient

comes from. Even if the bill is to be met by the patient's DHA, the referral obviously means loss of income for the referring hospital.

- DHAs whose residents now receive above average levels of treatment for specialist services may be less willing to continue to contract for services at this level and may prefer to spend resources on other priorities.

The future is largely unknown, but the new arrangements will shake up what has been a static pattern, resistant to change and "rationalisation". In the past there has been a failure to plan and manage specialist services in London. This failure is at the centre of the present difficulties in London's services. New threats, uncertainties and opportunities may suddenly transform assumptions about what is possible in the capital. There are already signs that, faced with some semblance of market forces, people are acquiring a new interest in national planning.

CHAPTER 2

Services for whom?

Does it matter that specialist services are so heavily concentrated in inner London? London also has proportionately more tourist attractions, orchestras, theatres, and opera houses. The starting point must be to clarify what we want from specialist services, and assess the benefits and costs of the concentration of specialist services.

The important features of good specialist acute services are:

- clinical quality;
- accessibility;
- co-ordination with local acute services (bearing in mind that the boundary between them is neither precise nor fixed);
- efficiency;
- promotion of research, teaching, and new developments.

Clinical quality

Clinical quality may require the concentration of services in specialist centres: results tend to be better in centres where volume is higher. There are also benefits in specialist services being associated with research and teaching. However, treatment in "centres of excellence" is not a guarantee of quality. There are great variations in success, in terms of outcome and complication rate, for different units. Clinicians in the past have sometimes used clinical freedom to develop new treatments or techniques, whether or not they had received any specific training. The present system allows this. An example is the development of heart transplants in London: five centres undertake heart transplants and a sixth is planning to start. However, the proliferation of centres makes no sense in terms of quality of patient care, technical standards, or cost. The overall number of transplants is restricted by the limited supply of donor organs. Given this, one could determine how many centres would be appropriate in London – almost certainly, it would be less than the present number.

It should not be assumed that the concentration of services in a few centres is always the most appropriate way of delivering services. Cardiology, for example, has both a specialist and a local role. The treatment of heart disease, the commonest of all causes of death, must be a central part of services in all districts. While there are good grounds for ensuring that cardiothoracic surgery – a dynamic and developing

speciality – is carried out in specialist centres, there are no grounds for cardiology being restricted to the same centres. Yet cardiology in such a centre will be different from ordinary districts. Moreover, a specialist service, developing new techniques, is not going to have an impact on morbidity and mortality, unless it is associated with improvement in cardiology and health promotion in other districts. Hence the need for strong links within the cardiac service between all the district general hospitals and the regional centres.

Cancer is also a common disease for which specialist treatment is generally available in only a few districts. Surgery and chemotherapy are available in most hospitals, though not as designated oncology services. Radiotherapy, on the other hand, requires expensive equipment. Department of Health policy is that centres should serve a population of not less than one million. Radiotherapy is, therefore, a specialised service. However, a recent report to one of the Thames regions questioned this policy and suggested that, from the point of view of quality, appropriateness, and access to services, radiotherapy should be based in each district (MAS, 1990). Obviously, this would affect the level at which a comprehensive oncology service could be planned. Outcome and clinical effectiveness are important in determining the provision of services, but are rarely taken into account.

Box 2.1

THE USE OF SPECIALIST SERVICES BY DISTRICT

CORONARY ARTERY BYPASS GRAFTS (CABGS)

(The number of admissions of district residents treated in any DHA per million district resident population.)

	Inner London DHAs	Outer London DHAs	Outer Thames DHAs
Average	248	241	193
Highest DHA admissions	464	386	325
Lowest DHA admissions	82	135	69

END STAGE RENAL SERVICES

(The number of admissions of district residents treated anywhere per million district resident population.)

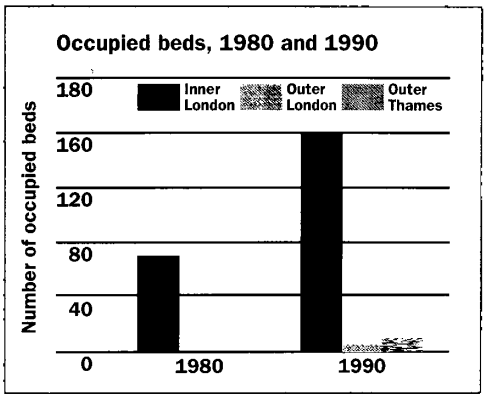
	Inner London DHAs	Outer London DHAs	Outer Thames DHAs
Average	51	15	28
Highest DHA	146	44	170
Lowest DHA	14	3	3

Source: Department of Health, *Health Service Indicators* (1989–90)

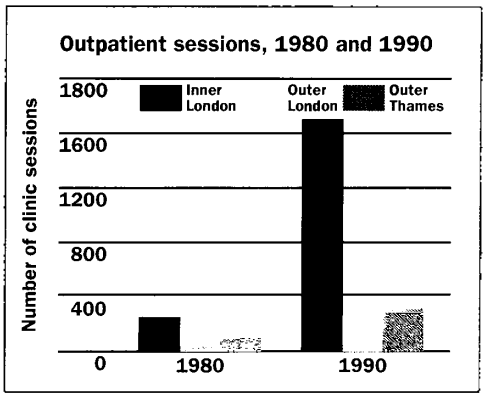
Box 2.2

MEDICAL ONCOLOGY

The LHPC in 1980 noted that medical oncology (the medical treatment of cancer) would be increasing and that each district should have a medical oncologist spending most of the time there.



Oncology has developed since 1980, but almost entirely in inner London.



Although, unlike radiotherapy, there is no reason for oncology outpatient services not to be available in all districts, this has not yet happened. The increase in clinic sessions has been in inner London.

Sources: **SH3 Hospital Statistics (1980); Körner aggregated returns (1988–89) (NWTRHA and SETRHA); Körner aggregated returns (1989–90) (NETRHA and SWTRHA)**

Who uses the services?

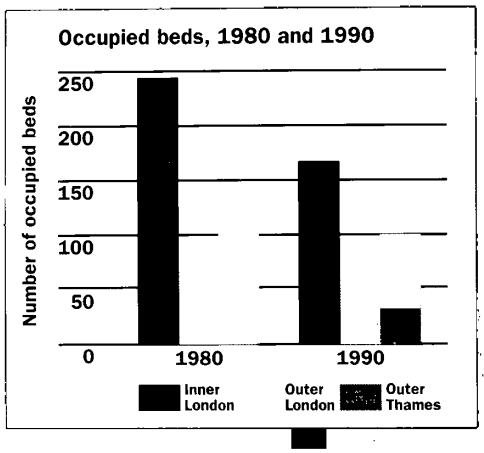
In many instances, potential demand for specialist services exceeds supply. It is therefore important that the criteria for referral should be clear. In reality there is a good deal of evidence that someone living near a specialist centre has better access (see Box 2.1).

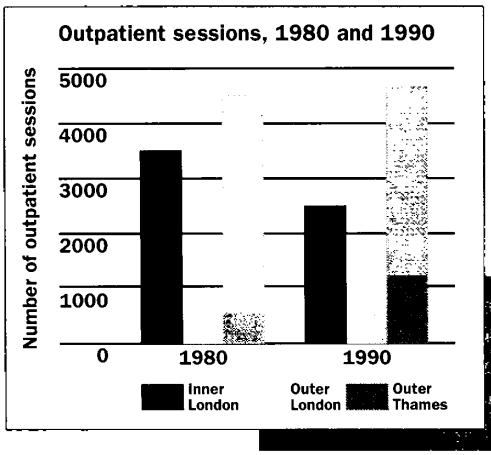
Most people have to travel for specialist services. This deters some people from wanting to be referred to a specialist centre, but it does not alone explain the inequalities in access. It is likely that general practitioners and clinicians in local hospitals distant from the specialist centres make fewer referrals because they are less aware of the services available for their patients. Custom and practice perpetuate these differences. As a result, though regional services are funded for all regional residents, most use is made by people living near the centres. Taking information from regionally funded specialist services in the North West Thames RHA as an example, a general picture emerges (see Boxes 2.2–2.7).

- In general, about twenty to thirty per cent of patients come from the host district.

Box 2.3

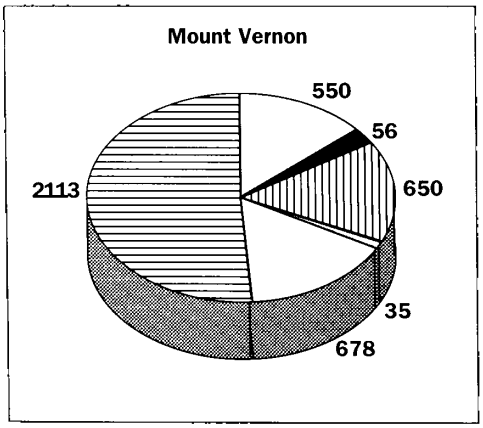
RADIOTHERAPY

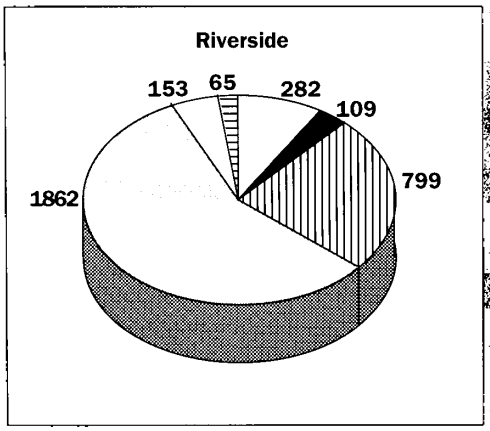


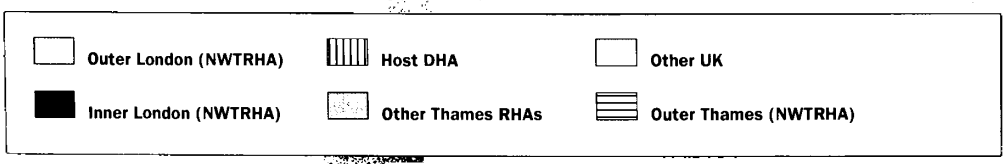


WHO USES REGIONAL SPECIALTIES? (NW THAMES RHA)

The varied pattern of use of services is also shown for radiotherapy in the two North West Thames RHA units, Riverside and Mount Vernon.







Distribution of specialist services in London 1980 and 1990
Maps 1a and 1b: Radiotherapy

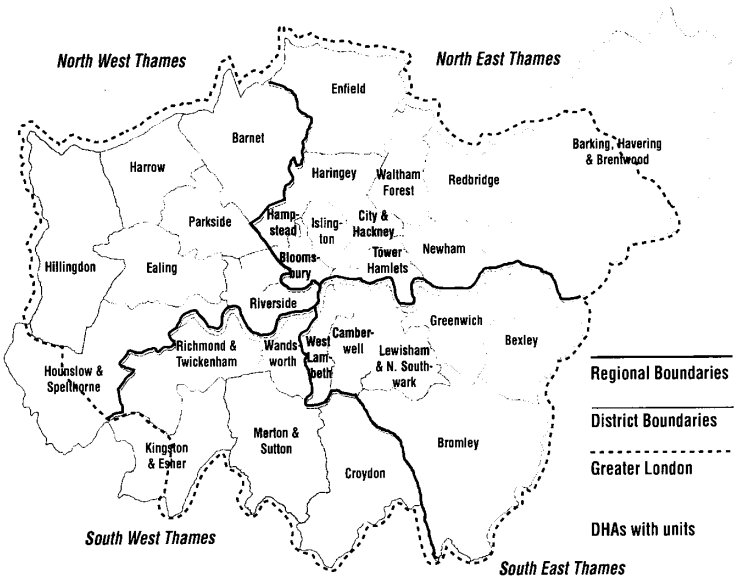
Map 1a: 1980

N W Thames
1 Mount Vernon
2 Westminster
3 Charing Cross
4 St Mary's

N E Thames
5 Middlesex
6 University College
7 North Middlesex
8 Royal Free
9 St Bartholomew's
10 London
11 Oldchurch

S E Thames
12 St Thomas'
13 Guy's
14 King's College

SHAs (postgraduates)
15 Hammersmith
16 Royal Marsden, Chelsea
17 Royal Marsden, Sutton



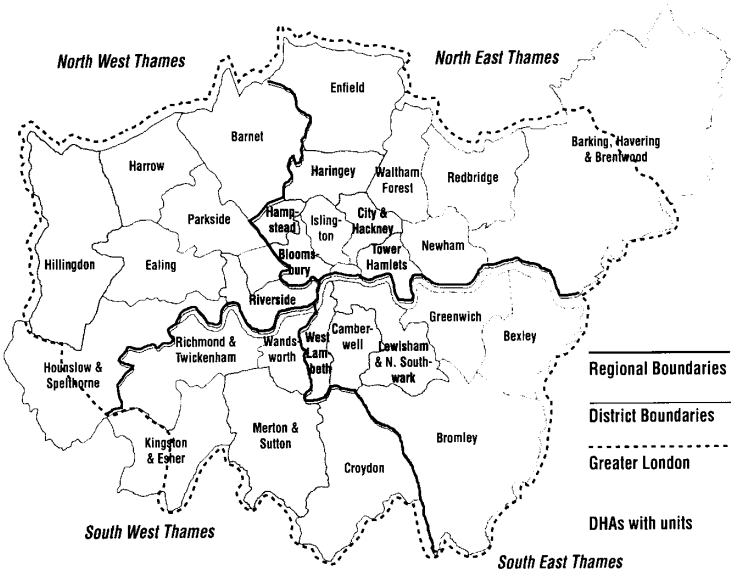
Map 1b: 1990

N W Thames
1 Mount Vernon
2 Charing Cross
3 Westminster

N E Thames
4 University College
5 Middlesex
6 North Middlesex,
7 Royal Free
8 St Bartholomew's
9 Royal London
10 Oldchurch

S E Thames
11 St Thomas'
12 King's College
13 Guy's

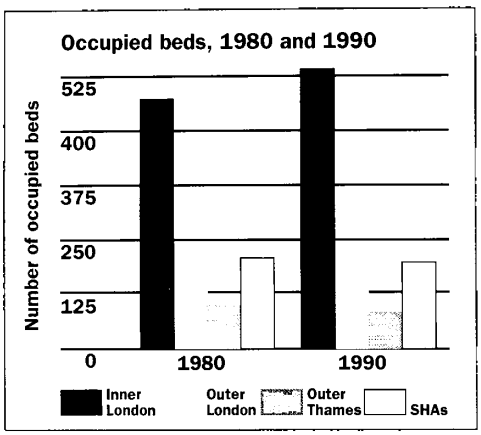
SHAs (postgraduates)
14 Hammersmith
15 Royal Marsden, Chelsea
16 Royal Marsden, Sutton



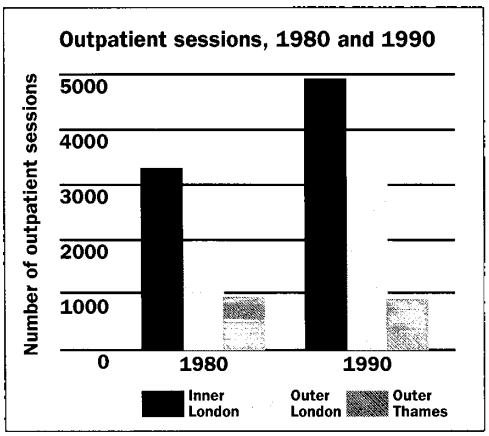
Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

Box 2.4

CARDIOTHORACIC SERVICES



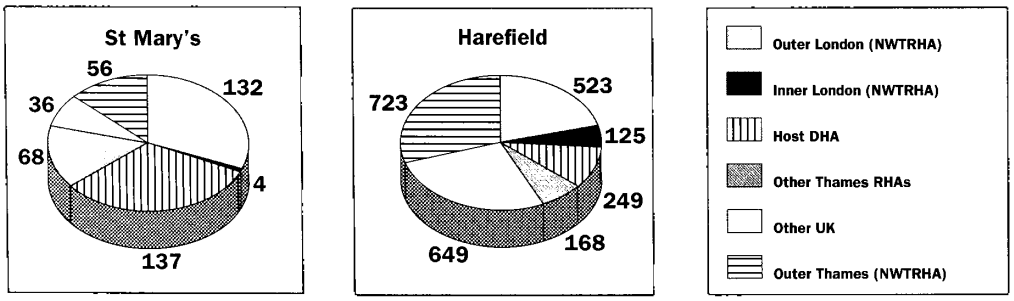
Cardiothoracic services have increased in the last ten years in inner London as new treatments have developed.



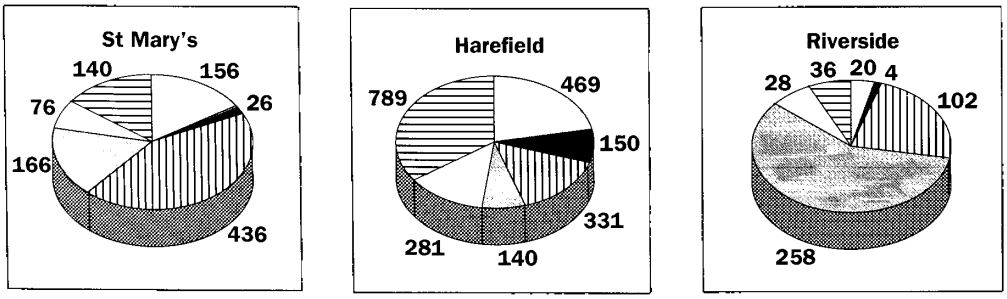
There has been a general increase in outpatient clinics in both inner and outer London, but not in outer Thames DHAs.

WHO USES REGIONAL SPECIALTIES? (NW THAMES RHA)

Cardiothoracic surgery is undertaken at St Mary's and Harefield Hospitals.



Cardiology is undertaken at St Mary's, Riverside and Harefield Hospitals.



Sources: SH3 Hospital Statistics (1980); Körner aggregated returns (1988–89) (NWTRHA and SETRHA); Körner aggregated returns (1989–90) (NETRHA and SWTRHA); information on the use of regional specialties (1989–90) from NWTRHA

Distribution of specialist services in London 1980 and 1990
Maps 2a and 2b: Cardiothoracic centres

Map 2a: 1980

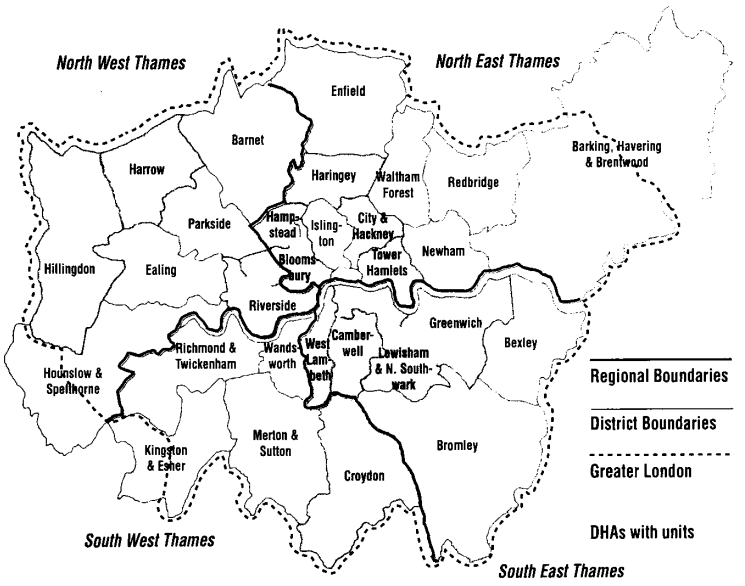
N W Thames
- 1 Harefield
- 2 Northwick Park (major investigations only)
- 3 Charing Cross (cardiology)
- 4 St Mary's
- 5 Westminster

N E Thames
- 6 Middlesex
- 7 North Middlesex
- 8 Royal Free
- 9 St Bartholomew's
- 10 London

S E Thames
- 11 Brook General
- 12 Guy's
- 13 St Thomas'
- 14 King's College

S W Thames
- 15 Mayday (cardiology)
- 16 St George's (SW1)

SHAs (postgraduates)
- 17 Hammersmith
- 18 Great Ormond Street
- 19 Brompton
- 20 London Chest
- 21 National Heart



Map 2b: 1990

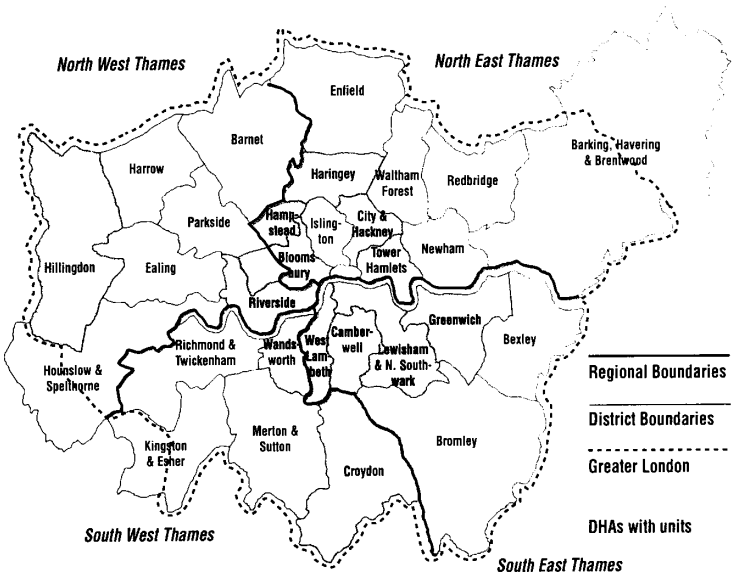
N W Thames
- 1 Harefield
- 2 St Mary's
- 3 Charing Cross (cardiology)

N E Thames
- 4 Royal Free
- 5 St Bartholomew's
- 6 Royal London
- 7 Middlesex

S E Thames
- 8 Greenwich
- 9 St Thomas'
- 10 King's College
- 11 Guy's

S W Thames
- 12 Mayday (cardiology)
- 13 St George's

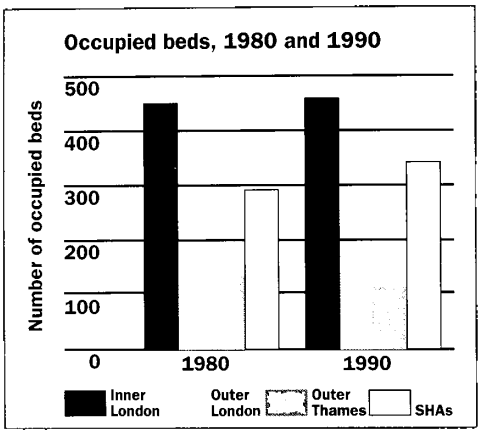
SHAs (postgraduates)
- 14 Brompton
- 15 Great Ormond Street
- 16 Hammersmith
- 17 London Chest
- 18 National Heart



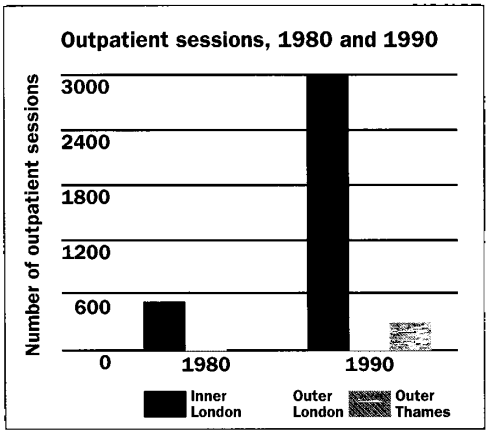
Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

Box 2.5

NEPHROLOGY



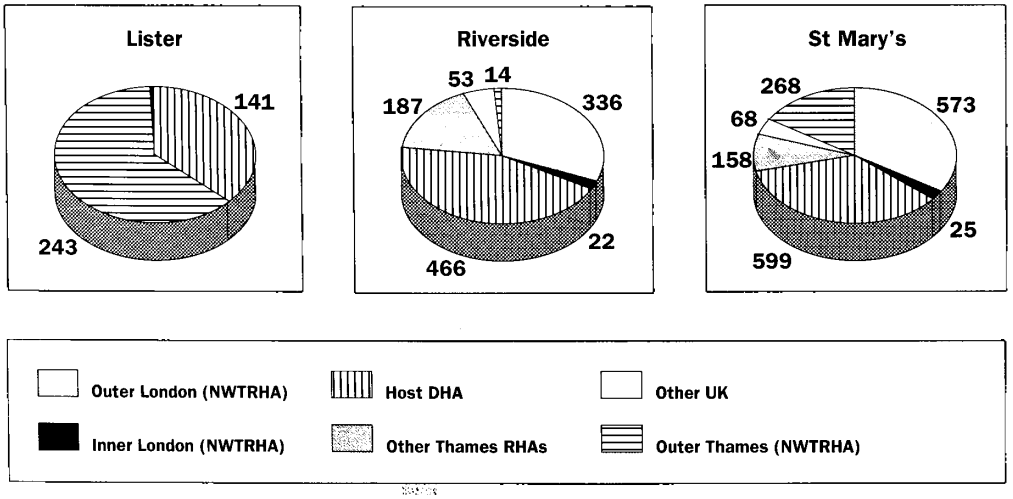
Department of Health policy has been reflected in an increase in beds numbers and centres specialising in renal services. (Maps 3a and 3b)



The main increase in both occupied beds and outpatient sessions is in inner London.

WHO USES REGIONAL SPECIALTIES? (NW THAMES RHA)

Regional specialties in NW Thames RHA are used heavily by residents of the host DHA. Renal services are provided at the Lister (Herts), Riverside and St Mary's.

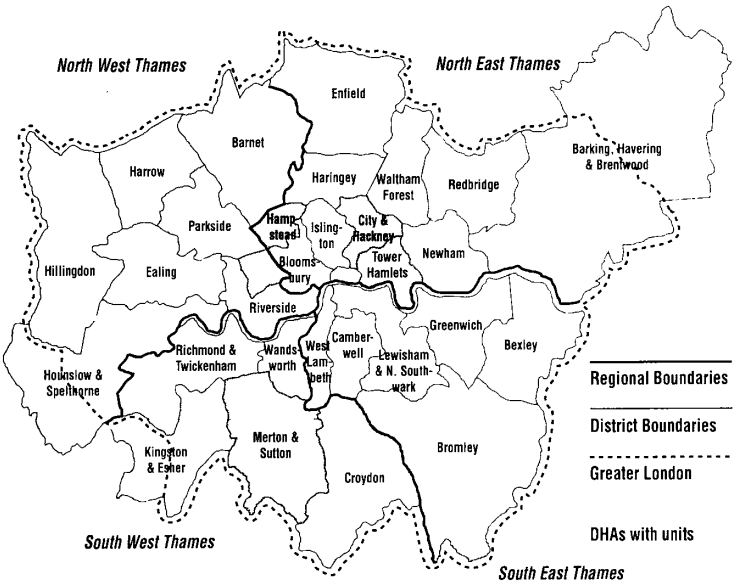


Sources: SH3 Hospital Statistics (1980); Körner aggregated returns (1988–89) (NWTRHA and SETRHA); Körner aggregated returns 1989–90 (NETRHA and SWTRHA); information on the use of regional specialties (1989–90) from NWTRHA

Distribution of specialist services in London 1980 and 1990
Maps 3a and 3b: Renal services (Nephrology)

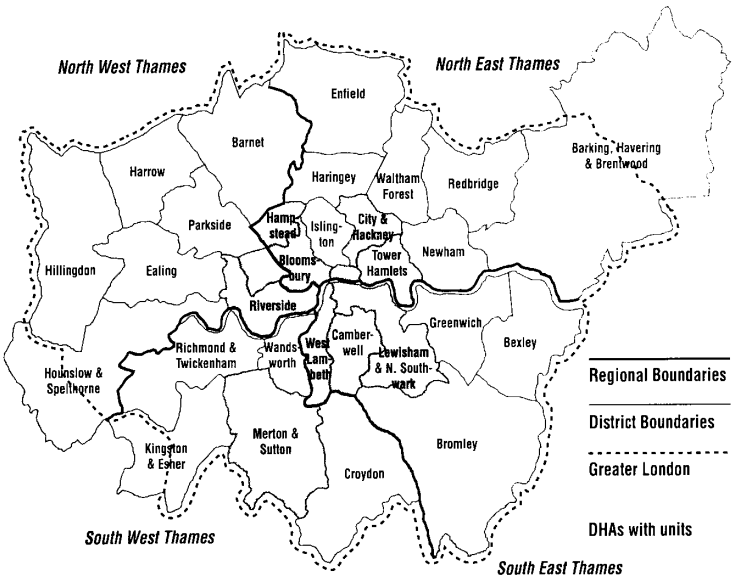
Map 3a: 1980

N W Thames
1 St Mary's
N E Thames
2 Royal Free
3 London
4 St Bartholomew's
S W Thames
4 St Helier
S E Thames
No information
SHAs for postgraduate teaching hospitals
No information



Map 3b: 1990

N W Thames
1 St Mary's
2 Charing Cross
N E Thames
3 Royal Free
4 St Bartholomew's
5 Royal London
6 St Peter's
S W Thames
7 St Helier
S E Thames
8 St Thomas'
9 Dulwich
10 Guy's
SHAs for postgraduate teaching hospitals
11 Hammersmith

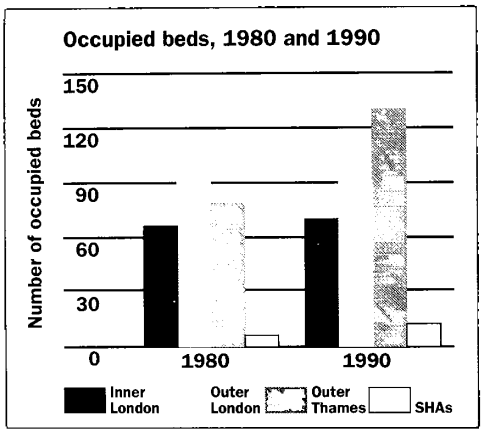


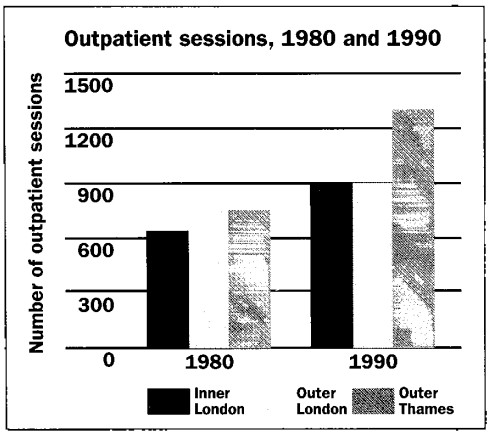
Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

Box 2.6

PLASTIC SURGERY

Plastic surgery developed in the Second World War, with the major centres for both North West Thames and South West Thames located in outer London (Mount Vernon and Queen Mary's Roehampton) rather than in the inner London teaching hospitals.



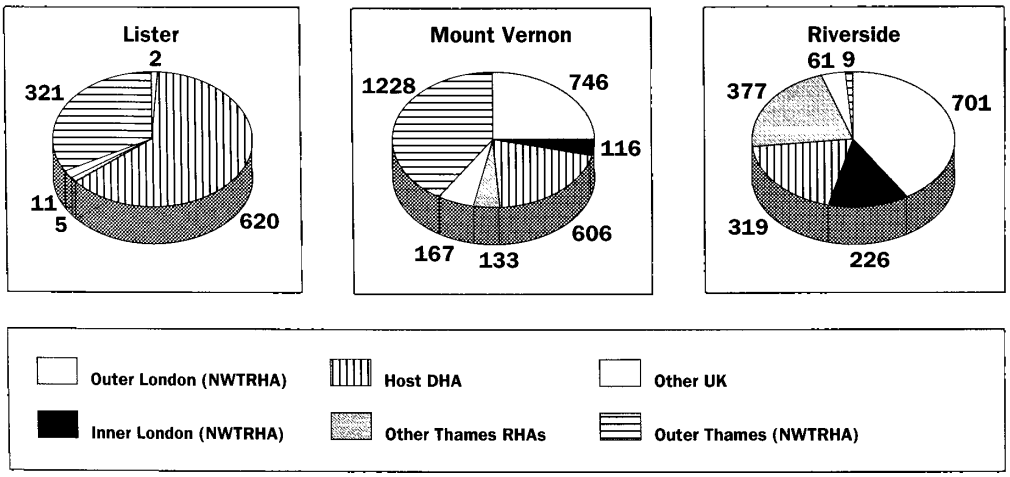


The number of occupied beds in outer London has decreased, but it has increased in the outer Thames DHAs, with little change in inner London.

Outpatient clinics outside London are better established than in other specialties. Plastic surgery is the only specialty in the Thames regions where more outpatient sessions are in outer London and the outer Thames DHAs than in inner London.

WHO USES REGIONAL SPECIALTIES? (NW THAMES RHA)

Plastic surgery is a regional specialty in Riverside, Hillingdon (Mount Vernon) and North Herts (Lister).

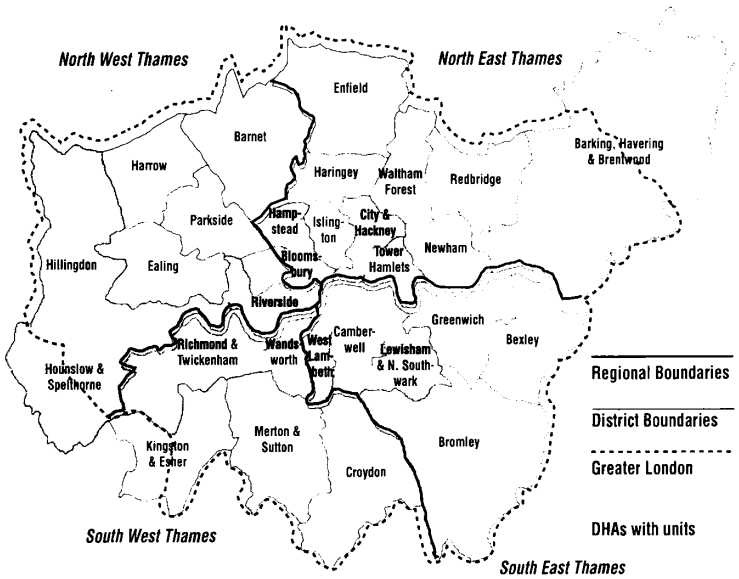


Sources: SH3 Hospital Statistics (1980); Körner aggregated returns (1988–89) (NWTRHA and SETRHA); Körner aggregated returns (1989–90) (NETRHA and SWTRHA); information on the use of regional specialties (1989–90) from NWTRHA

Distribution of specialist services in London 1980 and 1990
Maps 4a and 4b: Plastic surgery

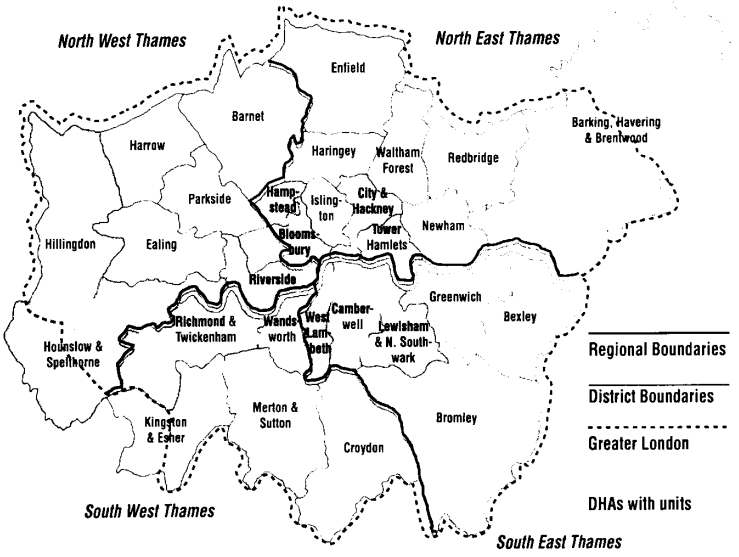
Map 4a: 1980

N W Thames
1 Mount Vernon
2 W Middlesex
3 Charing Cross
N E Thames
4 University College
5 London
6 St Bartholomew's
7 Royal Free
S E Thames
5 St Thomas'
9 King's College
10 Guy's
S W Thames
11 Queen Mary's, Roehampton
12 St George's
SHAs for postgraduate teaching hospsitals
13 Hammersmith



Map 4b: 1990

N W Thames
1 Mount Vernon
2 W Middlesex
3 Charing Cross
N E Thames
4 University College
5 Royal Free
6 St Bartholomew's
7 Royal London
S E Thames
8 St Thomas'
9 King's College
10 Guy's
S W Thames
11 Queen Mary's, Roehampton
12 St George's
SHAs (postgraduate)
13 Hammersmith

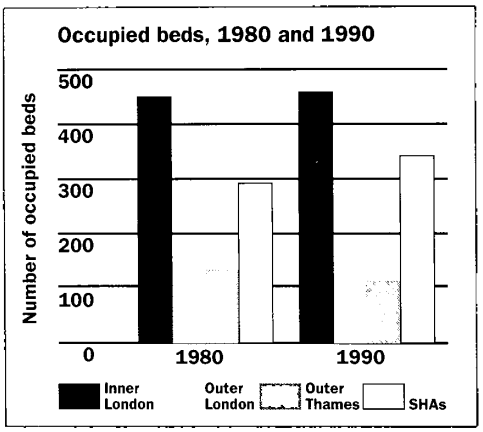


Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

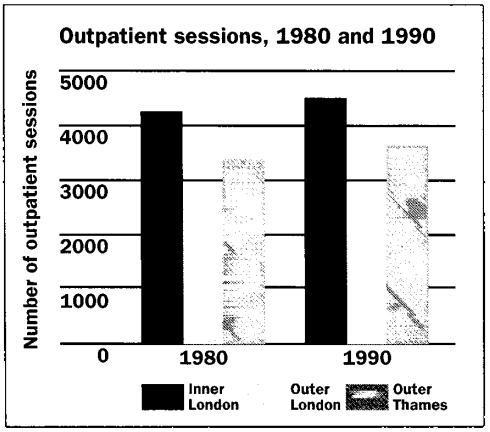
Box 2.7

NEUROSCIENCES

Neurosciences are concerned with disorders of the nervous system. Frequently these conditions are also treated by general physicians and GPs, with neurologists available for specialist opinions. Neurosurgeons mainly treat congenital neurological conditions, such as spina bifida and hydrocephalus, brain tumours, cerebrovascular aneurysms, head injuries and spinal tumours, and degenerative conditions.



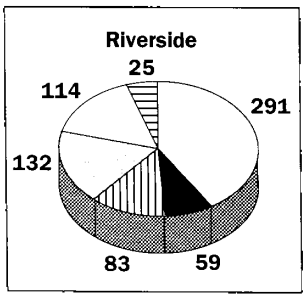
There has been little change in the number of beds between 1980 and 1990 in the neurosciences.

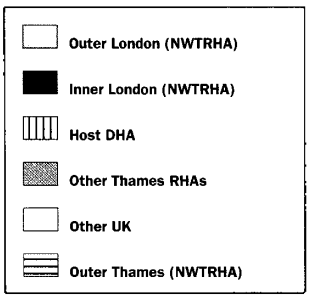


There has been little change in the distribution of outpatient clinics in the neurosciences.

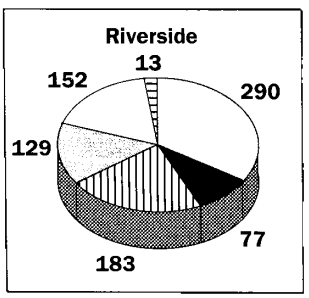
WHO USES REGIONAL SPECIALTIES? (NW THAMES RHA)

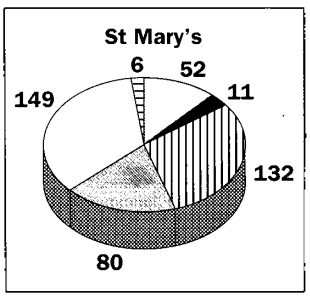
Neurosurgery is carried out at Charing Cross Hospital.





Neurology is a regional specialty in Riverside and St Mary's.



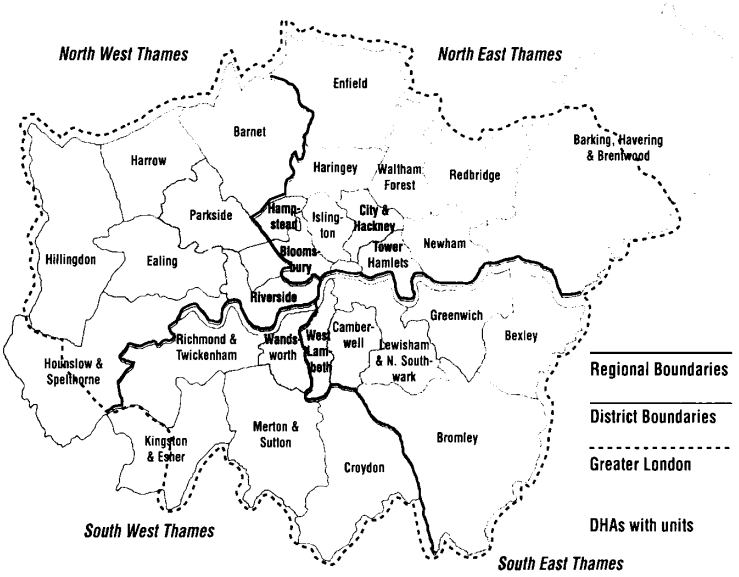


Sources: SH3 Hospital Statistics (1980); Körner aggregated returns (1988–89) (NWTRHA and SETRHA); Körner aggregated returns (1989–90) (NETRHA and SWTRHA); information on the use of regional specialties (1989–90) from NWTRHA

Distribution of specialist services in London 1980 and 1990
Maps 5a and 5b: Neurosurgery

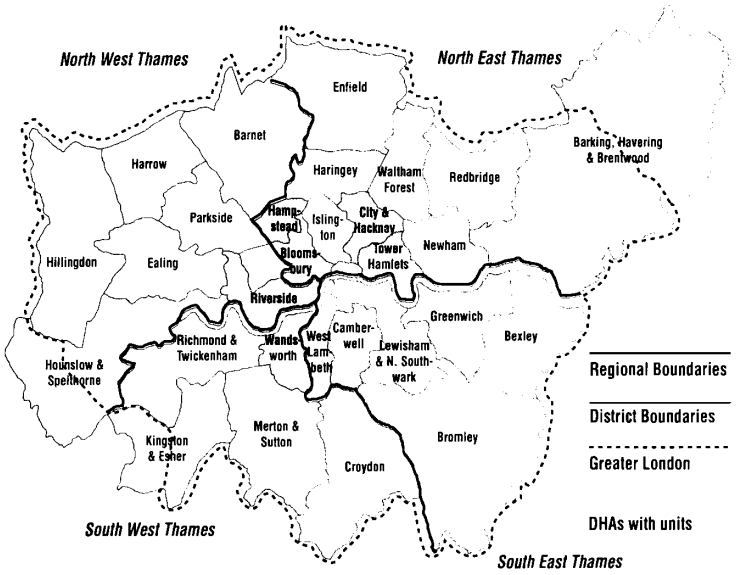
Map 5a: 1980

N W Thames
1 Central Middlesex
2 Charing Cross
3 Westminster
N E Thames
4 Middlesex
5 University College
6 Oldchurch
7 St Bartholomew's
8 Royal Free
9 London
S E Thames
10 Brook General
S W Thames
11 Atkinson Morley
SHAs (postgraduates)
12 Nervous Diseases
13 Great Ormond Street
14 Maudsley



Map 5b: 1990

N W Thames
1 Charing Cross
N E Thames
2 Oldchurch
3 St Bartholomew's
4 Royal Free
5 Royal London
S E Thames
6 Brook
S W Thames
7 Atkinson Morley
SHAs (postgraduates)
8 Nervous Diseases
9 Great Ormond Street
10 Maudsley



Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

Distribution of specialist services in London 1980 and 1990
Maps 6a and 6b: Neurology

Map 6a: 1980

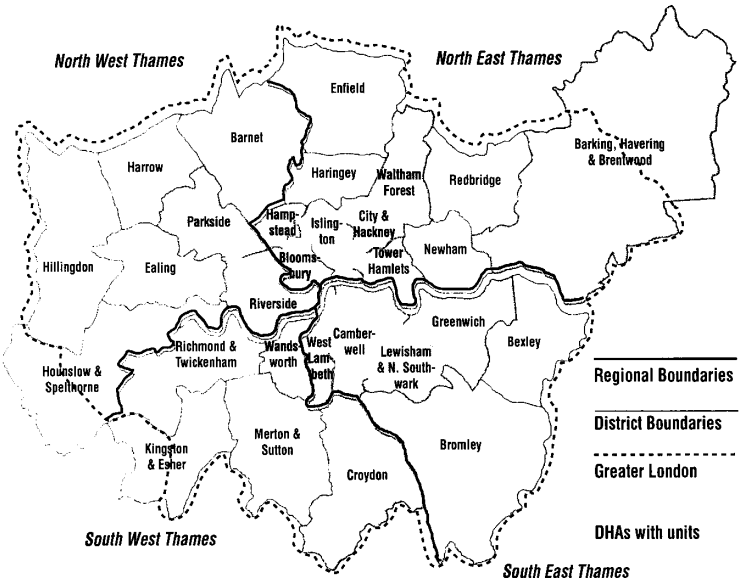
N W Thames
1 Central Middlesex
2 Charing Cross
3 St Mary's
4 Westminster

N E Thames
5 Middlesex
6 Oldchurch
7 Royal Free
8 University College
9 St Bartholomew's
10 London
11 Whittington

S E Thames
12 Brook General
13 King's College
14 Dulwich
15 Guy's
16 St Thomas'

S W Thames
17 Atkinson Morley
18 Mayday

SHAs (postgraduates)
19 Hammersmith
20 Nervous Diseases



Map 6b: 1990

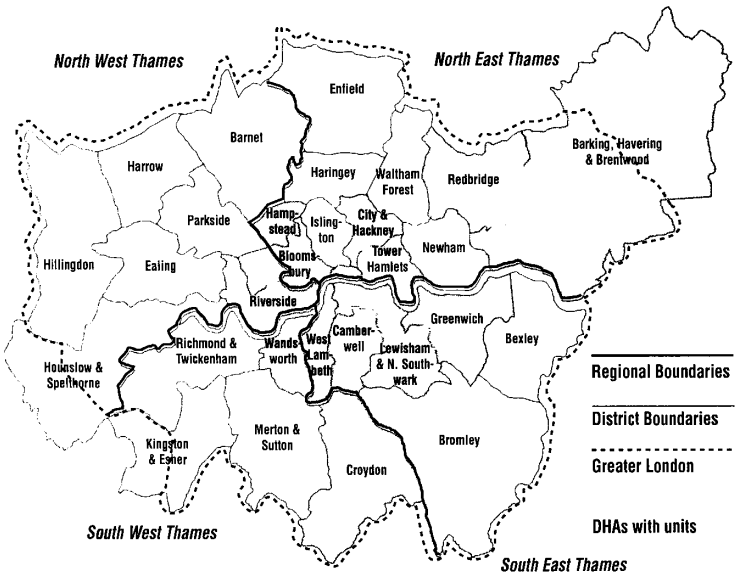
N W Thames
1 Charing Cross
2 St Mary's

N E Thames
3 Middlesex
4 Oldchurch
5 Royal Free
6 St Bartholomew's
7 Royal London
8 King George

S E Thames
9 Brook
10 King's College
11 Guy's
12 St Thomas'

S W Thames
13 Atkinson Morley
14 Mayday

SHAs (postgraduates)
15 Nervous Diseases
16 Hammersmith



Sources: Hospital Activity Statistics (1980) (SH3); LHPC study group reports; Körner returns (1989–90)

- There are enormous variations in the size of the catchment area for regional services. This may be partly due to the publicity given to a service. For example, Harefield Hospital, renowned internationally for its cardiothoracic surgery, received the most referrals from other RHAs (see Box 2.4).
- For North West Thames RHA's hospitals in inner London, about five per cent of patients came from outside the Thames regions. The highest proportion – thirty-five per cent – were treated by neurology services at Mary's Hospital.

Radiotherapy normally requires daily visits to a centre over a number of weeks; this can be difficult for people who live far away or who are ill. As a result, it is not surprising that radiotherapy is given most frequently to those who live near radiotherapy units. In Riverside there was, until recently, a radiotherapy unit at both Charing Cross and Westminster Hospitals, as well as units in Hammersmith and the Royal Marsden SHAs. Twenty-five per cent of Riverside residents with cancer received radiotherapy, compared to ten per cent of cancer patients in Hounslow, where there is no centre (North West Thames RHA, 1987).

For many diseases, there are alternatives to specialist care. For renal failure, however, there is no alternative to dialysis or transplantation: without treatment the patient will soon die. Inequalities in access are as pronounced for renal services as other specialties: the nearer you live to the centre, the more likely you are to receive treatment.

The most obvious way to develop a more equitable distribution of services across London is for staff from specialist centres to run outpatient clinics in other districts, and to work with staff in the catchment area to ensure more appropriate referrals. This has not happened. In most specialties, where there has been an increase in outpatient sessions held between 1980 and 1990, this increase has been in inner London, where the centres are situated, and not in outlying areas.

Co-ordination

The management of health services in England and Wales is split between hospital and community services, general practitioners and local authorities. This can lead to fragmented service for patients and their carers, and such fragmentation could increase with the advent of NHS trusts. To ensure that patients are provided with a "seamless" service, acute units have to give priority to communication and shared care with community services and general practitioners. For specialist services attracting referrals from a wide catchment area, co-ordination with local services is likely to be a particular problem.

Specialist services, such as cardiothoracic and cancer services, and the neurosciences, often treat common conditions. As a result, they need to be linked into local services and rehabilitation. The difficulty in balancing technical quality and integration with local services is particularly evident in the neurosciences.

Neuroscience is the only clinical specialty where there are no general physicians specialising in neurology. The Royal College of Physicians only recognises specialist neurologists. The advantage is that neurosciences are concentrated in centres of excellence (ideally alongside neurosurgery) with access to a range of diagnostic procedures.

> *This maximises the opportunities for research, and allows individual consultants to pursue specialised interests to the benefit of patients.*
>
> (South West Thames RHA, 1985)

However, it is all the more imperative that neurologists should be available in hospitals other than their own for consultation by general physicians. Strong links with local services are also essential for the rehabilitation of neurological disabilities. There is the further problem that nearly all people with neurological problems will have attendant social and personal difficulties, and there are high rates of psychiatric problems among patients, which are often unrecognised by specialist neurologists (Bridges and Goldberg, 1984). In international terms, neurology is a particularly interesting example of Britain's highly structural patterns of referral. We have far fewer neurologists than other developed countries. The standard of their work is extremely high, because they are true specialists, but access to them is dependent on the decisions of general physicians and general practioners (GPs).

Efficiency

The concentration of specialist services in a few centres may be cost effective. This is especially true where expensive equipment for diagnosis and treatments needs to be purchased and maintained. However, specialist services are heavily concentrated in hospitals in inner London, where costs are higher, and access may be difficult if they depend on referral from a considerable distance. In general, between 1980 and 1990 there has also been a trend towards centralisation of beds in the teaching hospitals rather than in outer London.

Outpatient clinics are mainly held in specialist centres. Where there has been an increase in the number of clinics held, this has been in inner London. This may not be the most efficient use of resources: there are striking differences in the unit costs of outpatient clinics held in inner London, outer London and the outer Thames DHAs. Unit costs in inner London in all specialist services can be up to three times that of the DHAs in the Thames RHAs which are outside London, according to recent research by CIPFA (1990). With the exception of plastic surgery, the more patients attending outpatient clinics, the higher the unit costs. This is not what might be expected and needs further examination. It is also likely to be affected by differences in the underlying assumptions about cost allocation between outpatients and inpatients. For the future, one would expect to see an increase in specialist clinics held away from the specialist centres, in order to improve access.

Research, teaching and the special health authorities

A third of all medical students in the UK train in London (almost entirely in *inner* London, although this is beginning to change). In addition, all the postgraduate institutes and most of their associated hospitals are in inner London. The special health authorities (SHAs) for the postgraduate teaching hospitals hold a central position in the provision of London's specialist services. There are eight SHAs funded directly by the Department of Health, which manage sixteen hospitals with over 3000 beds. (see Box 2.8). This compares with some 9100

Box 2.8

SPECIAL HEALTH AUTHORITIES IN LONDON, 1989–90

	Bed numbers	Consultant episodes* 1989–90	Revenue 1991–92 £'000s
Institute of Child Health			
Hospitals for Sick Children SHA	468	19,987	48,539
Great Ormond Street (348)			
Queen Elizabeth, E2 (120)			
Institute of Neurology			
National Hospitals for Nervous Diseases SHA	328	4,473	27,293
Queen Square (192)			
Maida Vale (79)			
Finchley (27)			
Chalfont (Epilepsy, 30)			
Institute of Ophthalmology			
Moorfields Eye Hospital SHA	149	11,581	19,516
Institute of Psychiatry			
Bethlem Royal Hospital and the Maudsley SHA	521	955	31,010
Institute of Diseases of the Chest			
National Heart and Chest SHA	450	19,221	42,240
Brompton (240)			
National Heart (70)			
London Chest, E2 (140)			
Institute of Cancer Research			
The Royal Marsden Hospital SHA	359	16,440	31,875
Fulham Road, SW3 (194)			
Sutton (165)			
Royal Postgraduate Medical School/Institute of Obstetrics and Gynaecology			
Hammersmith and Queen Charlotte's SHA	829	20,381	66,987
Hammersmith (593)			
Acton (Geriatric, 72)			
Queen Charlotte's (Maternity, 164)			
Eastman Dental Hospital SHA	0	1,741	7,421
Total	3104	94,779	274,881

*A consultant episode is the time a patient, using a hospital bed, spends in the continuous care of a single consultant. It is finished when the patient is transferred to another consultant or is discharged.

Source: Revenue and consultant episodes, Department of Health, *Health Service Year Book 1990* (bed numbers).

beds in the acute sector managed by inner London districts and trusts.

Postgraduate teaching hospitals are intended to act as centres of outstanding performance in teaching, research and service and more specifically to:

- act as national centres for specialist teaching of graduate clinicians for both rare and common conditions (treatment for common conditions should be carried out to a standard that should establish a reference for clinical work in environments throughout the NHS);
- provide training for nurses and other professional and technical staff who specialise in the discipline;
- carry out and promote research and development in their specialties;
- act as national centres for tertiary referral and advice to doctors and nurses working elsewhere in the NHS;
- provide services as necessary for research and development, together with other services agreed with the Department of Health, RHAs or DHAs;
- disseminate new ideas and cost-effective good practices in the treatment and care of patients so that these may influence practitioners throughout the NHS and promote the development of the specialty concerned, within agreed priorities for use of resources.

With these aims in mind, there are two questions which need to be considered: who uses the services and how far do the SHAs provide a national or a regional service?

Services provided

Information on the activities of SHAs is not easy to obtain. Only recently, with the development of contracts, is information becoming available to RHAs about the activities of some of the SHAs.

Some services provided by SHAs are not available in other hospitals. However, many services provided in the SHAs are not specialist services *per se* and are not necessarily different from those in other hospitals; this is not surprising. For teaching and research purposes, the postgraduate hospitals need a mix of work, ranging from the rare to the common. The SHAs in fact provide a valuable service to the Thames regions. As one example, forty-one per cent of the operations carried out by Moorfields Hospital were cataract operations. From 1974 to 1982, Hammersmith Hospital was the district general hospital for North Hammersmith and part of the North West Thames RHA. It has SHA status because of its association with the Royal Postgraduate Medical School.

In the last few years, closer relationships have developed between the SHAs and the Thames regions: for example, the Royal Marsden SHA undertakes radiotherapy for SW Thames residents. The National Hospitals for Nervous Diseases SHA undertakes neurosurgery for Bloomsbury, and the neurosurgery units in the Middlesex and the University College Hospitals have closed.

Research is not confined to teaching hospitals, let alone post-

graduate hospitals, but the latter have exceptional opportunities to concentrate on research in their particular field. SHAs are funded directly by the Department of Health and do not have responsibility for providing comprehensive services to a catchment area. As a result they have more freedom to introduce new techniques and drugs which have cost implications. They also often have strong links with research charities and suppliers in their field of interest.

In education, they are national centres for postgraduate training, not only for doctors, but also for nurses and others. In oncology, for example, a very high proportion of nurses specialising in work with cancer patients have trained at the Royal Marsden.

Where do patients come from?

In the past, information on the area of residence of patients has not been accurately collected in some SHAs. Existing evidence indicates that SHAs mainly provide a service for the Thames regions (see Box 2.9).

In its forecast for 1991–92, Hammersmith and Queen Charlotte's SHA estimates that seventy-one per cent of patients will come from London DHAs in North West Thames, and in total eighty per cent of patients will come from the four Thames regions. Eighty per cent of NHS renal transplant patients at the Hammersmith come from the four Thames regions, as do eighty-eight per cent of cardiothoracic patients (excluding EEC, overseas and private patients).

The pattern is replicated to varying degrees in all the SHAs. At the Royal Marsden, seventy-five per cent of patients come from the Thames regions, with over half from South West Thames. The hospital has an agreement to provide radiotherapy services and nuclear medicine to that region. Moorfields Hospital provides a service mainly to inner London residents in North East Thames RHA.

Who benefits?

How far are London's teaching hospitals providing a national, regional, or local service? From the evidence, it seems that the service is most used by people living near specialist centres. Many SHAs draw from a wider catchment area than undergraduate teaching hospitals, but they remain primarily a service for the Thames regions.

The concentration of specialist services provides the basis for centres that combine service, teaching, and research. This is important for the future development and maintenance of quality in the health service nationally. Nevertheless, it is curious that all the postgraduate hospitals and institutes should be in London. If this gives Londoners unfair advantages in terms of access to these services, there are also costs to London which need to be weighed against these benefits:

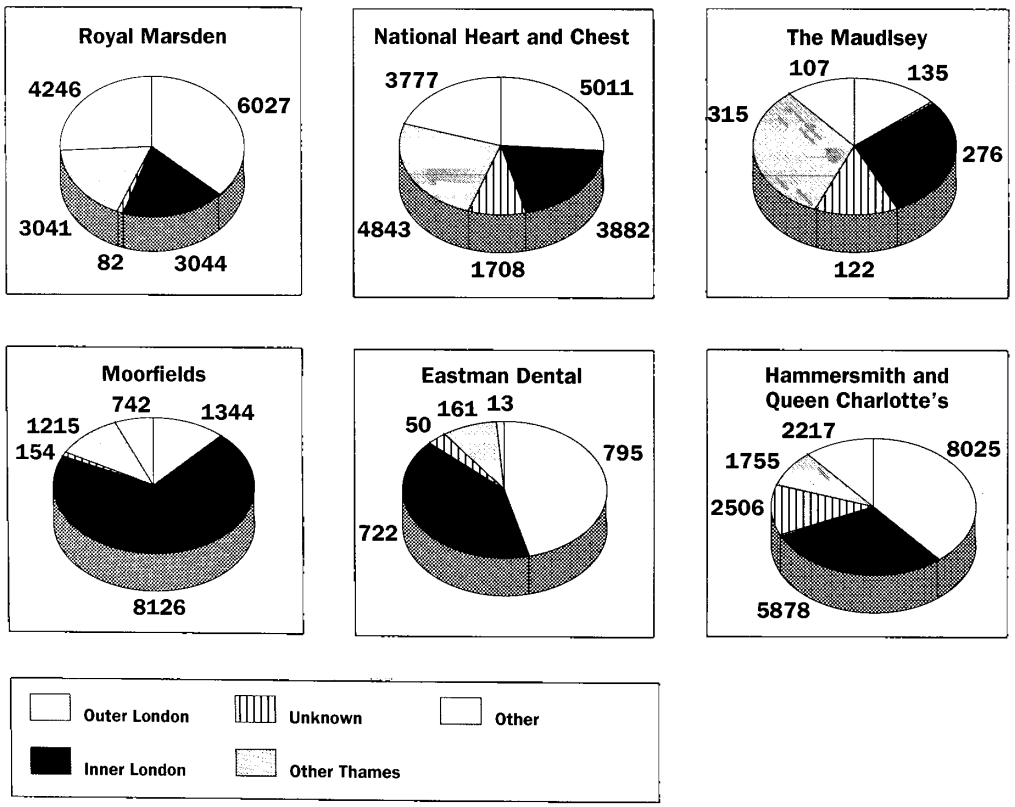
- Specialist services have often been planned in isolation from district acute services. This has sometimes led to undue attention being given to specialist treatments rather than to co-ordinating and integrating specialist services into district services. Costly specialties, which have regional and even national catchments, and which have

funding that has been protected, may also be absorbing resources at the expense of local acute services.

- Varied access to treatment in different DHAs within the London conurbation is not acceptable in terms of equity. There is little evidence that there have been attempts by specialist services to address this issue.

Box 2.9

SPECIAL HEALTH AUTHORITIES FOR POSTGRADUATE TEACHING HOSPITALS: WHERE PATIENTS COME FROM, 1989–90



Source: Department of Health (Accurate figures for 1989–90 were not available for the Hospitals for Nervous Diseases or the Hospitals for Sick Children.)

CHAPTER 3

Managing specialist services

The challenge, faced in 1978 by the LHPC, was to protect high standards, encourage new developments – and be responsive to the needs of local communities. The recommendations of the LHPC have been largely ignored. The reason for this may lie in the way that specialist services are managed and funded. From an understanding of the present situation, we can then go on to consider more appropriate ways of managing specialist services in the future.

The management of specialties is fragmented and largely unplanned. New funds tend to be given only to established centres, which are historically based in London. London teaching hospitals are divided between four regions and the postgraduate teaching hospitals into eight SHAs. The way they are planned and managed makes the overall picture difficult to see.

Teaching hospitals

The London undergraduate teaching hospitals began as voluntary hospitals providing care for the poor. Doctors gave their time free of charge, but were able to use their charity hospital work as a basis for building up their practice. What are now known as the postgraduate teaching hospitals were established from the middle of the nineteenth century, as specialisation in medicine developed. General physicians usually opposed the development of specialties as they felt that they "narrowed the mind and led doctors to diagnose their favourite condition in every patient they saw" (Rivett, 1986). In order to practise in their specialties, doctors often set up separate hospitals (usually small in the first instance) which then competed with other voluntary hospitals for public funds and charitable contributions.

But the march towards specialisation in medicine was the path of the future, and the voluntary hospitals soon began to provide specialist services themselves. By 1945 they provided a mix of local and specialist services. They were also very conscious of their status, feeling themselves to be substantially superior to local authority hospitals. Accordingly, they fought for, and won, a different status. Until 1974 all postgraduate and undergraduate teaching hospitals had their own boards of governors and were funded directly by the Department of Health.

In 1974 undergraduate teaching hospitals were brought into the main structure of the NHS, and they were required to take on the functions of district general hospitals. The teaching hospitals were not always enthusiastic about their new role: there were some real tensions between their local and their national responsibilities (Rivett, 1986).

Compromises were made to make the change more acceptable. Each teaching hospital was given its own district to ensure that the teaching needs of the students were taken into account in planning services. This led to some unwieldy boundaries, such as the division of the Royal Borough of Kensington and Chelsea and the City of Westminster into three districts. As a result, the City of Westminster had to liaise with three health authorities, and Kensington and Chelsea with two. The London Borough of Hammersmith was divided into two districts. To counteract the effects of these decisions, there have been repeated boundary reorganisations since 1974.

Special health authorities

Meanwhile, in 1974 it was decided that area health authorities would not be able to manage postgraduate teaching hospitals and that they should continue to be managed directly by the Department of Health for a further five years. At that time it was noted that there were no special advantages in the geographical separation of undergraduate and postgraduate teaching hospitals (King's Fund, 1975).

The management of postgraduate teaching hospitals was last reviewed in 1975 (King's Fund, 1975). This review outlined five possible management structures:

- retention of boards of governors;
- integration of the hospitals with health authorities;
- establishment of a single SHA;
- management directly by RHAs;
- management directly by the Department of Health.

The Department of Health, in a consultation document, favoured the establishment of one SHA which would then allocate resources to the postgraduate hospitals according to national priorities (DHSS, 1978). However, the postgraduate hospitals in 1982 were successful in resisting proposals that they should be managed by one London SHA. There are now eight SHAs managing services provided in sixteen hospitals. A few hospitals have been transferred to district management over the last ten years. These include St John's Hospital for Diseases of the Skin (West Lambeth), St Mark's Hospital for Diseases of the Rectum and Colon (City and Hackney), St Peter's, St Paul's and St Philip's Hospitals for Urology (Bloomsbury). The Royal National Orthopaedic Hospital in Stanmore and the Royal Throat, Nose and Ear Hospital were also transferred to Bloomsbury and have since become NHS Hospital Trusts.

Each hospital group has its own SHA accountable to the Department of Health. The SHA Chair and members of SHAs are drawn from the same pool as members of other health authorities. Community Health Councils (CHCs) in the district where the SHA is situated have observer status.

The postgraduate hospitals managed by SHAs have in general

Box 3.1

BEDS AVAILABLE IN POSTGRADUATE TEACHING HOSPITALS, 1978 AND 1990

	Bed numbers 1978	Bed numbers 1990
Special health authorities		
Hospitals for Sick Children	603	468
National Hospitals for Nervous Diseases	314	328
Moorfields	253	149
Bethlem Royal Hospital and the Maudsley	510	521
National Heart and Chest	713	450
The Royal Marsden Hospital	384	359
Hammersmith and Queen Charlotte's Hammersmith, Acton (Geriatric) and Queen Charlotte's	870	829
Eastman Dental Hospital	0	0
Total	3,647	3,104
Other postgraduate hospitals		
St John's (skin)	60	0
Royal ENT	230	90
Royal Orthopedic	384	227
St Peter's group (urology)	151	127
Total	825	444

Sources: DHSS (1978); *Health Services Year Book* (1990)

been less affected by reductions in beds than those transferred to district management (see Box 3.1). In 1983 the SHAs were informed that there would be no extra funds for the next ten years and that all new developments would have to be funded from internally generated resources. However, they do not have responsibility for providing comprehensive services for a catchment area. The SHAs have been in a better position than undergraduate teaching hospitals to maintain and develop their acute services.

The NHS and Community Care Act is bringing changes in the way that SHAs relate to RHAs and DHAs. In 1990, SHAs for the postgraduate teaching hospitals could have applied for NHS Trust status, though none did. The present arrangement continues, but they now have contracts with the Department of Health and more contractual relationships will be introduced with DHAs.

In the 1980s there was an increasing trend for DHAs to refer patients to the SHAs, where they were treated at no cost to the district's budget. This remains largely the position today. For 1991–92, DHAs can continue to refer to the level of the previous years but they may have to pay for any additional referrals.

This gives SHAs an advantage in the market place. They can provide services to existing levels at least for the next year at no charge. They may also be able to offer contracts at a lower cost than London teaching hospitals, because their general service is funded by the Department of Health. This arrangement is obviously "unfair" competition for other hospitals offering similar services and has a distorting effect on provision in London.

The relationship between SHAs and other hospitals, and between SHAs and GPs, needs to be clarified, and their role as providers of general acute services or specialist services defined. To make the best use of all specialist services they will need to develop mechanisms to ensure appropriate referrals, perhaps by giving priority to tertiary referrals.

Supra regional specialties

Arrangements for funding of services which need to be planned on a national level were introduced in England in 1983. Broadly, supra regional services require a high degree of expertise and are required by only a relatively small number of people (see Box 3.2). They include heart and liver transplantation and services for rare cancers such as

Box 3.2

CRITERIA FOR SUPRA REGIONAL SPECIALTIES

The criteria for designation as a supra regional specialty were outlined in the Department of Health Circular (HN(83)36) as "the small number of specialised health services which, in order to be economically viable or clinically effective, need to be provided for a population substantially larger than that of any one Region".

Additional guidance was issued in 1988 in EL (88)P/153). The criteria are given below.

- **The service should be an established clinical service, not a national research or development activity.**
- **There should be a clearly defined group of patients having a clinical need for the service.**
- **The benefits of the service should be sufficient to justify its costs and set against alternative uses of NHS funds.**
- **The cost should be high enough to make the service a significant burden for the providing regions. In 1988 this was taken as at least £250,000 per unit.**
- **Supra regional funding, as opposed to regional or sub regional developments, should be clearly justified either:**

  - by the small number of potential patients in relation to the minimal viable workload for a centre, or

  - by the economic and service benefits of concentrating the service in fewer and larger units shared between regions (this does not include services organised mainly at regional level in which two regions agreed on joint provision as a matter of mutual convenience), or

  - as an interim measure by the scarcity of the relevant expertise and/or facilities.
- **The units to be designated should be capable of meeting the total national case load for England and Wales.**

The rarity of the condition to be treated was defined in 1988 as to be such that the population served by each unit is a minimum of five million and should normally be capable of being treated in fewer than ten units. In practice this has meant that the national case load would not exceed 1000 and would often be about 400).

Since 1988, funding is only given to SHAs for services which are provided by both RHAs and SHAs. Where a service is only provided by the SHA, it is deemed to be already funded by the Department of Health in the overall allocation.

Box 3.3

ACUTE SUPRA REGIONAL SERVICES, 1990–91

	£m	1990–91 £m	1991–92 £m
Choriocarcinoma		.74	1.3
Charing Cross Hospital	.46		
Trent RHA	.28		
Cranio-facial services		1.26	1.8
Great Ormond Street SHA	.51		
Oxford RHA	.43		
W Midlands RHA	.32		
Services for primary bone tumours		2.47	5.1
Middlesex Hospital	1.02		
W Midlands RHA	1.45		
Heart transplants		11.98	21.1
Harefield Hospital	5.14		
St George's Hospital	.42		
Great Ormond Street SHA	.51		
Northern RHA	1.63		
E Anglia RHA	2.80		
N Western RHA	1.06		
Trent RHA	.42		
Liver transplantation		9.76	14.7
King's College Hospital	2.39		
East Anglia RHA	3.09		
W Midlands RHA	3.17		
Yorkshire RHA	1.11		
Neonatal and infant cardiac surgery		11.45	21.3
Harefield Hospital	.44		
Guy's Hospital	1.01		
National Heart and Chest SHA	1.35		
Great Ormond Street SHA	1.77		
Northern RHA	.94		
Yorkshire RHA	.88		
Wessex RHA	1.08		
S Western RHA	.69		
W Midlands RHA	1.89		
Mersey RHA	1.40		
Retinoblastoma services and Stereotactic radiosurgery		.665	1.3
St Bartholomew's Hospital	.375		
Trent RHA	.290		
Specialised liver services		3.45	6.1
King's College Hospital	2.21		
W Midlands RHA	1.24		
Total		41.78	72.7

Note: Spinal injuries, the National Poisons Information Service and two centres providing psychiatric services for deaf people received funding of £17,108 in 1990–91 (£24m in 1991–2)

choriocarcinoma and primary bone tumours. Supra regional services are funded directly by the Department of Health.

Every year some new services gain – and others lose – the advantage of direct national funding. This is generally because they are considered to be sufficiently developed to become regional specialties. For example, in 1988 ten centres providing services for end stage renal failure in children lost their designation because it was decided that they should now be developed as regional specialties. Currently, heart transplantation centres are being expanded. Until 1986 there were only two centres which qualified for supra regional designation: by 1990 seven hospitals had recognition (see Box 3.3).

Funding is allocated annually by the Secretary of State, who receives advice through the chair of RHAs from an advisory group. A similar fund is available for Scotland, but not for Wales. A representative of the Welsh Office attends the advisory group which recommends allocations. Membership of the advisory group is heavily dominated by managers and the medical profession. It has thirteen members, six of whom are doctors, five are managers, and one a nurse member. There is no epidemiologist, health economist or user group represented.

Funding is only given to centres where expertise has already been developed in a particular area of medicine. Apart from capital allocations, designation as a supra regional service does not release new money. When a service was first designated as a supra regional service, the money that was to be spent on providing it was deducted from the amount available for general distribution, added back as a separate allocation to the health authority concerned. It was then protected from redistribution through the RAWP formula.

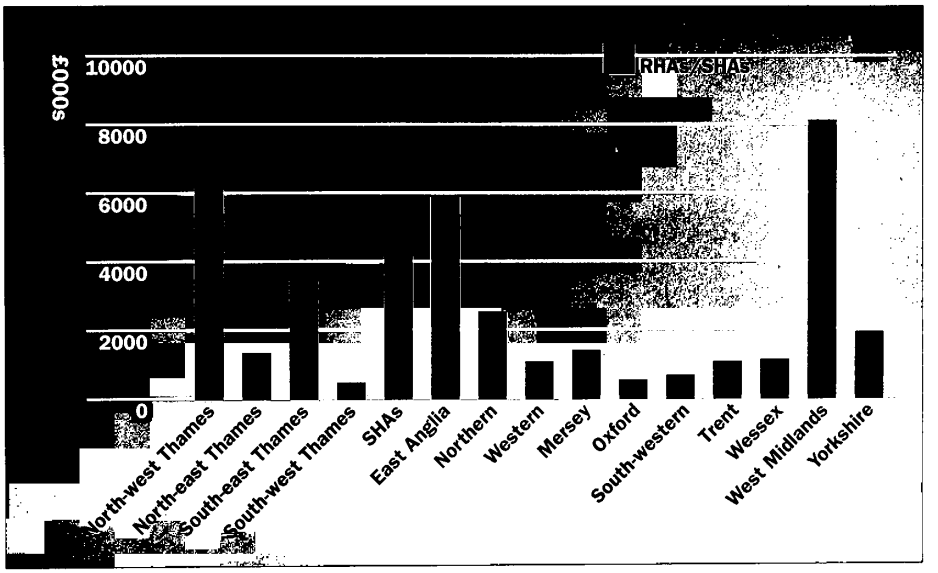
In subsequent years, the level of funding was determined by the Secretary of State anually. As a part of the move towards contracts, supra regional centres were asked to cost the services they provided. This showed that their real costs were often substantially higher than the allocations they received and many DHAs were thus subsidising supra regional services. As a result, the overall budget for supra regional specialties was increased by 100 per cent in 1991–92 from £48.69million to £97million.

It had been planned that, from April 1991, contracts would be introduced for supra regional specialties, with eighty per cent of costs provided centrally and the balance being met on a cost per case basis by the DHA of origin. The advantage of this new funding policy was seen to be that it would place non-designated centres at a considerable financial disadvantage compared with designated centres. DHAs who referred patients to non-designated centres would have to pay 100 per cent rather than twenty per cent of costs. Because of the practical difficulties, this arrangement has been postponed until 1992–93. It was feared that DHAs might not refer patients, if they had to pay even twenty per cent of costs.

Supra regional funding is not a large amount of money (£97million in 1991–92), but it is important in enabling new and experimental services such as heart or liver transplants to become established, and in

Figure 3.1

Supra regional specialties – allocations 1990–91



protecting services for rare diseases. It has the potential to provide a strategic, if small-scale, approach, involving all RHAs, in the national planning of specialties.

Supra regional funding is not particularly flexible since it is largely used to maintain existing centres. As a result, the impact it can have in spreading specialist services to a wider catchment area is limited. Fourteen out of the thirty-three services funded by the Department of Health are located in London and all, except Harefield Hospital, are in inner London. Over the last five years there has been a shift of five per cent from the Thames regions to other regions (see Box 3.4).

Regional specialties

RHAs have been responsible for planning the development of health services and allocating resources to DHAs. A part of this process has been deciding which services are most effectively provided on a regional basis. These services could then be planned and targeted regionally. Without separate funding, specialist services could only be provided at the expense of local services. Of course, the distinction is not necessarily permanent. A regional service can in time become sufficiently established and widespread to become a district service. There are two broad types of services which have been planned on a regional basis:

1 "Low-tech" specialties
These may be established services where demand does not warrant an inpatient service in each district, such as infectious diseases, ophthalmology, drug dependency, and services for younger disabled people. Arguably, ear, nose and throat (ENT) and audiology can also now be planned in this way, as well as, possibly, vascular surgery.

Box 3.4

REVENUE ALLOCATIONS FOR SUPRA REGIONAL ACUTE SERVICES: 1986 AND 1990

	1990–91 £000	1990–91 % of total allocation	1986–87 £000	1986–87 % of total allocation	% of population
Inner London					5
RHAs	5729	14.5	5251	27	
SHAs	4138	10.4	2097	10.9	
Outer London	5582	14.1	1320	7	9
Outer Thames	-	-	-	-	15
Total Thames	15,449	39.0%	8668	44.9%	29%
E Anglia	5889	14.9	2105	10.9	4
Northern	2565	6.5	1064	5.5	7
Western	1067	2.7	619	3.2	8
Mersey	1399	3.5	1403	7.3	5
Oxford	432	1.1	-	-	5
S Western	689	1.7	536	2.8	7
Trent	990	2.5	133	0.6	10
Wessex	1078	2.7	685	3.5	6
W Midlands	8075	20.4	2696	14.0	11
Yorks	1993	5.0	1391	7.2	8
Total other regions	24,177	61.0%	10,632	55.1%	71%
TOTAL ENGLAND	39,626	100%	19,300	100%	100%

Source: Department of Health

2 "Hi-tech" specialties
These services often require expensive equipment and scarce technical expertise. Research and development may often be an integral part of such services, which currently include cardiothoracic surgery, treatment for end stage renal failure, neurosciences, and radiotherapy.

There is neither a national strategy nor guidelines from the Department of Health on the services to be provided at district, regional or national level. As a result, RHAs have developed different strategies. Some have not funded any specialties at regional level, while others have funded many services. In general, the following are the main acute services which RHAs have designated as specialties: bone marrow transplants, cardiology and cardiac surgery, thoracic surgery, oncology and radiotherapy, neurosciences, plastic surgery, infectious diseases, end stage renal failure, and neonatal intensive care (Hogg, 1989). In addition there are variations within regions for historical or local reasons. An example was the Highlands Hospital in North East Thames which, until recently, cared for patients from the encephalitis epidemic of 1919 as a regional specialty.

DHAs with regional centres received additional funding based on an estimated case load and "protection" from the RHA's application

Box 3.5

REGIONAL SPECIALTIES, 1989–90

	NW Thames £000s 1989–90	NE Thames £000s 1989–90	SE Thames £000s** 1991–92	SW Thames £000s 1989–90
Inner London				
Communicable diseases		2,210		1,317
Tropical diseases		4,071		
Haemophilia		2,597	5,040	549
Cardiothoracic/cardiology	3,749	7,496	23,414	6,424
Thoracic surgery		10,161		418
Neonatal I C	2,076	1,149	2,501	1,197
Neonatal/paediatric surgery	1,132			
Neurosciences	6,569	13,353	9,554	6,427
Radiotherapy	3,862	10,645	4,433	
Medical oncology	2,690	3,755		
Bone marrow	862	2,693		
Nephrology	6,094	12,912	18,391	650*
Vascular surgery	607			
Liver services		3,894	1,691	
Plastic surgery	1,846	1,327	1,283	
Breast screening	488			
Other acute	610		1,552	620.5
Other non-acute	976	509		617
Total Inner London	31,561	76,772	67,859	18,219.5
Outer London				
Neurosciences		3221		
Radiotherapy	4,434	2350		
Breast screening	2,706			
Renal services				4,878
Neonatal I C	3,496			
Cardiothoracic services	8,948			
Cardiac catheterisation				204
Limb/prothesis				949
Plastic surgery	4,103			3,319
Oral-maxillo facial surgery				796
Paediatric surgery				1,668
Communicable diseases	554	1991		
Other acute	4			227
Other non-acute	3,247			1663
Total Outer London	27,492	7,562		13,704
Other Thames DHAs				
Plastic surgery/burns	1,019	4,107	3,974	
Neurosciences			70	3,466
Radiotherapy		2,873	5,998	3,114
Oncology	173			
Breast screening				832
Cardiology/cardiothoracic			706	
Haemophilia			127	
Neonatal IC	1,107		2,545	135
Thoracic surgery				840
Nephrology	1,050	220	6,659	
Other acute	34		1,993	352
Other non-acute	2,983	354		559
Total other Thames DHAs	6,366	7,554	22,072	9,298
TOTAL	65,419	91,888	89,931	40,572

*Provided by SETRHA
**Revenue contracts for 1991–92
Note: These figures do not include funds for AIDS services

of the RAWP formula internally. In the Thames regions, regional specialties are mainly in the teaching hospitals. The amount of regional funding received by London teaching districts was often as much as fifteen to twenty per cent of the total district budget. In the last year of regional funding (1990–91), the funding for inner London was £76.8 million for North East Thames RHA alone. By way of comparison, only £15.1million went to other DHAs in the region (see Box 3.5). Regional specialty funding was a significant proportion of the allocation in teaching hospitals. For example, in 1989–90 it amounted to about twenty-five per cent of the allocation for hospital services in Hampstead and Tower Hamlets DHAs, and twenty per cent in City and Hackney DHA.

However, regional funding for specialties is not continuing. Under the NHS and Community Care Act 1990, two basic changes in funding were made (Department of Health, 1989).

- The RAWP formula was discontinued, so that resources were no longer to be transferred from the "richer" regions and districts to "poorer" ones on such a straightforward basis as before.
- Adjustments for cross-boundary flow were replaced by direct payments. Hospitals are required to develop contracts with referring DHAs, and RHAs are required to make agreements about the costs of services for DHAs in other regions.

By 1992–93 all RHAs will receive their main funding allocations on the basis of their population, adjusted for age, morbidity, and relative costs of providing services. DHAs will also be funded on a population basis, weighted for age and morbidity. Morbidity will be measured by standardised mortality ratios.

Following the NHS and Community Care Act 1990, decisions on services which are currently organised on a regional or multidistrict basis will presumably be taken locally, in the sense that it will primarily be up to DHAs to decide what services they want to buy. In the long term, the costs of tertiary referrals are to be met by the referring hospital. Hospitals will therefore need to make an assessment of the likely number and costs of tertiary referrals when negotiating contracts with DHAs.

This means that in many areas the principal specialist services will no longer be protected by regional designation. These services include cardiothoracic surgery and associated cardiology, oncology and radiotherapy, neurosciences, plastic surgery, infectious diseases, end stage renal failure, and neonatal intensive care.

There will be difficulties for highly specialised services where:

- there are small and erratic flows of patients from many different DHAs;
- the referrals may be urgent;
- the treatment is expensive for each patient;
- referrals come from a very wide catchment area.

Block contracts are not possible in these circumstances and patients will

often have to rely on extra contractual arrangements. These may not be a priority for DHAs. Unless there is pressure from users or GPs, referrals to specialist centres may well decrease, and some treatments may be available for residents of some DHAs but not others. Currently, some teaching hospitals may receive referrals from sixty to seventy DHAs from five or six regions, and they are beginning to receive referrals from budget-holding GPs. It will not be possible, therefore, to have block contracts with everyone who sends them patients. If a sizeable proportion of a hospital's work is dependent on extra-contractual referrals, both activity levels and income will be uncertain. This will make planning and operating local units very difficult.

RHAs are taking different approaches to the purchasing and contracting of regional specialties. They vary mainly in the amount of protection they are providing to services and how much is left to the decisions of individual DHAs (see Boxes 3.6 and 3.7).

The impact of the loss of regional "protection" is difficult to assess.

Box 3.6

PURCHASING REGIONAL SPECIALTIES

Some RHAs – *South East Thames, East Anglia* and *Yorkshire* – had withdrawn regional specialty status from many services before the introduction of contracts. Others still have a variety of services accumulated over the years. There seem to be broadly three main approaches to the purchasing of regional services:

1 No regional protection for specialties

Regional specialties will become a part of the internal market and contracted in the same way as any other specialties. In effect this means the end of protected funding for regional centres. This approach is favoured by *Wessex, North East Thames* and *Oxford.*

In *North East Thames* and *Oxford,* the money will be devolved to DHAs on the basis of the use made in the previous year, and to go to the regional units. The greatest users of services are the residents of the host DHA and so those DHAs will benefit most and the current trends of use will continue at least in the first year. In 1992/93 the market will operate.

***South East Thames* will be commissioning all regional specialties provided by its own specialty units for its own and other residents for 1991/91. From 1991–92, the commissioning of regional specialty services will be devolved down to local commissioners, in line with the NHS reforms.**

In *East Anglia* and the *Northern RHA,* purchasing consortia have been set up to purchase regional specialty services on behalf of member DHAs. The *West Midlands RHA* is acting as an intermediary, between DHA purchasers and providers, although not purchasing on behalf of DHAs.

2 Purchasing services by region

***North Western* is purchasing services for its residents by block contracts with provider units. *Trent* is contracting services for regional residents. The provider units will make separate contracts with DHAs or RHAs concerned for non-Trent residents.**

3 Retaining a few regional specialties

***North West Thames* will set contracts for 1991–92 via purchasing consortia for each regional specialty led by the primary provider for that specialty. Infertility services and neonatal intensive care will be paid for on an extra contractual referral basis.**

***South West Thames* is continuing funding for six of the currently designed regional specialties (neonatal intensive care, paediatric surgery, paediatric neurology, clinical genetics, child prosthesis, and limb surgery and fitting). These will be managed by the host district on behalf of the Region, which will be responsible for contracting.**

***Yorkshire* has divided funding between DHAs to enable them to make their own contracts for regional services. The RHA is co-ordinating the purchasing of three services: bone marrow, magnetic resonance imaging (MRI) and Burns.**

Sources: **RHAs, and survey undertaken by Bloomsbury and Islington Health Authority (February 1991)**

Box 3.7

REGIONAL FUNDING TO TEACHING DHAs NORTH EAST THAMES, 1989–90

	Regional funds £000	Revenue allocation (hospital) £000	% of Budget
Hampstead	21,458	77,771	27
Bloomsbury (exc. Islington)	16,576	140,128	12
Tower Hamlets	20,770	80,118	26
City and Hackney	17,968	91,745	20

Sources: RHAs, Health Service Indicators

Regional contracts cover specialised services not elsewhere available and so there may not be such a fall in referrals as in general acute referrals. However, in specialist services the numbers involved are often small; even a small reduction in referrals may affect the overall cost per case for the remainder. It may well be that the units which do the best marketing and make the most advantageous contracts will attract more cases and be able to expand. Others may reach a point where the service is not viable.

Funding for regional specialties may have protected specialist services from local battles for resources and the redistributive effects of the RAWP formula. It ensured that, by funding specialist services separately, they did not develop at the expense of services provided to local people. In addition, regional funding made possible a better distribution of services within regions to ensure that specialist services were located in units accessible to regional residents. It also meant that, implicitly, specialist services were given priority and sometimes suffered less from health services cuts than local services.

District specialties

After 1992, many regional centres will be in the same situation as other specialist services, which are funded by hospital or research budgets. New techniques and services are mainly developed in one hospital (or sometimes more than one, following similar development routes at the same time) and then diffused throughout the NHS. Additional teaching and research funds are available for teaching hospitals, which facilitate the development of new techniques and services outside DHA funding. In teaching hospitals, clinical, academic and support staff are funded by the Universities Funding Council (UFC). The Service Increment for Teaching and Research (SIFTR) has been paid to teaching districts in recognition of their greater costs. The allowance is worked out at three-quarters of the average extra costs of teaching hospitals. SIFTR provided an additional £154.9 million in 1991–92 to London teaching districts: this was forty-three per cent of the national allocation for all teaching hospitals. A particular attraction of self-governing status for teaching hospitals is that they retain control over SIFTR.

The systems for regional and supra regional funding have encouraged the development of specialist services from hospital budgets. Only once a service is developed could it achieve recognition as a regional or supra regional specialty.

It has been difficult to identify some specialties in the past. These "hidden specialties" may undertake the same work as regional centres, without protected funding, and generally treat a high proportion of people from outside their district. The development of specialties without planning is possible because clinicians have discretion in deciding which conditions are given priority for treatment and which remain on the waiting list. Dramatic examples of "hidden specialties" include heart transplants (St Bartholomew's and the Royal London Hospitals), bone marrow transplantation (Northwick Park Hospital), and in vitro fertilisation (Royal Free, King's College, St George's, St Bartholomew's, and Guy's Hospitals).

Hidden specialties have been extensive in the London teaching hospitals. In 1986–87, Bloomsbury DHA undertook a survey to identify hidden specialties among local acute services. It was undertaken by clinicians to argue for increased funding. The survey found that approximately twelve per cent of the case load among inpatients in local acute services was actually specialist. It demonstrated how new specialties develop in clinical practice in an evolutionary way. Current examples would include minimal invasive surgery, such as laparoscopic and laser surgery.

In 1988, Tower Hamlets DHA reviewed its acute services so as to identify hidden specialties. It considered that these services should be cut in preference to services to the local community, in order to meet financial targets. The review identified eleven services. By imposing restrictions on the freedom of clinicians to prescribe expensive drugs and prosthetics, and on the individual patients to go to a hospital regardless of where they lived, the DHA estimated that it could close seventy beds.

However, specialties will not necessarily remain hidden. As a result of the NHS reforms, clinical work has to be costed individually and there are incentives to identify and market new services.

In the new arrangements, hospitals are either directly managed by DHAs or separately as NHS Trusts, accountable directly to the Department of Health. The likely impact of this is again difficult to assess. New techniques which reduce costs may be more readily accepted and disseminated. For some new techniques, marketing to consumers, to GPs, and to DHAs, may foster demand and pressure for them to be widely available. Local units providing specialist services may try to compete with the more established, and generally better equipped, regional centres.

On the other hand, it may prove harder for new techniques to make the transition from research and development to become a part of the service and be covered by contracts. The medical schools are concerned about the lack of any reserves to support, for example, a newly appointed reader or senior lecturer whose clinical interests are not strongly represented in the hospitals' business plan.

The Department of Health has recognised that it is necessary to exclude the costs of research and teaching from pricing decisions and that it may need to protect medical teaching by "ring-fencing" the costs in future. The Undergraduate Steering Group on Medical and Dental Education (representing the Department of Health and the Department of Education and Science) is due to make recommendations in 1991. It is probable that it will recommend direct funding from the Department of Health to RHAs or to SHAs, though an alternative would be direct funding from the Department of Education and Science.

It is the loss of the general acute referrals to teaching hospitals which concerns the medical schools.

> *Undergraduate teaching, however, requires a broad clinical base and it is the "run of the mill" cases essential for teaching which are most likely to be lost to teaching hospitals which are dependent on cross boundary flow ... The situation of the main teaching hospitals associated with some medical schools in inner London is sufficiently serious as to raise doubts about their future ability to deliver a viable educational programme, unless urgent corrective action is taken.*
>
> (Universities Funding Council, 1991)

The future

Changes in funding and referrals are causing problems for teaching hospitals. However, services will also suffer because of the loss of overall co-ordination and planning, previously undertaken – with mixed success – by the regional health authorities. This is illustrated in the possible effect on perinatal intensive care (see Box 3.8).

The separation of the management and planning of postgraduate and undergraduate teaching hospitals has its origins in history. Specialist hospitals were not set up simply because it was felt that separate specialist hospitals were desirable, but also because the principle of specialisation was not accepted in general hospitals in the last century. The fears of the medical profession over a hundred years ago – that specialisation would lead to a narrow focus – are by and large still valid. The boundaries between specialties are not clear cut, and multidisciplinary approaches, which facilitate the treatment of the patient as a whole person, are more likely in a general hospital than in one concerned with a single specialty.

If the postgraduate hospitals had been situated outside London, they probably would have been incorporated into the main NHS structure in 1974, along with other specialist hospitals. The separate management of postgraduate hospitals took them out of most service planning and disguised the fact that, from the service viewpoint, there are too many specialist beds in central London. In service terms there is no convincing reason for the separation of undergraduate and postgraduate hospitals. SHAs are research and teaching establishments, but also major hospitals in inner London. They must be seen as an integral part of the London "picture".

Box 3.8

PERINATAL CARE

The care of very small or very ill babies illustrates the importance of regional planning for specialist services. The Royal College of Physicians, endorsed by the Government, has proposed that the best and most efficient way of providing care for very small or ill babies is a three-tier regional structure of services. Each region needs two major centres for perinatal care for serious problems, about five sub regional centres to provide intensive care, and all maternity units need to be equipped to provide short-term care for ill babies prior to transfer to a regional or sub regional unit.

However, there has been a shortage of intensive care cots. The result of the shortage has been a haphazard development in the provision of cots in district maternity services. One of the consequences of this is a poorer survival rate for low birth weight babies born in hospitals with small units.

As a result of the NHS changes, it is likely that maternity units with more than 2000 births a year will have intensive care cots. Non-specialist units will undoubtedly be able to provide a cheaper service, but it is likely also to be a poorer quality service in terms of the number and training of staff, since there are not enough trained medical or nursing staff to provide services in all maternity units. There are no mechanisms to ensure that facilities provided are adequate.

The Thames Regional Perinatal Group is considering options for protecting the regional three-tier system.

- **Option one would regard all admissions of babies for intensive care as extra contractual referrals, as are all admissions via the accident and emergency department.**
- **Option two would be a contract between the regions and regional and sub regional centres. However, if all the beds to which the RHA had contracted were full, this option might not enable transfer between units in all the Thames regions as happens at present.**

The preservation of the existing system, which is generally regarded to work well, depends on the adoption of the same policies by all the Thames RHAs.

Source: **Thames Regional Perinatal Group (1991)**

The current duplication and possible future competition between SHAs and undergraduate teaching hospitals will be wasteful, and the role of the SHAs in the new structure has to be faced. In the NHS of the internal market, the SHAs will be competing with the other specialist referral hospitals but with great financial advantages, so they may thrive in the internal market at the expense of the undergraduate teaching hospitals. Unless this anomaly is sorted out, it may be damaging to the development of specialist services in hospitals in inner and outer London. This would increase the isolation of specialist services and inhibit integration.

CHAPTER 4

A framework for the future

The planning of specialist services has, until now, been resistant to change and "rationalisation". Whatever happens following the NHS and Community Care Act, change is inevitable. Resources and purchasing power have been transferred to the outer London and other Thames DHAs, away from the inner London DHAs. The decisions on which specialist services are to be provided to DHAs now lies with individual DHAs and NHS trusts, and this may lead to increased fragmentation and duplication.

The opportunity now exists to develop more effective ways of planning and managing specialist services, based on service requirements, not medical teaching or history. Five key principles should guide this process: clinical quality, equity of access, integration of specialist and local services, efficiency, and the promotion of research, teaching and new developments.

Equity of access

There is no framework to ensure consistency and equity of access to specialist services. Some DHAs may decide that certain drugs and treatments should not be available to their residents, which will cause confusion and distress to patients.

RHAs might develop guidelines for DHAs and providers on minimum standards for specialist services, taking into account the views of users and their carers. This might also be included in regional performance reviews.

Developing services in outer London

For rare diseases, the concentration of services in a few central London centres is justifiable on grounds of cost and expertise. For more common conditions, it may be justifiable that treatments which require expensive equipment or particular expertise, such as radiotherapy, cardiothoracic surgery or neurosurgery, are available in only a few centres. The evidence is that outcome increases with "volume": as more patients are treated in a unit, expertise increases and so results improve.

However, there is a need to provide a comprehensive service within each specialty, at local and regional levels. Regional centres should have close supportive links with the districts. There are a number of ways these can be developed.

Firstly, new technologies offer possibilities of decentralising

services to outlying hospitals without a loss of standards. For example, newer diagnostic tests such as computerised tomography (CT) scanning and magnetic resonance imaging use computers and data and not X-ray film. Images can be transmitted from the site of the machine to outlying centres so that doctors at both the centre and the local hospital can see the results. Doctors at one site can ask for an expert opinion from a specialist centre (Stocking, 1991).

Technological advances also allow some specialist care, generally associated with hospitals, to be carried out at home. These include diagnostic and monitoring devices, pathology tests, intravenous drug therapies, treatment for end stage renal failure, and nutritional and oxygen therapies. High technology homecare is further advanced in the USA and is likely to expand here in the future (Marks, 1991).

Secondly, as a part of their contracts DHAs can insist that outpatient services are held within the district. If staff from specialist centres take services to outlying areas, this will contribute to the quality of services in general hospitals and assist in appropriate referrals.

Thirdly, criteria for the selection of patients who will benefit most from specialist services needs to be available to GPs and clinicians in local hospitals. This is essential to ensure that centres receive appropriate referrals.

There will need to be new incentives to encourage new techniques and develop services in outer London, with the end of regional funding for specialties. For example, pump-priming funds might be made available to help establish new centres in outer London.

Monitoring standards

Specialist services often involve invasive and irreversible treatments. In order to protect patients from unnecessary risks, specialist services need to be monitored. It may be that this is an appropriate role for RHAs. This might be done in a number of ways.

Firstly, DHAs need information about outcome and complication rates for different units for all clinical specialties so that they can make the most appropriate choice of services to purchase for their residents. An accreditation scheme for specialist units might be established with agreed standards of staff training and equipment, and systems for audit and evaluation.

Secondly, there is a need for co-ordinated research on the use and effectiveness of specialist services, taking into account users' views.

Planning specialist services

The Department of Health has recognised that there are serious problems in the introduction of the internal market for specialist services. For this reason they have for the moment protected the services they fund directly – SHAs and supra regional specialties – from competition. This, however, gives an "unfair" advantage to the SHAs in competing for patients.

The Medical Committee of the Universities Funding Council has

strongly recommended that the present arrangements for SHAs should continue. They point out that no arrangement makes "sense which places the SHAs in the position of having to enter into contracts with the multiplicity of purchasers that constitute their national service responsibilities" (UFC, 1991). This is undoubtedly true. However, it is also true for the undergraduate teaching hospitals. If the market will not work for one group, it will not work for the other.

If the market encourages specialist centres to have a high public profile and promote particular treatments where there is a consumer "demand" (or one can be created) the consequences for the balance of health services in London is serious. For example, it may be that all cardiothoracic units wish to prove that they are at the forefront of modern techniques by undertaking heart transplants. This has certainly happened in the USA.

A solution to the problem must lie in the development of mechanisms to protect teaching and research, while tackling the long standing problems of duplication and lack of co-ordination of specialist services in London. In order to avoid duplication and competition it is important that the services provided by both SHAs and NHS trusts are a part of London-wide planning, with accountability to RHAs or a London strategic body.

Research and teaching

Research, training and development in relation to new techniques are essential for the future of the NHS and they will need to be protected from the impact of competitive costing. National funding for them is essential, wherever undertaken, in SHAs, NHS Trusts or other hospitals.

However, the funding for research and development might be more closely monitored and linked to performance than may have been the case in the past. RHAs, for example, may use the SIFTR allowance to encourage medical schools to work in new ways.

Whatever else happens, over the next two years there are likely to be changes in hospital services in central London; changes which attempts for 100 years have failed to achieve. It is crucial that a framework is developed, based primarily on the interests of people who use the health service, not the interests of markets, clinical freedom or teaching needs.

Appendix Definitions and sources

Division of London

This report uses the same definitions of Inner London as the King's Fund report, *Back to Back Planning*. The following DHAs are included as inner London:

Bloomsbury and Islington
Camberwell
City and Hackney
Greenwich
Hampstead
Lewisham and North Southwark
Riverside
Parkside (Paddington and North Kensington part only)
Tower Hamlets
Wandsworth
West Lambeth

Outer Thames DHAs includes DHAs outside the Greater London area within the four Thames RHAs.

There were boundary changes in the period studied in this report. Hammersmith is included as an SHA in the 1980 figures and Middlesex as North East Thames.

Statistical sources

Figures for 1980 came from SH3 returns available in the RHAs and the Department of Health Library. For 1989/90, figures came from RHAs and the NHS Management Executive's performance indicator package, Health Service Indicators.

Definitions of specialties

There are a number of inconsistencies and problems in defining specialist services, including the emergence of new categories and the different methods of categorisation between regions. Categorisation of newer specialties was particularly unreliable for 1980. Cardiac surgery was sometimes included under thoracic surgery, and oncology and nephrology were not always identified separately.

For graphs and tables on cardiothoracic surgery, thoracic surgery and cardiac surgery were included for 1980; cardiology includes coronary care.

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The King's Fund Commission on the Future of London's Acute Health Services' terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.

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