London specialty reviews

Spell out a challenging pattern of care

London's hospitals face an uncertain summer. Institutions that thought they were safe from the government's proposals for restructuring health care in London[1] now find themselves made vulnerable by the recommendations of the reviews of six specialty services (p 1709).[2-8] Others who thought they were doomed can see reasons to fight for survival. Yet if institutions' reactions are merely to fight their corners then the reviews will have failed. For underlying the reviews' recommendations is a model for specialist services that depends on collaboration and which will affect clinicians well beyond London and the six specialties under review.

The specialty reviews—of cardiac, renal, and cancer services, neurosciences, plastic surgery and burns, and children's specialties—were charged with advising ministers on how each service should be organised in London to improve patient services, strengthen their academic base, and be cost effective. Each team was headed by a clinician from outside London, supported by the chief executive of a London purchasing authority, with other members predominantly from outside London. Their reports vary in weight and depth, but all abandoned attempts to compare costs and to a lesser extent patient activity because of a lack of data.

The principles on which the groups base their recommendations are unexceptionable. There should be fewer but bigger units, to allow adequate staff cover, subspecialisation, and multispecialty cooperation; to support teaching and research; and "to direct money from infrastructure costs to patient therapy." The reviews embody a vision of how each service should operate—what some of them call a "hub and spoke" model. In this a tertiary referral centre is only one part of a service that is linked to secondary services in other hospitals and beyond to primary and community services.

The model is best developed in the renal review. This envisages five tertiary transplanation centres; five to seven more centres in the Thames regions (including Brighton, Canterbury, and Stevenage) providing a nephrology service with dialysis; and several more satellite dialysis units so patients need never travel far for regular treatment. Generally consultants based at the tertiary centres, with facilities for complex investigation and inpatient care, will consult in secondary hospitals, providing outpatient clinics and maybe day surgery. The general practitioners, therapists, and patient representatives on the review teams emphasised that collaboration must follow the patient back home.

The review groups recognise the difficulties this will pose within the internal market as they are asking clinicians to collaborate across trust boundaries. Indeed, some suggest that the tertiary centres should be responsible for ensuring the necessary secondary and community contracts as part of the overall service they provide. The hub and spoke model presents particular challenges to London, however, because of its teaching hospitals' traditions of self sufficiency and because of the chasm that separates London consultants and GPs. As much will depend on ministers keeping their promises to strengthen primary care as it will on them providing the necessary capital to implement the reviews' recommendations.

The principles may be easily agreed: the arguments will be over where these fewer, bigger units should be sited. When the reviews started it was widely thought that the tertiary centres would be shared out. Instead the reviews recommend that concentrations of tertiary clinical services should match the concentrations of teaching and research round the multifaculty colleges of the University of London.

Thus there are three clear concentrations of tertiary services: at the Royal London (all five adult services); at University College Hospital-Middlesex Hospital (cardiac, renal, and cancer, preferably on the Middlesex site); and at Guy's-St Thomas's (all five, preferably at Guy's). As in *Making London Better*, the lone medical college at St George's Hospital remains the maverick, recommended as the base for specialty services in south west London.

The picture is less clear in west London. The neurosciences, renal, and cancer reviews would have liked to expand these services at Charing Cross Hospial, but *Making London Better* suggested that Charing Cross should close. Thus the neurosciences group falls back on the Hammersmith Hospital (not yet linked to the multifaculty college at Imperial); the cancer group still prefers Charing Cross to the Hammersmith; the renal group recommends expanding the unit at the Hammersmith and linking it with a continuing service at Charing Cross, but "we do not believe that a two site option can be other than temporary."

Nor is everything clear cut in the north. In at least one case the Royal Free's services came out better than those at the Middlesex, but the Middlesex was selected because of its academic links with the research powerhouse of University College. However, the Middlesex may not have room for all the recommended services; in that event the review groups recommend reconsidering the Royal Free rather than building a new hospital at University College Hospital.

Underlying this pattern of concentration is an implicit differentiation among teaching hospitals, with some providing predominantly tertiary services and postgraduate education and others predominantly secondary services and undergraduate education. Many will resist this differentiation, but it is the desire for self sufficiency in so many teaching hospitals in London that has led to the current fragmented specialty services and the lack of acute general beds for Londoners.

The specialty reviews show clearly that some clinical services in London are not as good as they should be. Yet there are no easy options for restructuring London. Since the advantages and disadvantages of each option usually lie in different facets—clinical service, accessibility, research strength—balancing them will be difficult and messy. Those who will ultimately make the decisions on London should not lose sight this summer of the fact that their aim is to improve services for Londoners and the people of the Thames regions (while encouraging the research necessary to produce good services for future generations); it is not to protect institutions. This requires two things of the politicians: that they must find from somewhere enough money to make the necessary structural changes (including in primary and community care) and that they don't lose their nerve.

JANE SMITH

Deputy editor, *BMJ*

1 Secretary of State for Health. *Making London better.* London: Department of Health, 1993.
2 Dillner L. London's specialties cut by half. *BMJ* 1993;**306**:1709-10.
3 *Report of the review of London renal services.* London: London Implementation Group, 1993.
4 *The provision of neurosciences services.* London: London Implementation Group, 1993.
5 *Report of the cardiac services review group.* London: London Implementation Group, 1993.
6 *Plastic surgery and burns services for Londoners.* London: London Implementation Group, 1993.
7 *Review of specialist cancer services in London.* London: London Implementation Group, 1993.
8 *Children's specialty review.* London: London Implementation Group, 1993.