Functions of the regional genetic services

Strategies for reaching targets

Several general strategies are required. National feasibility studies for screening programmes for the presymptomatic diagnosis of late onset cancers and other genetic diseases should be a high priority. It is hoped that the new central research and development committee¹² will promote genetic programmes of this type. There is also a need to ensure that all appropriate patients have equal access to screening for Down's syndrome and to other well evaluated screening programmes, including those for thalassaemia and Tay-Sachs disease. Additional screening should be introduced for carriers of cystic fibrosis and the fragile X syndrome as soon as these tests have been evaluated. In parallel with these screening programmes there must be study of the social, community, educational, ethical, and logistic issues that may be expected. It will also be important to ensure by medical audit that the highest standards of clinical and laboratory services are achieved and maintained.

The Health of the Nation identifies the "role of the centre to develop new key areas." This is particularly

important in medical genetics, which is a new and vulnerable specialty. Regional genetic services must be preserved (figure). This need is recognised by the Royal College of Physicians of London¹³ and by other royal colleges and has been endorsed by the Department of Health. It will be extremely damaging to the welfare of patients with genetic disorders and their families, who often live in different health districts, if regional genetic services are splintered by hasty devolution to districts.

In addition to central initiatives, regional genetic committees with multispecialty representation should be charged with strategic planning. They should also provide impartial professional advice to the regional health authority, recommend priorities for developments, and advise on monitoring regionally purchased genetic contracts so as to achieve and maintain an efficient quality service with equal access for patients in all districts.

Advances in medical genetics have implications for other medical specialties. All clinicians should pay increasing attention to this aspect of patient care.

I thank Dr A W Johnston for helpful comments.

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The New NHS: Six Months On

West Suffolk: changes in the offing

Jane Smith

Nobody in West Suffolk thinks that patients will have noticed much difference in the health service—either for better or for worse. But six months into the reformed NHS there undoubtedly have been changes, and more are in the offing. The plan to redevelop Newmarket Hospital as a community hospital is before the Secretary of State for Health, as is a proposal to merge East and West Suffolk districts from October 1992. Both the acute and the community units have applied to become third wave trusts. On the other hand, some of the same old problems are there: as far as the general practitioners are concerned patients are still on waiting lists, and West Suffolk Hospital suffered

ward closures throughout August in an attempt to save money.

Extracontractual referrals

One headline hitting problem that does not seem to have affected West Suffolk's patients is extracontractual referrals. The district set aside 1.5% of its budget for these, and all requests have so far been honoured, with the district still within its budget. Dr Roger West, the director of public health, wishes, however, that extracontractual referrals were not costed at average specialty costs: one patient having a

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sebaceous cyst removed had cost the district over £1000. Though the referrals may be being honoured, general practitioners are not happy about the system. Dr John Calvert, a general practitioner in Newmarket, spoke of his irritation at being quizzed by a manager on what was wrong with a patient he wanted to refer outside the district and the longer term implications of the referral. "It's yet another person getting clinical information to make financial decisions."

The district has another sort of problem with extracontractual referrals—Newmarket Hospital has not been getting as many as expected and consequently is £100 000 overspent. Moreover, when its maternity unit closed earlier this year patients could choose whether to go to West Suffolk Hospital in Bury St Edmunds or to Addenbrooke's Hospital in neighbouring Cambridge district. Many more than expected had opted to go to Addenbrooke's, and each was an extracontractual referral. Dr Calvert remarked that next year this flow would have to be recognised contractually—"or you'll remove patient choice."

The district

For the district the merger with its neighbour to the east makes strategic sense. Ambulance services, the family health services authority, and social services are all run on a county basis, and a larger purchasing unit can share scarce skills and keep administrative costs down. "It's a marriage between consenting adults," said Grant Elliott, the district finance director. Though no one will admit it publicly, there's a feeling that it's better to get into bed with East Suffolk than with Cambridge, where Addenbrooke's teaching hospital is seen as a black hole sucking in resources. The need to conserve scarce skills has struck Grant Elliott particularly as several of his finance staff are leaving for other jobs in provider units and at regional level. Indeed, so acute is the problem that the finance departments of the two districts plan to merge in all but name next spring.

Likewise, even if there had been no proposal for a merger, the public health departments of the two districts would have joined forces. According to Dr West, the NHS reforms have exposed the weaknesses of a small public health department. With the equivalent of six consultants rather than three, said Dr West, the new, merged department will allow its members to specialise. But it will also allow each consultant to relate to a particular locality of about 16 general practices and to a particular provider unit. One of the fears about the merger—and an undoubted factor behind the applications for trust status—is that the authority will be more remote. Dr West thinks that it is important to structure the public health department and its activities to counter that feeling.

He sees his role as relying on national data on health and outcomes and interpreting them for local circumstances. His annual report will identify some priorities for next year. West Suffolk has higher mortality from lung cancer than the rest of the region and increasing rates of both ischaemic heart disease and lung cancer in women aged under 65. One cause of frustration is that there is likely to be little money in the short term so these priorities will have to be tackled over years. The other reason for waiting is the lack of information. His department has just completed its health and lifestyle survey of West Suffolk, though the data have not yet been analysed. In a couple of years' time "we will have accurate hospital usage data from the purchaser's database—for the first time we will know where the district's population is going and what care it is getting."

One fruitful outcome of the new NHS has been collaboration with the family health services authority.

Dr West had asked the independent medical adviser to the authority to join in departmental meetings, and an even more tangible benefit was funding from the family health services authority for district physiotherapy. The district health authority had piloted physiotherapy services for general practitioners in some parts of the district but could never afford to extend them. This year the family health services authority has funded two extra physiotherapists.

The hospital unit

The acute unit, based round West Suffolk and Newmarket Hospitals, is £500 000 overspent, partly because of the shortfall in extracontractual referrals at Newmarket but also because of incremental drift as staff turnover is down because of the recession. The dilemma for Bob Jones, unit general manager, is that if cost cutting affects services then purchasers will start to invoke penalties. They haven't reached that point yet because the unit has managed to maintain its contracted workflows. West Suffolk Hospital closed some wards during the summer to save costs—to the concern of general practitioners, who found it hard to find beds for acutely ill patients. "If it's like this in the summer, what's it going to be like in the winter?" asked Dr Ted Cockayne, a general practitioner in the east of the district.

The district medical committee had also condemned as madness a system that would allow the hospital to employ a locum to work through a waiting list using money from the waiting list initiative but would not allow the same money to be used to keep routine lists going with the normal staff. The other bit of lunacy that struck Dr John Calvert was the waste of facilities caused by the reforms. Newmarket Hospital would by the end of the year have completed its contracted workload for the year. That meant that for the rest of the financial year it would have facilities lying idle.

Further problems will arise if the secretary of state approves the redevelopment of Newmarket Hospital as a community hospital. To cope with the transferred workload the unit has plans for a dedicated day surgery unit at West Suffolk together with the conversion of some geriatric beds to acute medical beds, but Bob Jones hopes that the region will provide some help over the transition either with extra funds or through some management of the market. "The existence of the internal market undoubtedly makes the transition harder to manage."

At West Suffolk itself the hospital is broadly keeping to the workflows agreed with purchasers, though more day surgery and less inpatient work are being done. The lesson there, he thinks, is to involve medical staff earlier in contracting negotiations. Now consultants are writing business plans for their own specialties for next year. Mr Jones claimed that most had been positive about doing this because it provided a rational framework for talking about developments in the service, but one consultant was less sanguine: "If it needs money, forget it." Dr West confirmed that gloomy view in his comment that many of the items in the hospital's business plans would probably increase either the unit cost or the volume of activity and that there was not a lot of scope (or money) for change in the short term. On the other hand, he thought that providers would continue to make the running in the short term—until the district had good data on needs.

Meanwhile, the hospital is appointing business managers to work with the lead consultants in each clinical area (West Suffolk's version of clinical directorates) and has been sorting out its information needs with the help of management consultants. Mr Jones hopes that the hospital will be accepted into the

main resource management programme in October. Dr Henry Fell, a consultant microbiologist, remains ambivalent about resource management. If it can show what needs doing then it may have a purpose. He had been impressed at a regional meeting by the fact that the cardiologists at Papworth Hospital, who had accurate costs for coronary artery bypass grafting, had calculated the number of operations the population needed and then worked out, from the amounts districts were planning to spend, that most districts were not buying enough. Dr Roger West had obviously been looking at similar data because increasing the number of coronary artery bypass operations is one of his plans for next year—"although it doesn't seem to be a major problem with general practitioners."

The community unit

For the community unit things are going reasonably well, though the reforms have thrown up some problems. The unit seems not to be achieving all its activity levels, but Mrs Marie Deakin, the unit general manager, thinks that this is because of the way that activity is expressed in community units. Patient contacts or visits by health visitors do not really discriminate between very different activities and workloads. She is trying to start a debate about measuring community workloads within the region, and the unit has been given regional funds for resource management, which she hopes will produce better information. "But the dilemma is about spending money on that when we need it badly for direct patient services."

Like Roger West, Mrs Deakin is also pleased about the developing relationship with the family health services authority. The authority has funded a community dietitian, who is employed by the unit but works closely with general practitioners.

Earlier in the year Marie Deakin had spoken of the possibility of making a bid to provide community care for some patients in Cambridge served by general practitioners in Newmarket. She said in August that she probably would pursue that, "though it's not big money." If the unit really wanted to expand it would be looking at some of the services currently provided by the acute unit—such as nursing beds for elderly people or hospital at home services. Her other plans for the future include a "campaign" among general practitioners over the next six months or so to find out what they really want in the way of services.

On the wider front, anxieties remain about the plan for local authorities to take over community care and

their ability to do so. Dr Cockayne has found that the main new need identified by health surveillance of elderly people has been for home helps. As a result of all the new requests, however, many longstanding users of the service have had their home help cut or curtailed. At the other end of the district Dr Calvert's practice last year decided to call together a forum of all the local statutory and voluntary bodies concerned with community care. He saw this as an opportunity for the people who do the work to get together, assess the problems, and thrash out a strategy for coping with the work, but he has found the experience disheartening. "There seem to be so many managers involved that it is hard to pinpoint the people who can actually say something meaningful. Who are the people with the power? There is no real sense of consultation." He feels the same sense of frustration, for the same reason, with the district medical committee.

Conclusion

Have any views changed since I talked to the doctors and managers of West Suffolk in the winter? I had not expected the hospital to apply for trust status quite so soon. In fact, a ballot of the consultants showed a majority against (30 v 8), but most did not vote. The medical advisory committee acquiesced reluctantly, but Dr Fell said that the fact that West Suffolk was likely to disappear into a larger district was a factor in its acquiescence. Likewise, the community unit is seeking trust status largely to protect itself. Many of the managers, however, also see trust status as a natural consequence of the purchaser-provider split and they remain optimistic.

Bob Jones conceded that it was too early to make judgments about benefits to patients, but he thought that the reforms still had the potential to benefit them. He agreed, however, that there was "a hell of a lot of work to do to get things up and running." Marie Deakin enjoyed the opportunity to do formal planning, to be able to innovate, and to think broadly. And Grant Elliott, despite the turbulence in his finance department, still thought that the reforms would work.

Dr Calvert probably summed up the doctors' view: "There's always been problems with money, but doctors at one time felt everyone was in the same boat—there was a sense of good will and of making the best of it. Now there are probably the same problems with money but the style of management is such that doctors' good will has been sapped. They feel less inclined to patch up the NHS."

THE MEMOIR CLUB

In Spain all members of our club remember well a certain operation. It was a partial gastrectomy. We went into the theatre and, having taken our seats, saw a young man in his 20s walk in. He took off his shirt, dropped his trousers down, took off his slippers, and lay naked on the operating table. A nursing sister dressed as a nun approached him with a razor—a dangerous sight—and dealt with his suprapubic area. Next, a screen was put up to block his view of the operation and a further nun was put in charge of his head. She had a fan. When opened this was to give him some fresh air, but when closed she would give him a brisk tap on the forehead and remind him how lucky he was to have as his surgeon the famous Gonzales Bueno. We called him "Gonzales the Good." She also pointed out to the patient that he should appreciate that he was being watched by so many eminent surgeon visitors, all of which may have impressed him but did not ease the pain as the whole gastric operation was being carried out under a local anaesthetic with him being conscious throughout. The surgeon, a large man, entered wearing a long towelling dressing gown,

with a label on his chest which told us that he was indeed Gonzales Bueno. The operation had no special feature; it was more a pylorotomy than a partial gastrectomy. Finally the wound was closed in one layer by through-and-through wire sutures. These were twisted and cut short so that the wound looked, and I suppose also felt, like a piece of barbed wire. We waited for a trolley to come and take the patient back to bed, but no, in came his shirt, trousers, and slippers, and he walked out of the theatre. Several of us went to see him afterwards expecting to see him at last in bed, but he was sitting in a chair as the surgeon said his diaphragm and breathing worked better when he was sitting up. We felt his pulse, and I certainly would have put his head down as he was now certainly quite shocked.

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