From the Editor

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Evolution of the National Health Service – reflected in a microcosm

Microcosm: from the Greek, mikros cosmos – *little world; a miniature representation of the whole.*
(*Shorter Oxford English Dictionary*, 5th edn)

The sheer scale of National Health Service delivery is daunting. The changing patterns on a more human scale, reflecting changes in NHS delivery overall, are more easily appreciated.

South Warwickshire lies some 20 miles south-east of the West Midlands conurbation. The principal towns are Warwick (population 126,000), Royal Leamington Spa (61,000) and Stratford-upon-Avon (111,000). Warwick is characterised by the magnificent medieval castle of the Earls of Warwick which stands in a commanding and picturesque position on a rocky outcrop above the River Avon. Natural springs have been recorded in the Leamington Spa area since 1586, but the town only became a popular destination from 1786 when the Baths were built around some of the saline springs. The town received its Royal charter in 1838 at a time when 'taking the waters' for health reasons was beginning to lose its popularity. Stratford-upon-Avon is inextricably linked with William Shakespeare. Although his birth date is uncertain, his baptism on 26 April 1564 is recorded in the Holy Trinity Parish Church.

At the inception of the NHS in 1948, each town had its own acute hospital. The Warneford Hospital in Royal Leamington Spa, originally built as a voluntary hospital, was the oldest. Warwick Hospital was formerly run by the County Council, and in Stratford the cottage hospital was extended and used by the Royal Canadian Air Force (RCAF) as an acute hospital during the Second World War.

Remarkably, in 1948 only two consultant physicians and three house physicians (one in each hospital) provided the medical service for all three hospitals – supported by two surgeons who had formerly been local general practitioners (GPs) and one consultant paediatrician. One consultant pathologist provided haematology, clinical chemistry, microbiology and histopathology services for the group. If things went well, the results of a serum urea and electrolyte estimation could be expected within three days of the initial request. There were several long-stay wards for the elderly in a quiet corner of Warwick Hospital, visited on a weekly basis by the consultant geriatrician. In an elevated position on Warwick's western edge, there was a long-stay psychiatric hospital (Central Hospital) with 600 beds and a chest hospital with pavilions and balconies for the treatment of patients with pulmonary tuberculosis.

When I became acquainted with the group in 1966, the same three acute hospitals were still open and three consultant physicians, three house officers and three senior house officers provided the medical care. Each hospital was on acute medical take one day in three but, of course, at least one of the two junior members of the medical team was always on duty at each hospital to care for the inpatients. Individual consultants for haematology, biochemistry and microbiology had been appointed. There were also two histopathologists and two consultant paediatricians.

The junior doctors at Warwick Hospital were also on call for acute medical problems at the Central Hospital which housed 1,200 long-stay psychiatric patients in accommodation built for 600. The beds were so close together that the patients normally got into them by clambering over the bed end. The opening manoeuvre to any consultation entailed moving four or five beds together to create enough space by the side of one so that the patient could be examined.

Forty years on, the pattern of care has been transformed. A neat suburban housing landscape has replaced the Warneford Hospital in Leamington Spa, the Central and the chest hospitals. The

original hospital in Stratford-upon-Avon is now a luxury hotel, although some services, run by the local GPs, are still available on the former RCAF site.

The acute services for South Warwickshire are now all provided on the Warwick Hospital site where the full facilities of a modern district general hospital are available in acute medicine and its subspecialties – general surgery, obstetrics, paediatrics, accident and emergency medicine, orthopaedics and trauma. Even these facilities are under threat, in particular because of the development of the surgical subspecialties and the centralisation of cancer services. There is considerable pressure for many of the acute services to be relocated to a new hospital which is under construction in Coventry, some 10 miles to the north.

The closure of small acute hospitals and their amalgamation into an often rather remote large, district general hospital is a common pattern. The threatened closure of each of these local hospitals was met with fierce resistance. There is a wide gulf between the wishes of the community, with a strong preference for local services, and the need to centralise medical and surgical services and their subspecialties in order to maintain a high quality cost-effective service.

Could the planned introduction of diagnostic and treatment centres go some way to resolve the dilemma? The GP would remain the mainstay of primary treatment with an expansion of community-based services, while the diagnostic and treatment centre would provide local outpatient referral advice, laboratory and radiological assessment and day-case work in medicine and surgery. In the event of an acute or more major problem, then travelling some distance would inevitably remain an integral part of the service to ensure high quality care with access to a wide range of specialty services, should these be needed.

Before the proposals can be embraced and encouraged certain questions need to be addressed and answered. The term 'independent sector treatment centres' has been introduced. There is no sense here of a partnership between the acute hospital and the local centre. Might the new local centres drain medical and nursing staff from the acute hospital and detract from the services for the acutely ill? Will the local centres be as cost effective and safe as the large centres for technical procedures such as endoscopic services? Will the independent centres contribute to education and training for the next generation of medical and nursing staff? Will the relocation of specific services to the independent centres deprive trainees of valuable experience?

Striking the correct balance between community-based services with their diagnostic treatment centres and the more remote, but specialised inpatient care is a challenge to be addressed in the interests of high quality care for all patients.

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