

## CENTRES OF EXCELLENCE AND SUPRA REGIONAL UNITS

1. The Supra Regional Services Advisory Group has on a number of occasions discussed the distinction between those centres of excellence which qualify for supra-regional designation and those which do not. This paper endeavours to define the distinction between supra regional service units and other centres of excellence. It also deals specifically with the position of Special Health Authorities.

Supra-Regional Services

2. Circular HN(83)36 defines supra regional services 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." This was expanded into the following criteria:

- a. The service should be an established clinical service, not a research or development activity (for which alternative sources of funding exist).
- b. There should be a clearly defined group of patients having a clinical need for the service.
- c. The benefits of the service should be sufficient to justify its cost when set against alternative uses of NHS funds.
- d. The cost should be high enough to make the service a significant burden for the providing regions.
- e. Supra-regional funding, as opposed to regional or sub-regional developments, should be clearly justified either
  - i. by the small number of potential patients in relation to the minimal viable workload for a centre, or
  - ii. 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
  - iii. as an interim measure, by the scarcity of the relevant expertise and/or facilities.
- f. The units to be designated should be capable of meeting the total national caseload for England and Wales.

3. In the arrangements for handling bids for supra-regional recognition quantitative criteria are used which have been agreed by the Advisory Group.

i. The rarity of the condition to be treated must be such that the population served by each unit is a minimum of 5m and the total national caseload should normally be capable of being treated in fewer than ten units. (Although no precise guidelines have been given, in practice this has meant that the national caseload would not exceed 1,000 and would often be about 400).

ii. The cost high enough to make the service a significant burden for the providing regions has been taken as at least £250,000 per unit.