

I am speeding around the community doing rheumatology clinics, how can I manage my rehabilitation unit? Multi-tasking is possible on one site, but not on many. Trainee teaching will collapse as the diversity of case-mix, a virtue of service concentration, will be lost. The opportunity to collect cases for clinical trials will dissipate. Departmental morale will collapse. A two-tier service of superspecialist care in big teaching centres and barefoot specialist care elsewhere will develop. These are not my arguments alone; I asked my chronic disease 'focus group' (our local National Rheumatoid Arthritis Society network group) whether they would prefer to be seen by me in the hospital clinic or in their own GP surgeries. Without exception they expressed a preference to be seen at the hospital, citing many of the above concerns. Ask the wrong people and you get the wrong answer.

Concentration brings benefits. The clearest example of this is surgical; in the first world war facial injury care for Great Britain and the Dominions was concentrated in one hospital (mine, as it happens) and the advances in plastic surgery thereby generated were unmatched on the continent where facial injury was dealt with in a fragmented way. Furthermore the patient support that grew from this obviated the need for a self-help group, whereas in France 'les gueules cassées' developed because of the isolation and dispersion of sufferers.³ To create a specialist diaspora will recreate the disadvantages of dilution. We must learn from history.

Lastly, Care in the Community often means very little, or no, care. As social service budgets contract and input from carers diminishes we have already seen the adverse effects and must do everything we can to avoid this in medicine.

That is not to say that hospital-based care is cheap or that we should not look for ways of making it cheaper, for example by running telephone clinics for those on long-term follow-up. As Patterson points out, hospitals are encouraged to maximise income, while PCTs try to limit access because Payment by Results (PbR) tariffs are unaffordable. But we do not need to disperse specialists to address this; as the musculoskeletal services in Stoke and Bolton have shown it may be possible to avoid sub-

stantial transactional costs by changing management from acute trust to PCT without necessarily altering the physical structure of the service. We should also remember that those services turning a profit in an acute trust (rheumatology outpatients is one) will prop up the loss leaders (acute medicine is one). So pulling out profitable services may compromise the whole of acute hospital-based care – unless the purchaser-provider split is abolished, which, for me, would be the essential and final outcome of Teams without Walls.⁴

I firmly believe that care closer to home is a concept based on flawed research and the turning of a blind eye to economic reality. Specialist medicine as a whole will be seriously damaged if we fail to examine its risks.

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Conflict of interest

AB is employed by an acute trust.

References

- 1 Stoate HGA, Jones B. *Challenging the citadel: breaking the hospitals' grip on the NHS*. London: Fabian Society, 2006.
- 2 British Society for Rheumatology. Response of the British Society for Rheumatology to the consultation document 'Improving our patients' experience of healthcare in Cumbria and Lancashire: clinical assessment, treatment and support centres'. March 2007 <http://sidcuprheum.org.uk/bsractionplan/bsr%20response%20lancs%20icats.doc>
- 3 Harold Gillies: surgical pioneer. *Trauma* 2006;8:143–56.
- 4 Royal College of Physicians. *Teams without walls. The value of medical innovation and leadership*. London: RCP, 2008.

In response to both

I agree with Dr Cohen that general practitioners (GPs) with a special interest have an important role. It is essential that they feel part of the specialist service and participate in audit, continuing professional development and so on with specialist colleagues.

They also need to be able to discuss patients easily with consultants and to access more specialist opinion when needed, as well as bringing their expertise as to how patients can be managed in the community.

Dr Cohen also makes the point that the challenge is not to deliver more of the same just in a different location – which very well answers Dr Bamji's concerns. Moving expertise into the community, working more closely with GP colleagues, community nurses and other professionals to deliver consultant input in a different way is not just an argument about geography. There are undoubtedly logistical difficulties in providing services in different places, but these can be overcome (and many consultants already deliver outpatient services in locations away from their home base). The point of consultants working in community settings is to develop better pathways of care which are more joined up across the old primary–secondary care boundaries and to truly build Teams without Walls.

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Managing capacity and demand across the patient journey

Editor – Walley and colleagues recently highlighted the problem of reduced bed capacity which has an impact on coping with healthcare demand (*Clin Med* February 2010 pp 13–5).

I would like to comment on the long-term planning and that bed requirements are based on average demand and average length of stay, the author felt that this can create a problem as once there is random variation in demand and staff capacity, bed shortages will occur. I do not feel that we have a bed shortage in England. However, the discharge process is patchy and lengthy and there is a lack of coordination between hospital staff or secondary care and primary care as well as between NHS and social services.

I agree with the author that a 'systems' approach is the only solution where healthcare staff and social services, primary and