Conflicts of interest

The author has no conflicts of interest to declare.

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Editor – we read with great interest the opinion piece concerning consultant job planning for a 7-day service authored by Dr Matthew Lewis in last issue of *Future Hospital Journal*.[1] We were each previously medical directors, with a combined experience totalling some 25 years, and found the examples of how to plan for 7-day services both clear and compelling. Lewis' conclusion that 'effective job planning allows finite resources to be used to the greatest effect' is one with which we entirely concur. Managing the way our workforce is deployed to ensure their skills are applied to best effect will ensure we are able to offer high-quality care to our patients in the most efficient way. This fundamental principle underlies the implementation of a number of the 15 recommendations of Lord Carter's report into unwarranted variations in the performance of NHS acute trusts in England.[2] Evidence of such variability has emerged previously in the report of the British Orthopaedic Association authored by TB.[3] This 'getting it right first time' (GIRFT) philosophy has led to real improvements in surgical outcomes within elective orthopaedics services and, for the first time, a fall in litigation claims – an important surrogate for quality. The GIRFT programme has now been funded to expand to more than 30 specialties. Each has a national lead, usually a clinician of national or international stature, and access to data that will ensure we know 'what good looks like' in terms of both outcomes and service delivery. Clinically conceived, clinically led and delivered by clinicians, hospital visits are already underway, at which the GIRFT leads engage face to face with the consultants and other clinical staff responsible for delivering each service 'on the ground'. This ensures they adopt best practices as defined by royal colleges and specialist societies, which have without exception expressed their support for the programme. Matching job plans for medical and non-medical clinical staff (eg allied health professionals, pharmacists) and those providing diagnostic services will be crucial to ensure best practice can actually be adopted and thereby meet the (7-day) needs of patients, the demands of actually providing the service and to maximise the beneficial impact of the NHS' physical (eg operating theatres, imaging equipment) and human resources. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

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3 Lord Carter of Coles. *Operational productivity and performance in English NHS acute trusts: unwarranted variations.* London: Department of Health, 2016.

Now, where are those matches at the end of this tunnel?

Editor – 20 years ago, pretty much to the day, Professor JR Bennett wrote 'will the last one out please turn off the lights in the emergency admissions ward'.[1] I fear Paul Jenkins' matches are far too little and much too late.[2] And, anyway, we are nowhere near the end of the tunnel.

Professor Bennett is the Cassandra of this tale. His editorial, 'The general physician – dinosaur or superman?', pretty much predicted all that has come to pass.

The catastrophe that is acute general medicine is a consequence of the syzygy of four separate, not altogether unconnected, events. I will describe the Norwich experience – Dr Jenkins hails from Norwich – although I know this has been replicated in teaching hospitals across England. It is worth pointing out that district general hospitals (DGHs) have weathered the storm far better as they do not have the luxury of multiple belligerent specialists to shoe-horn into creaking general internal medicine (GIM) rotas.

First came the closure of rehabilitation/convalescent hospitals. In Norwich, the canary in the coal mine was the sudden appearance of a flock of geriatric colleagues in the acute hospital offering to take over the care of elderly GIM patients. Slightly baffled, we specialist physicians seized the opportunity at face value. Only subsequently did we realise that the geriatricians had been rendered cageless as Norwich lost all of its community beds.

Secondly, the Royal College of Physicians promised a new specialty to deliver acute medicine. Acute medicine, as part of the Acute Care Common Stem, is a necessary service; just not in its current incarnation. The trust was persuaded that this new specialty would assume responsibility not only for acute admissions – the 'front door' – but ultimately for GIM in its entirety.

Thirdly, specialists seized the opportunity to make an unseemly dash to specialisation and super-specialisation. Professor Bennett has pointed out the Kafkaesque disincentive in which training for 'generalists' is a year longer than for 'specialists', the rewards for which are: a delay in achieving certificate of completion of training; being forced onto GIM rotas; having a reduced exposure to specialty patients; and to earn the public's opprobrium – despite having identical specialist training to the 'specialist'. Cardiology were first out of the blocks and were immediately followed by respiratory medicine. Gastroenterology's solution was to arrange regional rotations such that their specialty registrars did their GIM training in regional DGHs and their specialist gastroenterology training in Norwich; thus, the gastroenterologists were lost to GIM services in Norwich. The last doctors standing – nephrology and endocrinology – looked over our shoulders to find that everyone else had taken two steps back and we had been volunteered to manage the hippogriff. I advised at the time that this flight from GIM would mean running out of the doctors to deliver it within 10 years. We did.

The final straw has been the King's Fund proposal – inimical to the interests of acute hospitals – to combine the health and social care budgets. This combination has happened *de jure* in Greater Manchester but is happening *de facto* across the country as community services achieve the budgetary event horizon and completely collapse. Some years ago, I trawled the medical wards and advised this trust that there were at least four wards of medically fit 'patients' waiting for a discharge destination. These 150-plus 'patients' entirely explained – and explain – our perpetual bed occupancy of >100% (patients sitting out the night on the dialysis ward for example), our cancelled surgical lists, our accident and emergency breaches, our nursing and medical staff shortfall, and our financial predicament.

I am delighted that former poachers are looking to become gamekeepers. It is essential that they learn the lessons from history and they should start by reading Professor Bennett's editorial. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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2 Jenkins P. Now, where are those matches at the end of this tunnel? *Future Hospital Journal* 2017;4:5–6.

Response

Editor – the purpose of an editorial is to introduce and stimulate debate and the receipt of this letter is therefore welcome. The facts regarding Norwich are accurate to a degree although I have to emphasise that it was never part of the local plan that the development of acute medicine should include responsibility 'for GIM in its entirety'. This is germane to the comments that follow.

The four events detailed by the author of this letter (can the number four, rather than pairs, constitute a syzygy?) are reasonably accurate but I cannot agree that they are solely responsible for the current plight of acute medicine. My view is that acute medicine has failed to achieve its initial promise because of an unrealistic and progressive demand for it to be multi-functioning. In addition to the management of acutely unwell medical patients at the front door, there has been a progressive demand for responsibility (by default) for patients with multiple comorbidities and a mix of problems that, although urgent, are often far from acute and commonly not even medical.

Secondly, I cannot agree that Professor Bennett was the 'Cassandra of the tale' 20 years ago. A number of us took his prophecies very seriously at the time and, personally, they contributed to my view (previously stated in this journal and elsewhere) that a rebirth of generalism is not only vital but should also recognise the need for subspecialties within the traditional sphere of general internal medicine. This view posits that, in addition to the established training programmes in geriatric medicine, subspecialty distinctions should include chronic disease management as well as acute medicine with cadres of physicians trained accordingly and with different emphasis.

Finally, while retrospective analysis is important and we should, of course, learn from historical mistakes, destructive criticism alone will not solve the current problems of hospital medicine. In fact, a penchant for exclusive focus on historical mistakes and bemoaning our current plight, rather than finding ways for improvement, may be part of the reason for the existing parlous situation.

Positive contributions to the debate are welcome; delivering on the fundamental aim of the last and previous editions of the *Future Hospital Journal*. ■

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The author has no conflicts of interest to declare.

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