

# Teams without Walls

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The value of medical innovation  
and leadership

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**Report of a Working Party of the Royal College of Physicians,  
the Royal College of General Practitioners and the  
Royal College of Paediatrics and Child Health**

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## Royal College of Physicians of London

11 St Andrews Place, London NW1 4LE  
www.rcplondon.ac.uk  
Registered Charity No 210508

## The Royal College of General Practitioners

14 Princes Gate, Hyde Park, London SW7 1PU  
www.rcgp.org.uk  
Registered Charity No 223106

## The Royal College of Paediatrics and Child Health

5–11 Theobalds Road  
London, WC1X 8SH  
www.rcpch.ac.uk  
Registered Charity No 1057744

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## Members of the Working Party

**Rodney Burnham** (*Chair*) MD FRCP  
Registrar, Royal College of Physicians

**Ken Aswani** FRCGP  
Member of Council,  
Royal College of General Practitioners

**Mike Cheshire** MB FRCP  
Clinical Vice-President, Royal College of Physicians

**John Dean** FRCP  
Medical Director for Quality and Care Improvement,  
Bolton PCT; Royal College of Physicians

**Agnelo Fernandes** MBE FRCGP  
Emergency Care Lead,  
Royal College of General Practitioners

**Clare Gerada** MBE MRCPsych FRCGP  
Vice Chair of Council,  
Royal College of General Practitioners

**Minoo Irani** MD FRCPCH MRCP  
Lead, NHS Alliance Specialists Network

**Simon Lenton** FRCPCH MRCP  
Vice President (Health Services),  
Royal College of Paediatrics and Child Health

**Colette Marshall** RGN  
Head of Clinical and Research,  
Royal College of General Practitioners

**Jonathan Steel** FRCP  
Chair, GP Network Steering Group,  
Royal College of Physicians

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## Executive summary

**The intention of this paper is to inform professions, policy makers and commissioners about the options available for moving care 'closer to home' and to develop the concept of 'Teams without Walls'.**

**Teams without Walls is an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians.**

The aspiration behind this paper is to create an NHS that puts the patient at the centre of everything we do – involved, empowered and enabled to achieve the very best outcomes for their health. Services will be organised around patient journeys through the NHS, translating the latest evidence into practice, with patients cared for by competent teams, delivering services close to home where it is safe and sustainable to do so.

This paper encourages innovation throughout the NHS, in particular for clinicians who work at the primary/secondary interface. This boundary is fast being eroded as care traditionally provided in hospital is now provided in community settings.

For patients to really benefit from this new approach, hospital and community teams need to merge to ensure that the patient sees the right person, at the right time, in the right setting. This will require innovation and leadership from doctors, as well as a commitment to continuous improvement year on year driven by collaboration and learning rather than by competition and targets.

Teams without Walls endorses clinical innovation, leadership and learning as the primary method of improving patient experience and outcomes within the NHS, and this paper provides examples of successes in implementing this way of working.

This approach may challenge some of the recent NHS reforms, but promises to be a more sustainable solution to some of the entrenched problems the NHS must overcome if it is to succeed in the long term.

Examples of this thinking and its impact on patient care are offered throughout the paper.

## Key messages

- ▶ Government policy initiatives should lead to care that is excellent, safe and affordable. Boundaries that hinder effective collaborative working between health professionals should be removed.
- ▶ A jointly commissioned model of integrated health services should be provided by primary and secondary care working together. This would significantly reduce the potential for unhealthy competition between primary care trusts and hospital foundation trusts and contractual and cultural conflicts.
- ▶ Clinical leadership is required for successful commissioning.
- ▶ The incentives/disincentives of Payment by Results need to be re-balanced to bring integrated specialist and generalist care closer to the patient's home.
- ▶ Future healthcare should build on the successes of today, using the better policy initiatives as necessary but rejecting others that create barriers to effective change.
- ▶ In summary, there will need to be:
  - ▶ a clear vision and set of NHS values, shared by all, crossing traditional professional and organisational boundaries
  - ▶ an alignment between those commissioning, providing and regulating services
  - ▶ investment in leadership, innovation and the spread of audit and learning, to drive a new culture of continuous improvement
  - ▶ removal of boundaries between primary and secondary care.

## Introduction

The Government plans to change the way that healthcare is delivered. It proposes that care will be provided closer to home and whenever possible outside hospital, this process being supported by practice-based commissioning<sup>1</sup> and world-class commissioning.<sup>2</sup> The Department of Health recommends that ‘specialty organisations and Royal Colleges should define clinically safe pathways that provide the right care in the right setting, with the right equipment performed by the appropriate skilled person.’<sup>3</sup> This paper will show that this is indeed what the medical profession has been developing: creating Teams without Walls, delivering services that cross traditional primary/secondary, hospital/community boundaries to best meet the needs of patients.

Many of the Royal Colleges, sometimes with other professional organisations, have published papers that propose an erosion of the traditional boundaries between professional groups and individual NHS organisations; for example:

- ▶ the Royal College of General Practitioners (RCGP) and the Royal College of Physicians (RCP) joint statement, *Making the best use of doctors’ skills, a balanced partnership*,<sup>4</sup> which builds on their previous joint publication on chronic disease management<sup>5</sup>
- ▶ the Royal College of Paediatrics and Child Health (RCPCH) paper, *A guide to understanding pathways and implementing networks*<sup>6</sup>
- ▶ the Royal College of Surgeons paper, *Delivering high-quality surgical services for the future*<sup>7</sup>
- ▶ the joint paper between the NHS Confederation and the Joint Medical Consultative Council entitled *A clinical vision of a reformed NHS*.<sup>8</sup>

All of them emphasise the importance of shared working as the most effective way of managing patients with long-term conditions.

The challenge for the future is to ensure that government policy initiatives lead to care that is good quality, safe and affordable and that boundaries are removed that hinder effective collaborative working between health professionals. We believe this can best be achieved by accelerating the process of creating Teams without Walls.

## Aims of the paper

During 2007 and 2008 a Working Party from both the RCP and the RCGP, together with a representative from the NHS Alliance Specialist Network and latterly a representative from the RCPCH, has been looking at the redesign of healthcare in detail. The intention of the group was to inform the profession, policy makers and commissioners of the options available for moving care ‘closer to home’ and to develop the concept of Teams without Walls. This paper is the outcome of these deliberations and will give examples of current and innovative practice through service redesign. These demonstrate that specialists and GPs are embracing new ways of working and are willing and able to provide the leadership necessary to erode the boundaries between primary and secondary care.

## The need for integrated care

Patients with long-term conditions move between primary and secondary care at different times of their lives. As they get older or more unwell, these moves have a tendency to become more frequent and complex, requiring the additional involvement of social, voluntary and sometimes mental health services. Occasionally, demand management creates dislocation of close working between generalist and specialist practitioners. However, there is no doubt that in the changing world, they must work together in different ways to better meet the needs of patients with long-term conditions throughout the time of their illness.

This Working Party believes that an integrated model of care, where multi-professional teams work in a managed network across the interfaces and manage patients on a care pathway designed by local clinicians, is the best model for the future. We feel that Teams without Walls is the way forward to achieve the required improvements in the delivery of healthcare.

Examples already exist that reflect this in a number of specialties, for example respiratory medicine.<sup>9</sup> Although there are examples of high-quality General Practitioners with a Special Interest (GPwSIs), successful ones work in close partnership with consultants. A number of specialties such as dermatology and rheumatology have issued guidelines about the accreditation of such practitioners.<sup>10,11</sup>

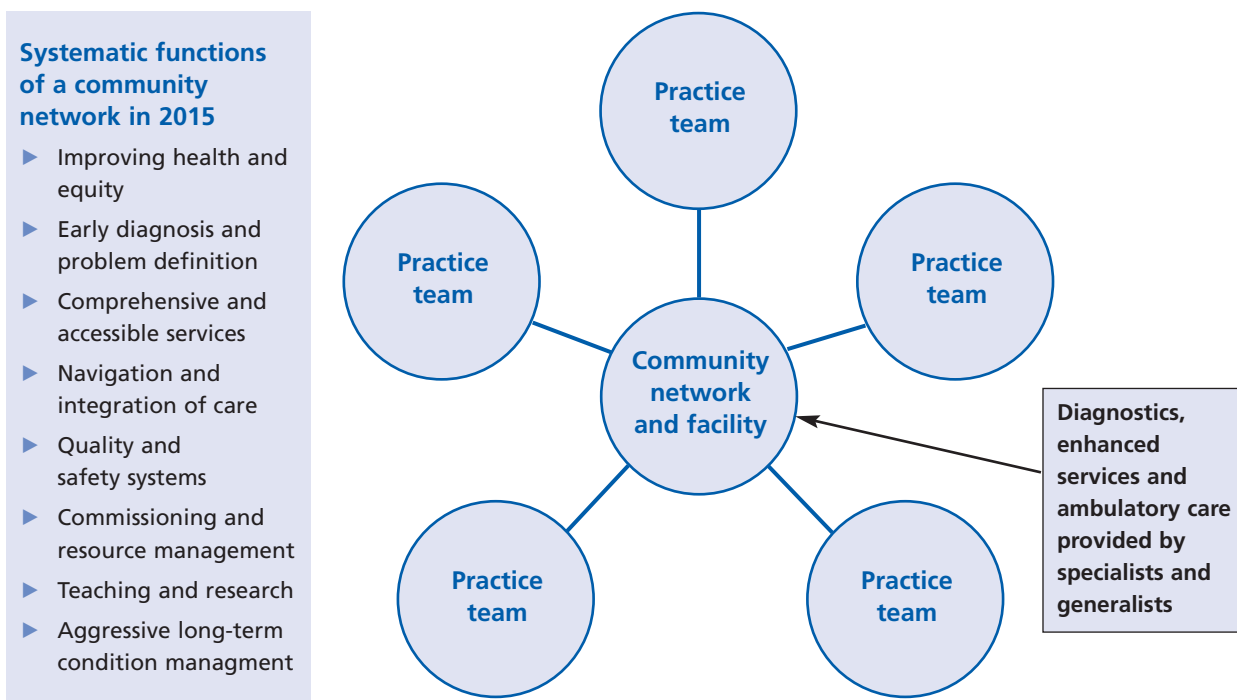
## Systems and strategies for providing integrated care

*The future direction of general practice – a roadmap (2007)*<sup>12</sup> outlined the future strategy for general practice and included a strong emphasis on developing effective integrated and networked services in the community (see Fig 1).

*The roadmap* noted that whilst most patients will present to the GP, it is important that effective care includes a partnership between other healthcare professionals working in a network to ensure that the patient pathway optimises care.

The Nuffield Trust has recently produced a briefing paper on clinically integrated systems that provides support for the system we are endorsing.<sup>13</sup> The authors highlight the tension between competition and collaboration in the provision of healthcare. It concludes that, up until now, more emphasis has been placed on competition because of the need to reduce waiting times for planned care or investigations. However, this competitive model may only work well in the surgical arena or where the individual has a well-defined clinical problem which is amenable to a single diagnostic test or intervention. The report suggests that in order to improve services for long-term conditions clinical integration between what we now call primary and secondary care and the development of clinical networks will be needed. It suggests that integrated commissioning should be used as a mechanism to develop this and that the performance of such systems in a competitive environment should be explored.

**Figure 1. Community network championed by clinicians.** (Reproduced from Ref 12.)



## Advantages of integrated care

There is good evidence as to the advantages of integrated working practices between primary and secondary care clinicians. These include better communication and educational exchange,<sup>14</sup> improved patient satisfaction,<sup>15</sup> greater efficiency and improved health outcomes.<sup>16</sup> However, an efficient mechanism to facilitate this integration has always been elusive. Case examples of hospital consultants providing sessional services in GP surgeries have not been systematically evaluated for efficiency or cost effectiveness and critics of the model state that economies of scale favour keeping specialist services in hospital. Therefore session-based work by hospital specialists in primary care may not be efficient or cost-effective in the long term, unless accompanied by specific training programmes, workforce planning and sophisticated contractual and career progression incentives.

In recent years some primary care trusts (PCTs) have supported clinician-led initiatives in the management of long-term conditions in community and primary care where efficient links with hospital services are maintained. Integrated health services would enable generalists (GPs, primary care nurses) and specialists (consultants, specialist nurses) to cooperate and collaborate in both the process of commissioning and providing health services that are sensitive to the needs of the local population. This would not just be about service provision but the development of new ways of working, from the idea through to its implementation. The role of PCTs and commissioners would then be to monitor and quality assure the process and outcomes. National standards and evaluation tools exist in some areas of practice<sup>11</sup> and can be used for this purpose. These new teams, made up from existing primary and secondary services,

would be sensitive to the wider health needs of the local population and maintain a more holistic and preventative focus, but also have skills which would enable them to support patients during hospital admissions or investigation, if required. The emphasis would remain upon keeping the patient out of hospital by health promotion, and by managing outpatient care and minor complications in the community. This approach recognises the balance that needs to exist in a health economy between that which is best provided in the community and the necessity at times for the services to be provided in a hospital setting.

A jointly commissioned model of integrated health services provided by primary and secondary care would significantly reduce unhealthy competition between the two and reduce the potential for contractual and cultural conflicts between PCTs and hospital foundation trusts.

Clinical integration would prevent monopolies from being created, as might be the case if hospital foundation trusts expanded to provide community and primary care. It would enable general and hospital practitioners to align their loyalties and best practice objectives and have a common vision for high-quality cost-effective service provision.

### **Aspirations for the NHS (a vision from clinicians)**

- ▶ Clinicians wish to see the NHS using resources wisely and achieving the best outcomes for all patients. To achieve this, patients need to be fully engaged in both the prevention and management of their conditions. They need to be involved, empowered and enabled to participate in their own care, with close family members where appropriate. In addition, they need to be involved in service design, improvement and evaluation.
- ▶ Services should be organised in a way that facilitates patients achieving their outcomes in the most efficient, effective and safe way. The use of patient pathways (some of which need to be developed and others adapted to local circumstances) as the building blocks for services is recommended, with the right balance between prevention, early identification, assessment, intervention and, when necessary, long-term support. This will have implications for commissioners, providers and regulators of services.
- ▶ The system needs to adopt a culture of continuous innovation, improvement and learning as the driver for better services in the future. To achieve this cultural shift, the NHS needs explicit values that influence day-to-day decision-making, and an assurance system which constantly first identifies and then rectifies the weakest point in the patient pathway.
- ▶ The Teams without Walls approach needs to be facilitated by either vertical or virtual integration of management structures, working in the long term towards managed clinical networks.



## How can this vision be achieved?

- ▶ *Population health needs and inequalities are considered* at the planning stage.
- ▶ *Communication and service gaps are identified*. Patient involvement is an essential part of this.
- ▶ *The service knowledge of local clinicians and public health data are essential*.
- ▶ World-class commissioning must strive for *world-class services*.
- ▶ *Clinical leadership* is required for successful commissioning – involving both generalists and specialists.
- ▶ *Regulators* should inspect for improvement based on care pathways as well as by regulating organisations.
- ▶ *Commissioning* must:
  - ▶ commission pathways, delivered by teams, working in networks
  - ▶ promote partnerships, leadership and enthusiasm in its local clinicians
  - ▶ set boundaries, support clinical innovation, monitor its effectiveness and use evidence that is valid, reliable and reproducible
  - ▶ ensure that local clinicians are enabled by its process and not hindered or inhibited by it.

*Practice-based commissioning* can be an effective tool to initiate clinical integration, but it needs to be developed further. General practitioners, hospital doctors and other clinical practitioners know most about their practice and patients, although they see them from different perspectives. Successful commissioning brings together all of those involved in the provision of care to patients, including patients themselves, in a true collaboration.

## Payment by Results

Payment by Results (PbR) is a tool for paying for health activity.<sup>17</sup> It may create perverse incentives so that it appears easier financially to admit the patient rather than manage them outside hospital or to commission separate specialist services in primary care, thus avoiding the full tariff price of a consultant-delivered service in an outpatient clinic. We believe that the incentives and disincentives of PbR need to be re-balanced to support integrated specialist and generalist care closer to home.

Teams without Walls offers a simple way of dealing with this issue by designing, commissioning and paying for new, cost-effective, service pathways which are beneficial to the patient. We are encouraged that the Department of Health PbR team are starting to do this; they could explore the concept of payment by pathway (PbP) for an episode of care, and annual payment by condition (a PbC) for long-term conditions.

## Examples of good practice

As part of our exploratory work, Fellows and Members of both the RCP and the RCGP were surveyed about new models of care in the community. In total, there were 288 replies from the physicians, and all but 20 were positive, with innovation right across the range of clinical specialties.\* The common thread was high-quality clinical involvement and partnership. The same exercise was conducted using RCGP networks to survey GPs about best practice with respect to shared/integrated services. The survey was sent to approximately 100 contacts, and 31 responses were received. Examples of both are listed in Appendix 1. We have tried to determine sustainability, efficiency and effectiveness but this has not always been possible since there are often no comparative measures in the data collected.

## Issues that accompany success and failure

We believe that integrated care can be successful especially where doctors provide leadership. Where doctors have not been engaged in planning and commissioning services they are less likely to succeed. This failure to engage may sometimes be due to professional inertia and an unwillingness to participate in difficult decisions, but in addition some government policies can have unintended consequences. One example of this was the setting up of independent treatment centres to increase competition, despite the existing healthcare provider supplying a good service and adequate capacity, thus discouraging clinician engagement.

### Elements that promote success

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- ▶ Clinical leadership and involvement

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- ▶ High-quality partnership between clinician and professional manager

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- ▶ Primary and secondary partnerships

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- ▶ Committed commissioners willing to innovate and fund flexibly

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- ▶ Clear patient focus for a defined group

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- ▶ Clear governance arrangements

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- ▶ Agreed measures and standards to improve the quality and quantity of work

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These were the common features of those services that work.

Success occurs where clinicians use the opportunities available to them but show leadership by rising above the strict implementation of the new government policies; paraphrasing the Chinese concept of Tao, 'going with the flow but remaining above it'.

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\*A list of these can be found on the Fellows and Members area of the RCP website at: [www.rcplondon.ac.uk/members/teamswithoutwalls.asp](http://www.rcplondon.ac.uk/members/teamswithoutwalls.asp)

## Elements that accompany failure

- ▶ Clear separation of managerial and clinical aims
- ▶ No clinical leadership
- ▶ Targets with unintended negative consequences
- ▶ A culture of competition rather than collaboration
- ▶ Financial flows that encourage efficiency without considering effectiveness
- ▶ A 'command and control ethos' that does not value learning

## The future

The current policy initiatives of commissioning, PbR and foundation trusts should be seen as tools to bring about change rather than a means to an end. One possibility would be to develop integrated provider organisations as envisaged in the report from the NHS Alliance.<sup>18</sup> 'World-class commissioning' must enable doctors to innovate and lead these improvements.

Future healthcare should build on the successes of today, using the better policy initiatives as necessary but rejecting others that provide barriers to effective change.

The examples in this document show that with imagination integrated services can be achieved using current policy mechanisms. Whilst some may feel that integration can only be achieved by co-location, integration is as much about systems for innovation, communication, clinical collaboration and shared learning as it is about bricks and mortar.

Linked intimately to the future success of this approach is the ability of both the generalist and specialist to learn to work in different ways in the future. This learning depends upon creating feedback systems using measures that can motivate those providing services to do things differently, if the service is not meeting patient or clinical expectations.

Current and future trainees should be trained in integrated care; during training they should be supported outside hospital as in hospital. Also, consultants in integrated care services need support with proper governance procedures and continuing medical education.

Widespread best care for patients and families will be accelerated by removing barriers to change and ensuring that clinical professionals can together design, deliver and evaluate local care to ensure that it meets local needs. Local clinical networks, strong clinical leadership and supportive management will enable services to be developed that best meet the needs of our changing population. Finally, clinical integration is about allowing individuals, services and organisations to align in order to improve patient care.

## Appendix 1

# Examples of integrated care

### **Care of the elderly scheme in Poole, Dorset**

After good engagement between hospital and primary care, the PCT wished to develop this further. Potential problems were overcome by good relationships between consultants and GPs and by support from the local authority. Sharing of risk, multiple funding sources and paperless referrals were additional advantages. A multidisciplinary team, based in hospital and in the community, helped admission avoidance and enhanced discharge; a strong patient voice was valuable.

### **Respiratory medicine in Hull**

An implementation group consisting of consultants, GPs and patients, with representatives from hospital and PCT management, developed an integrated service. Patient-centred guidelines were established and launched at a well-attended meeting. These guidelines emphasised early treatment and patient education. An essential feature was close collaboration between all parties, valuing the others' skills, which led to learning from each other. An outreach team was very effective.

### **Gastroenterology in Barnsley**

Patients with inflammatory bowel disease were educated and empowered to manage their condition without hospital attendance if they were stable. The results of blood test monitoring and advice were sent by email or text. This freed outpatient slots, saved an estimated £40,000 per year, and allowed rapid advice for patients suffering a relapse.

### **Community cardiology in Northampton**

This service was characterised by collaboration between the hospital trust and PCT, as well as clinical input from a GP with a Special Interest in Cardiology, a pharmacist and specialist nurses. Access to echocardiography and support from a consultant resulted in good care for patients and may have saved money by reducing admissions.

### **Rheumatology service in Birmingham**

A consultant rheumatologist initiated this service with support from GP colleagues, as well as collaboration from hospital and community managers. Agreed protocols and referral pathways were disseminated. Sixty of the 64 local GPs participated in this shared care scheme. Initial friction was overcome with support from the PCT.

### **Shared care scheme for patients with psoriasis in Manchester**

Engagement led by a consultant, GPs, nurse specialist and patient group led to a randomised controlled trial of management of psoriasis in primary care. This assessed the effect of written guidelines and education on the appropriateness of referral to secondary care. The trial was successful and patients are now seen by the right person in the right place at the right time. Patient feedback has been positive, as has an audit of the quality of care provided.<sup>19</sup>

## **Clinical integrated model in Bolton**

Supported by the hospital trust and PCT, physicians and GPs have led the development of clinical integration in Bolton. High-quality services in diabetes and rheumatology and the management of alcohol misuse have been established. The Diabetes Centre is based outside the hospital and the service extends into GP practices. It also provides an in-reach service to the hospital and this includes acute medical services.

## ***Examples of integration from children's services***

### **Colocated urgent care centre and emergency department – Homerton Hospital**

Children often present to emergency departments with conditions that should be managed by primary care teams. Some children present in primary care with an acute illness that requires further investigation or observation. Protocols and process were agreed between general practitioners, paediatricians and emergency department staff and now children are triaged by a children's nurse to either primary urgent care, emergency care or referred to the children's assessment unit on arrival in hospital.

### **Community children's teams for life-threatening conditions – Lifetime Service, Bristol**

Children with complex continuing healthcare needs often have acute exacerbations of their conditions that can be difficult to assess and manage in primary care due to their multiple co-morbidities. Community children's nursing teams, run from children's departments, proactively plan for these problems, give telephone advice, and at the end of life provide 24/7 nursing care.

## ***Examples from the primary care perspective on interface working***

### **Cardiology rapid access clinic in County Durham**

A PCT and trust funded a rapid access one-stop diagnostic clinic to assess patients with suspected heart failure and breathlessness. The clinic was run from the hospital with GP referrals, by a GP with a Special Interest in Cardiology, supported by PCT-funded specialist nurses with a consultant cardiologist available for advice. Outcomes included reduced hospital admissions and high uptake of evidence-based heart failure therapies.

### **Medical assessment unit in Plymouth**

In a trust medical assessment unit, patients are assessed and managed in a clinic setting from GP telephone referrals for acute medicine. Secondary opinions are easily sought, and the GP hands over admissions directly to the medical registrar on call. Alternatives have been found to acute hospital admission for approximately 40% of patients referred to medicine.

### **Musculoskeletal pain service in London**

Collaboration between the PCT, local practices, an independent provider specialising in pain rehabilitation and a healthcare trust provides a patient-centred approach to improve the journey of people with low back pain. This includes a fast-track service for treatment or investigations as well as a Pain Information Afternoon which 70% of patients rated as excellent.

## Appendix 2

# Role of the specialist in population-based healthcare

- 1 **Healthcare delivery planning:** advisory role across the whole population to enable the translation of clinical evidence into practice.
- 2 **Clinical advisory role:** development of guidelines and related documents.
- 3 **Educational role:** use of multiple formats to educate non-specialists and trainees in clinical and related specialist area.
- 4 **Community role:** to champion the treatment of disease or other areas within the community, and form links with community groups.
- 5 **Remote clinical role:** provision of clinical advice about patients to other practitioners.
- 6 **Direct clinical care:**
  - a. *Joint consultation:* together with generalist clinicians where the need for combined skills and knowledge will complement clinical care
  - b. *Direct clinical care:* where specialist skills and knowledge are required that are beyond those of the generalist practitioners.
- 7 **Research:** to advance understanding in the specialist area by direct or indirect involvement in research, or evaluation of research and appropriateness of translating research into practice.

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