

Teams without walls: the future of care closer to home

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General practitioners (GPs) and consultants have traditionally worked together for the benefit of their patients. In recent years, however, this relationship has been strained with a palpable split between primary and secondary care. Now things are changing once more and new life is being given to the notion that consultants and GPs should again work closely together.

A 2006 Department of Health report, *Our health, our care, our say*, proposed that care should be provided closer to home wherever possible and that:

specialty associations 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.¹

This is a challenge that should be welcomed and vigorously taken forward. It puts safe pathways before rhetoric and invites royal colleges to take a lead. One thing is certain, if they do not then others will.

One of the founding principles of the NHS has been that GPs have acted as a gateway to secondary or specialist care. This has generally worked well. Patients do not have to guess what is wrong or which physical system might be involved. As first contact, the GP makes this decision and then, depending on the nature of the problem, either manages the patient or refers them to the most appropriate specialist. General practitioners have developed their multiprofessional teams around them as have the specialists in hospital.

In December 2007, the Nuffield Trust produced a briefing paper which highlighted the tension between competition and collaboration in the provision of healthcare.² The paper concluded that competition may work for single planned procedures mainly, but not exclusively, in surgery. The need to improve services for long-term conditions, however, will require integration between primary and secondary care and the development of clinical networks. The Nuffield Trust suggests that practice-based commissioning should be used as a mechanism to develop this and the performance of such systems in a competitive environment should be explored.

The future direction of general practice: a roadmap outlined a strategy for general practice with a positive emphasis on developing effective integrated and networked services in the community.³ It recognised

that effective care includes other healthcare professionals working together to ensure that the care pathway is appropriate to the patient.

During 2007, the Royal College of Physicians (RCP) developed an interface group consisting of representatives of the Royal College of General Practitioners (RCGP), NHS Alliance and, more recently, the Royal College of Paediatrics and Child Health. The group explored working relationships and built on a joint statement issued by the RCP and RCGP in 2006.⁴ This statement emphasised the importance of shared working as the most effective way of managing patients with long-term conditions.

The RCP has surveyed all Fellows asking for examples of clinical partnerships with traditional hospital-based services and clinicians working out of hospitals in the community in partnership with GP colleagues. More than 250 replies were received and only 10 were in any sense negative. Most showed that with clinical leadership and a clear patient focus many services can be effectively provided, differently and better. The results of this paper will be published in Spring 2008.

The interface group coined the phrase 'teams without walls' and suggest that this may be the way for the future. New teams not bound by institutions but formed to provide high quality, sensitive and accessible care right across the primary–secondary interface.

There is good evidence to support this approach for, in particular, long-term conditions and the elderly. Benefits include better communication and educational exchange, improved patient satisfaction and health outcomes, and greater efficiency. This is not just about consultants providing sessions in the community; it really is about new teams with specialist nurses, therapists and pharmacists, moving away from the long-established pattern of referral letters, waits, hospital journeys for an opinion, tests, results, more letters and more waits. Teams do not work like this. They focus, communicate, share information, and use common records and investigations. They have high expertise and, if we get the models right, will become flexible for the neediest, with different professional groups moving in and out according to the patient's needs leaving them and their GP as the core team. The partnership of generalists and specialists should commission as well as provide services for long-term conditions. These

would be based locally, focusing on local need and involving social services, mental health, the voluntary sector and others as necessary.

There is a lot to do. General practitioners and hospital specialists are differently employed, is this important? Should they be employed in the new service and recognised as equals in this balanced partnership? Should the new services be commissioned and managed as a single service? There are others who have an equally important part to play in the team without walls: specialist nurses, therapists, pharmacists and many more. How do we integrate them? The clinical record is very important, how should this relate to the hospital and the GP record in this new service? Should it be a single-integrated record? What is the role of the primary care trust? One suggestion might be that the trust would set goals, monitor, quality assure, provide high quality public health data, help with analysis and decision making and commission the team without walls to design, implement and manage these new integrated services.

Clearly there are different ways of organising and providing services in the changing NHS which is still free at the point of access but with different providers and different models of care. The interface group strongly suggest that for the majority of local patients with chronic disease the networks and new teams that have been described would make sense, be effective and efficient and truly provide care closer to home.

Finally, widespread best care for patients and families will be accelerated by removing boundaries for change and ensuring that clinical professionals can together design, deliver and evaluate local care to ensure 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.

References

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- 4 Royal College of Physicians, Royal College of General Practitioners. *Making the best use of doctors' skills – a balanced partnership*. London: RCP, RCGP, 2006.