that are focused around the primary care practice with effective professional leadership and information. We are used to the concept of multidisciplinary team working both in primary and secondary care. Now we need partnerships across the previously sacrosanct boundaries of primary and secondary care. The language of primary and secondary care is becoming increasingly redundant. We should therefore use the terms "generalist" and "specialist".

Patients are best served by an appropriate balance of generalist and specialist skills: the benefit to patients of adequate numbers of specialists is undermined if there are insufficient general practitioners, or vice versa. The partnership between generalists and specialists needs to be focused within the community and not within the hospital and must encompass service, education, research and audit. In the model proposed by the RCGP and the RCP, clinicians would champion and lead local health economies. Groups of doctors and related healthcare professionals should be responsible for the healthcare of a geographically defined population. Commissioning must not become a tussle between specialists and generalists; instead, the focus should be on the development of care pathways. Most care, including that for mental health, can be given in the community; hospitals should be for acutely ill patients or where a

specialised procedure or treatment is required.³

Primary healthcare is delivered by teams, increasingly getting larger. Integration is crucial and it is possible to envisage specialists working as part of the team in a non-hierarchical way. The formation of effective teams first requires a shared characteristic or goal that is distinctive and specific to the members, and requires all members to work together to accomplish clear outcomes using individual end products. Although team members may not always be co-located, they will be united through their common focus on the delivery of high-quality healthcare to all patients facilitated by strong working relationships.

The future also brings with it the opportunity for joint education and training both at specialist level and after Certificate of Completion of Training. This will inevitably require new training models, shared where appropriate, with trainees moving seamlessly between what are currently defined as primary and secondary care. But as professional boundaries become increasingly blurred, it is essential that doctors work within their defined and verified areas of competence to ensure the quality and safety of patient care.

The central gate-keeping or navigation role of the general practitioner must be retained to ensure the most appropriate pathway for patients and use of resources.

To maintain the effectiveness and efficiency of the health service⁴ it is essential to ensure that access to specialists is through generalists by the use of the registered list and the gate-keeping or navigation function. There is a temptation to allow direct access for patients to specialists or any doctor, which is the feature of a "free market"; but this would be counter to the weight of thinking in health policy and risks fragmenting care, reducing quality and increasing costs.

Generalists and specialists working together in the community in new models is an exciting and enticing prospect. However, care must be taken to ensure that it is undertaken in a managed way and evaluated.

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Specialty care in the community

Specialist services in the community: maintaining quality of care

Mary Armitage

The need for joint training programmes and collaborative partnerships

The length of specialist medical training and past imprecision in medical workforce planning has led to relative inflexibility when developing new models of service delivery. Specialist care in the community may provide more convenient and accessible care for patients, but must not be at the expense of quality. It is important that new models of care are evaluated through pilots, for quality of care and cost effectiveness, before widespread implementation.

This care will require close collaborative working between all members of the multidisciplinary team and the Royal College of Physicians and the Royal

College of General Practitioners have signalled their wish to encourage working together across traditional professional boundaries to facilitate new models of service delivery. This will require new training models, with trainees moving seamlessly between what are currently defined as primary and secondary care. There are opportunities for joint education and training at a specialist level, and after Certificate of Completion of Training.

Many aspects of community care are embedded in hospital-based specialist training, including regular medication review, health education, the promotion of a healthy lifestyle and disease prevention as

well as team working. However, other aspects of community healthcare, including providing treatments in the home, working alongside a community-based multidisciplinary team, relationships with community social care and additional business management skills represent new challenges for the hospital trainees, who will need to spend time working in the community setting. Equally, general practitioners with a specialist interest need to be integrated within the local service model, with close working and training relationships with the secondary care specialist service.

The key issue is that all healthcare workers delivering specialist services work to agreed national standards of practice. Competency-based training and assessments should facilitate new training programmes to deliver the agreed specialist competencies. Joint training programmes will enable specialist care to be delivered in the community, and will build on collaborative partnerships to improve the service for patients.

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