

Manuscript Title: Paediatric 'Care Closer to Home': stake-holder views and barriers to implementation.

Introduction

The shift of healthcare from hospitals into community settings has been a theme running through policy for paediatric health services in the United Kingdom since the Platt Report in 1959 (Ministry of Health, 1959). Based on the philosophy that families' lives should continue as normally as possible when children require medical treatment, National Health Service (NHS) reforms have sought to ensure that children and young people who are ill receive timely, high quality and effective care as close to home as possible (DoH, 2004). New treatments and technologies in conjunction with a need to reduce demand on acute hospitals (DoH, 2006; Sibbald et al, 2007) have accelerated this initiative, which is also presented as desired by families (DoH, 2004).

Many of the Care Closer to Home (CCTH) evaluations carried out to date have focused on adult outpatient services (Bowling et al 1997, 2000; Bowling & Bond, 2001; Sibbald et al, 2007, 2008), or on preventing inpatient admission and reducing length of stay (Parker et al, 2001a, 2001b). Thus despite a policy drive for paediatric CCTH, there remain gaps in existing evidence about the appropriateness of this model for specialist paediatric outpatient services, namely the acceptability of the model by parents, patients and healthcare professionals, and the extent to which any of the proposed benefits have been achieved (McLellan, 1995).

Studies evaluating the shift of specialist adult care from large hospitals to smaller community settings have produced mixed findings. The reports of an initial evaluation of CCTH demonstration sites (Sibbald et al, 2007, 2008) concluded that moving specialist care into the community has the potential to lead to better communication between General Practitioners and consultants, to improve patient experience, and to provide better access to specialist services. On the other hand, the initiative runs the risk of compromising the quality of care that patients receive and may lead to increased costs with less efficient use of consultants' time. Two systematic reviews of specialist outreach clinics, including adult and paediatric care (Gruen, 2009; Powell, 2002) and evaluations of specialist outreach clinics in General Practice (Bowling et al 1997, 2000; Bowling & Bond, 2001) have reported an increase in patient satisfaction and improved processes of care, but negligible effects on health outcomes and service costs. Studies specifically evaluating the shift of children's specialist outpatient services into community settings are rare. One study which has described and evaluated consultant-led paediatric clinics (Spencer, 1993) concluded that these services can improve choice and access, while facilitating effective patient management and clinical-decision making, particularly in 'deprived areas where the need is

greatest' (Spencer, 1993: 500).

Initiatives such as CCTH have led to a number of specialist services being delivered in non-traditional places such as the home and community facilities (Williams, 2002). New conceptualisations of healthcare places are emerging which view them as more than their physical location and material environment (Rapport et al, 2007). Rather, they are understood as social domains which 'encompass our response to our surroundings and performance within in it' (Rapport et al, 2009: 315). Hence healthcare spaces provide experiences, attachments, symbolism and identity for their users (Andrews, 2006). This understanding of place beyond physical location and setting has led to a consideration of the meanings attached to where care is delivered, and how different stakeholders participate in the creation of new health places (Lehoux et al, 2007). Thus place and space are becoming increasingly important features in where and how families access healthcare.

The aim of this study was to explore healthcare professionals' and other NHS stakeholders' views and experiences of providing consultant-led paediatric outpatient clinics in both the traditional hospital setting, and in less traditional community settings, with a particular interest in how the place of service delivery might influence organisational processes, practices and clinical norms. Such an exploration is important because healthcare professionals and other NHS stakeholders can significantly facilitate or constrain policy implementation through their professional attitudes and behaviours (Bowling & Bond, 2001). Their engagement is thus imperative to the success of service redesign initiatives such as CCTH (Munton et al, 2011; Singh, 2006; Roland et al, 2006).

Methods

Study design and setting

This evaluation was carried out in collaboration with a specialist children's hospital in the United Kingdom and surrounding primary care trusts, situated in a large, diverse, urban area. The hospital currently provides two consultant-led general paediatric outpatient clinics in community settings; one in a health centre and the second in a 'Sure Start' children's centre, which offers a range of community-based support services for families. The use of semi-structured interviews enabled flexible data collection, providing the opportunity to elicit open responses, while ensuring relevant topics were covered in each interview (Kvale & Brinkmann, 2009; Britten, 1995).

Sample and Recruitment

A number of 'key informants' (Marshall, 1998) from clinical, managerial and commissioning backgrounds in primary and secondary care were purposively sampled for their knowledge and experience of planning, running or interacting with paediatric outreach clinics. We employed maximum variation and snowball sampling strategies (Creswell, 2007) in order to increase the likelihood that the findings will reflect a wide range of views and perspectives.

Data saturation, the point qualitative researchers refer to at which collecting additional data neither adds new information nor requires revisions to be made to findings already developed, was estimated to be achieved after approximately 30-35 interviews (Morse, 2000). Participants were recruited via email invitation with telephone follow-up. Data collection continued until no new information emerged and data saturation was achieved (Bradley, 2007).

Data Collection

This study was defined as service evaluation by the National Research Ethics Service and therefore NHS Research Ethics Committee approval was not needed, though ethical research practice standards were followed, including obtaining informed consent. As it was considered important that participants' views should be understood in the context of their profession, participation could not be completely anonymous. Therefore participants gave written consent in the full knowledge that identifiable information would be removed, but that their job titles would remain transparent. Each respondent participated in a semi-structured interview conducted between May and September 2010 with either GH or EC. A flexible schedule of open questions was used to guide the interviews, allowing for probing of further information and clarification where appropriate. Interview questions were generated by identifying salient issues in policy and reported research in relation to CCTH (Box 1). Interviews lasted around 40 minutes and took place in the participant's place of work. Each interview was audio recorded, fully transcribed and checked for accuracy. Participants were made aware of their right to withdraw from the study before, during and after data collection.

Data Analysis

Data were analysed using a thematic framework method (Ritchie & Spencer, 1994) which enabled themes to be developed both from the research questions and from the narratives of research participants (Pope et al, 2000). All data were coded and analysed according to the five stages of this method (Table 1). Regular meetings between the authors were held throughout data analysis, facilitating further exploration of participants' responses, discussion of deviant cases, and agreement on recurring themes.

Results

The sample, in total 37, included: nine consultant paediatricians specialising in General Paediatrics, Emergency Medicine, Dermatology and Respiratory Medicine; six General Practitioners; three paediatric Registrars specialising in Metabolic Diseases, Neurology and Paediatric Intensive Care; six other healthcare professionals (HCPs) including three Clinical Nurse Specialists, one phlebotomist, one Occupational Therapist and one Health Visitor; seven NHS executive team members; four NHS service managers and two NHS Commissioners. In this section, we focus on three main themes which were identified in the

analysis: 'Impact on Healthcare Professionals', 'Models of Service Provision' and 'Care closer to home: a moral imperative impossible to deliver?'

Impact on healthcare professionals

Participants acknowledged that the development of outreach clinics would involve a change in traditional ways of working and that the physical setting of the clinic would influence aspects of professional practice. The current 'drag and drop' model or replication of the hospital model in different settings, entails a lone consultant travelling between sites and carrying out routine tasks such as weighing and measuring children which, in a hospital clinic environment, would be carried out by a healthcare assistant. This was considered to be an inefficient use of time and resources.

As a consequence of moving services into community settings, some clinicians felt they were being "*stripped*" (Consultant 2) of a fundamental part of what it meant to be a Consultant, and of the "*prestige*" (Registrar 1) that comes from working within the "*Ivory Tower*" (GP 2, Consultant 8) that is the hospital. In the same way that outpatient services were perceived as "*a little bit second class in terms of [having] no beds and no real clout*" (Other HCP 5), moving away from the hospital and into community settings was thus associated in some cases with a decreased clinical status.

"I felt a little bit exposed... Part of my authority comes from the fact that I have the edifice behind me. So you know people come to see "the doctor at the Children's Hospital" and that has a therapeutic value in itself" (Consultant 2)

However, others viewed the distance from the hospital as potentially liberating, allowing them to take control of a clinic, released from the constraints of working within a large and busy organisation. In this case, closer to home services were perceived to provide a calmer and "*more peaceful*" (Consultant 5) working environment with smoother administration processes.

Furthermore, outreach clinics were seen as an opportunity for developing working relationships across the primary-secondary care interface, allowing healthcare professionals from different disciplines such as "*health visitors, midwives [and primary care] link workers*" (GP 2) to work together. Participants had differing perspectives on the potential for CCTH services to facilitate education and training. Although potentially advantageous, the personal experience of some participants indicated that knowledge transfer between clinicians rarely happens in practice. Evidence from existing paediatric satellite clinics and from former GP fund-holding initiatives were given as evidence for this claim, and lack of time was often given as explanation for the lack of clinical dialogue.

"It used to be thought that doing peripheral outpatient clinics, the hospital's expertise would transfer in some miraculous way to the General Practice or vice

versa. Bonkers! It just doesn't happen..." (Consultant 7)

Nevertheless, there were suggestions that CCTH services could positively influence referral practices by consultants providing feedback on the quality of referrals and encouraging primary care clinicians to manage less complex cases. However, a wholesale reorganisation of existing referral practices was thought to be a challenge.

Recently proposed reforms to the NHS (DOH, 2010) which advocated a shift in power to primary care were also discussed in relation to collaborative working. Specifically, GP consortia were seen as a potential facilitator of 'joined up working' as commissioners look to providers for "*better pathways... better education or a better set up generally*" (GP 5). The introduction of competition between 'any willing provider' however, was perceived as a barrier to collaboration with other clinicians which could "*potentially mean that they lose business*" (Commissioner 1).

Models of Service Provision

'Drag and Drop' model

Participants discussed different service models for the delivery of outreach clinics. The model utilised by the specialist children's hospital was described as "drag and drop", referring to a direct replication of hospital services in alternative settings. All hospital managers emphasised that outreach clinics, whether delivered in hospital or community settings, should be identical in terms of service provision and quality, and recognised that such services could use resources already available in the community. Commissioners and community-based executive's views on the other hand, reflected a requirement for redesign and reconfiguration of services in order to be cost-effective and sustainable.

"That's not the way forward, it's not sustainable. It doesn't really deliver what people need. It's trying to take a model that is designed and is developed in a hospital for a hospital into a setting that doesn't have those design features." (Commissioner 2)

Consultant Paediatricians were also in favour of outreach services that provide added value to relocation, for example, a more substantial "*ambulatory care*" or "*boundary-less hospital*" approach (Consultant 6), or a model incorporating education and joint working with community-based staff.

'Drop-in' clinics

The potential benefit of 'drop-in' access to outreach clinics was also discussed, together with the possibility that this benefit would encourage a sense of community ownership of the service for families and "*an atmosphere of availability, approachability*" (Consultant 7) by the hospital. It was noted that the walk-in option available at one of the current outreach clinics had not been greatly utilised, and consultants expressed concern that it might result

in inappropriate cases being seen: “...you’d end up with the walking well or the people who want a sort of a covert second opinion.” (Consultant 2)

‘One-stop-shop’ model

Many participants were strongly in favour of a ‘one-stop-shop’ model of service delivery for paediatric outpatient care, whereby patients could receive assessment and care from different departments on the same day. This was seen to be impractical in community settings, given the difficulty of organising multiple teams to be on-site, and the lack of diagnostic equipment available outside of acute care services. Participants expressed concern that families attending community clinics would thus be disadvantaged by having to attend multiple appointments. However scheduling difficulties often render same-day appointments equally impossible for patients attending hospital clinics.

In the case of specialist phlebotomy services for children, a walk-in clinic is provided at the hospital, so blood tests normally occur at the same visit (a service also used by GPs to obtain blood tests for children). Given the difficulties of providing a cost-effective phlebotomy service in the community for a small number of patients and the governance regarding transportation of samples, it was suggested that children likely to require any tests should be seen at the hospital rather than in the community. A range of participants suggested that case selection might be achieved by adopting a ‘follow-up only’ model which was thought to be less likely to generate investigations. Alternatively, patients likely to require tests could be screened out of the outreach clinic caseload at point of referral. However, clinicians reported that selection of patients would be difficult as insufficient information was provided in GP referral letters. A solution, suggested by One GP was a “*pro forma*” to provide more detailed clinical information (GP 5).

A further reported difficulty in providing outreach clinics was the management of patient records. Consultants had encountered significant problems regarding the removal of patient notes from the hospital and transport to outreach clinics. Several participants noted that remote access to electronic records could facilitate the running of outreach clinics.

Telemedicine

Alternative ways of providing CCTH, other than consultant-led outreach clinics, were also identified. Telemedicine, where advice is provided electronically or by telephone to families or to GPs, was highlighted by several participants.

“You can use health and telemedicine as an example of developing something, not just close to people’s homes but actually in people’s homes.” (Commissioner 1)

Participants reported both negative and positive experiences of such initiatives. A telephone line for families had proven to be effective in reducing hospital admissions within one paediatric speciality, but another had found their staff “*constantly struggling*” (Consultant 4)

to provide this additional service.

'Out-of-hours' clinics

Alternatives to providing CCTH were also suggested, including 'out-of-hours' clinics provided in the evenings, early mornings or at weekends and the development of 'GPs with special interest in paediatrics' (GPSIs). GPSIs were of interest to commissioners because they would allow consultants to remain in the hospital and might result in shorter waiting times for patients. It was recognised, however, that GPSIs would not be able to manage all cases, therefore requiring a "*differentiated system*" (Executive 7), and in some instances requiring families to return for a second appointment with a consultant.

Care closer to home: a moral imperative impossible to deliver?

The CCTH policy was supported by participants as a sound principle for guiding the provision of paediatric outpatient care and underpinning children's health service redesign. The idea of keeping children out of hospital was viewed as intrinsically desirable, particularly for those not requiring specific investigations. In contrast to the traditional service design which was perceived to reflect the needs of the organisation rather than those of patients and families, participants were keen to support a user-led agenda in which new, closer to home services were not only convenient, but also responsive to the healthcare needs of children.

"We need to be very different in how we deliver services based around what the patients and their families need and I think at the moment we're not. We're still focused on what's easier for us." (Manager 1)

However, the principle of providing care that is closer to patients' homes and tailored to their needs was seen as conflicting with the financial and practical challenges of setting up and maintaining clinics outside of the hospital.

Many participants also saw the moral imperative of needing to provide outpatient services in community settings which were, at minimum, an equivalent standard to hospital care. However, hospital based participants believed that community services would be of inferior quality due to a lack of specialist equipment and facilities. Anchored to this perception was the assumption that hospitals provide the ideal standard of care and that access to investigations constitutes improvements in care quality. GPs on the other hand were critical of this supposition, arguing that certain types of consultant would be better suited to the community, such as those who rely more on clinical judgement and less on technology.

'When I was doing general paediatrics, the paediatricians varied. Some investigated a lot; others were much more based on their assessment and clinical judgement, so maybe it depends on the nature of the consultant... there might be a certain type of consultant, this is what I'm saying, that is better suited to the community' (GP 5)

Regarding location, participants emphasised the need to deliver clinics in areas of high

referrals and places with good public transport links. It was suggested that clinics should be provided in areas of high deprivation or high levels of non-attendance at outpatient appointments to address inequalities in access to healthcare. This highlighted a tension between the need for a wide geographical coverage of services on the one hand, and the economies of scale needed for cost-effectiveness on the other. Given that it would not be economically feasible to provide outreach clinics in multiple areas with a low volume of patients, many participants proposed that decentralisation of services may have the perverse outcome of reducing access for some families.

“There isn’t enough of a local population to sustain an outpatients clinic and therefore you have to draw in from wider areas, and if you draw in from wider areas many of them aren’t on bus routes, or accessible by public transport as much as this place is [the hospital]. And therefore you have to ask both financially and in terms of access, do they [paediatric CCTH services] really work?” (Executive 3)

Although not “insurmountable” (Consultant 8), perceived difficulties in ensuring equivalence in standards of care provision and equality in access to services challenged the philosophy underpinning CCTH. At the time of data collection, a new government had been elected proposing radical NHS reforms (DoH, 2010). The political and economic context was therefore a key point for discussion by all participants when considering the cost-effectiveness of CCTH alongside improving access, patient experience and quality of care.

Discussion

Many of the hospital-based participants in this study positioned the hospital at the top of a healthcare hierarchy, presenting their ways of working as the ideal standard of care. Similar to the findings of a Canadian study on satellite dialysis units (Lehoux et al, 2007), hospital based professionals appeared keen to retain their professional culture and organisational practices regardless of place, promoting a ‘mini-hospital’ approach to paediatric outpatient CCTH. In contrast, primary care services were viewed as a part of the community and in tune with the needs of the local population, but with a lesser clinical authority and expertise. The two sectors were perceived by many hospital-based participants as separate and distinct entities, with hospital services extending their expert reach into community healthcare, rather than collaborating with it in new ways. Nevertheless, specialist outpatient services that are developed and delivered in partnership with primary care were perceived as advantageous for children and young people as they were seen to have the potential to provide enhanced continuity through bringing together elements of health, education and social care. Our study suggests that there are implicit assumptions about where quality and expertise are located which lead to hierarchies about legitimate health places. These are rarely acknowledged in policy initiatives.

The findings also demonstrate that place and professional identity are interrelated. Thus it may be difficult to change the location of care services without considering the impact on

the professional identity of service providers. While all participants in our study accepted the principles of CCTH in theory, hospital-based participants in particular were apprehensive about putting the policy into practice. This was mainly because CCTH policy implementation was thought to involve considerable changes to existing working practices and to challenge their sense of professional authority. Previous research on place and identity has similarly highlighted how people use places to communicate qualities of the self and to form a sense of affiliation (Williams, 2002). In this study, healthcare professionals attributed different meanings and values to healthcare settings, such as the hospital conveying authority and expertise that would be diminished in a community setting, despite being a less pressured environment that potentially enables better communication with families. These complex barriers regarding place and professional identity may have implications for full CCTH policy implementation, despite desires to provide accessible and child-centred care. Moreover, hospital service providers expressed only minor concerns over the existing outpatient set-up so they may feel little pressing need to change, seeing few apparent gains from doing so. This could explain why, in this case and more generally as Munton et al (2011) suggest, CCTH has been implemented on a small scale and has largely been driven by the enthusiasm and motivation of a few individual clinicians. Wider-scale implementation may need to address issues related to clinicians' sense of professional identity while being clear about the benefits to patients, families, communities and clinicians of a shift of services into community settings. In order to address organisational issues identified by participants and to improve access to specialist care, CCTH may also require considerable redesign such that the principles of primary healthcare (WHO, 2008) are upheld rather than merely relocating the existing hospital outpatient model. This may include, for example, collaboration between sectors and appropriate use of technology.

Finally, we suggest that confusion about the primary purpose of relocating outpatient services for children into community settings has led to challenges in implementing the CCTH policy for paediatric patients. There appear to be a number of goals for paediatric CCTH. The original aim set out by the Platt report (1959) outlines the broad philosophical position that child-focussed CCTH is fundamentally good, in and of itself. Thus one policy goal is to reduce disruption to families' lives and keep children out of hospital. A second goal is to reduce health inequalities by improving access to specialist paediatric healthcare regardless of demographic, socio-economic or geographical status (DoH, 2007). There is an implicit assumption that improving access to outpatient care will lead to a decrease in levels of non-attendance at clinic appointments. A third goal relates to health service reforms and attempts to relieve demand on acute services by reducing the number of hospital contacts and redesigning services (e.g. outreach clinics or telemedicine). This lack of clarity regarding the purpose of CCTH contributed to difficulties in making judgements about a suitable model for community-based outpatient care. This finding, which is echoed by Parker et al (2011b), suggests that clearer objectives may facilitate CCTH policy implementation by providing a set of desired outcomes from which models can be developed, implemented

and evaluated. This should include a number of factors, such as the mix of patients, professional skills, equipment and training required for each service and each population, as well as ensuring that the physical environments of service delivery are sufficient, appropriate and child-friendly (DoH, 2003). This will also help to make CCTH more acceptable to families.

This is the first qualitative study to explore NHS stakeholders' views on moving paediatric outpatient clinics into the community. It had a diverse sample of primary and secondary care clinicians, members of executive teams, managers and commissioners. Furthermore, the findings highlight issues that are relevant to service redesign and policy implementation in organisations providing other services, including adult care. The credibility of this study was enhanced by the use of multiple analysts to independently code data and review interpretations. One limitation was that the views participants chose to share may have been influenced by the role of the researchers. Although based in the hospital, the researchers were also part of an external research programme and inevitably had to maintain dual insider-outsider roles. We are currently carrying out work to explore the views, experiences and behaviours of parents, children and young people regarding community-based paediatric outpatient clinics. This is important as families' views are underrepresented in existing evidence (Parker, 2011b); despite policy dictating that 'closer to home' services will deliver patient-centred care.

Conclusions

Our findings demonstrate that from the service provider perspective the place of service delivery is not only an issue of physical location and supportive infrastructure, but also involves professional and organisational identities. Policy initiatives which ignore assumptions about place, power and identity, or which challenge them too strongly, are likely to meet with limited success (Currie et al, 2009). Shifting outpatient clinics into the community will require physical relocation as well as service redesign which take practitioners' professional identities and organisational loyalties into account. Our findings suggest that in order for CCTH initiatives to be implemented, they require the dismantling of professional and service boundaries, clarity on the advantages of working in new locations and in new ways, and explicit benefits to patients and families. CCTH will thus need to be designed both pragmatically and ideologically, taking into account the needs and views of service users as well as those of service providers.

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