

# Specialists in out-of-hospital settings

Findings from  
six case studies

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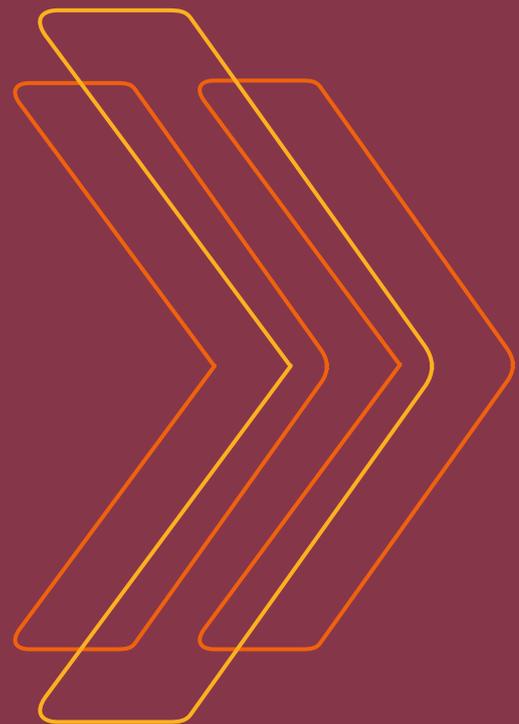
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October 2014





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# 1 Introduction

Over the past 20 years, both the volume of patients and the complexity of cases requiring treatment in the community have increased ([Smith et al 2013](#)). Demographic changes, technological advances and the changing pattern of disease have driven this growth, as has the transfer of the care of whole groups of patients to primary and community settings – such as those previously cared for on long-stay geriatric wards.

At the same time, there has been no commensurate shift of resources and expertise to the community. Consultants have become increasingly specialised and their knowledge has largely remained within their hospital's four walls.

This has left many patients struggling to get care in an overloaded out-of-hospital system. Their treatment can be fragmented, as different parts of the system often fail to communicate effectively or understand each other. Patients can miss out on care or wait weeks for an appointment at their local hospital for diagnosis or treatment that could be completed in a primary or community care setting if the necessary skills and resources were available to do so ([Goodwin et al 2010](#)).

As part of the drive to keep patients out of hospital and better integrate services across settings, consultants are starting to develop new models of care that link secondary, primary, community and social care professionals. Although community-based work is a common part of consultant roles in some specialties – for example, palliative care and mental health – in most, working outside hospital is rare. This new way of working is, however, a key element of the Royal College of Physicians' vision for the 'future hospital', which calls for radical changes to the way hospitals are structured. They recommend that medical teams bridge hospital and community settings to provide a co-ordinated seven-day service, close to patients' homes ([Future Hospital Commission 2013](#)). Ensuring employees are equipped to staff a newly integrated health care system is a key concern for those planning future workforce needs ([Health Education England 2014](#)). Evidence shows that specialist input into the delivery and co-ordination of out-of-hospital care, coupled with GP work to co-ordinate hospital and community services, can improve patient



outcomes and patient and staff satisfaction, and can reduce hospital use (**Shape of Training 2013**).

To investigate the different ways in which consultants are working beyond their traditional boundaries, The King's Fund visited six different services in which consultants were delivering or facilitating the delivery of care outside hospital. Through document review and interviews with staff involved in the design and delivery of the services, we sought to identify the key characteristics of this new way of working, explore the challenges in establishing services of this type and understand what benefit they could bring for patients and the NHS.

The six case studies can be broadly split into two groups:

- services that enable more complex patients to be treated at home or in primary care (via joint delivery of care, multidisciplinary team-working and education of primary and community care practitioners and patients):
  - Whittington respiratory service
  - Portsmouth and South East Hampshire diabetes service
  - Leeds interface geriatrician service
  - Imperial child health general practice hubs
- intermediate services that treat patients who need specialist care that cannot be provided in general practice:
  - Sunderland dermatology and minor surgery service
  - Haywood rheumatology centre.

The traditional model for shifting specialist care to the community consists of a consultant-run outreach clinic based in a community hospital or GP practice. The six case study services described in this report go beyond this 'drag and drop' approach of simply relocating a hospital outpatient clinic into a community setting. They put education at the core of their approach and redesign the patient pathway, the roles of professionals, or both.

The following table provides an overview of the key characteristics of the case study services featured in this report. A more detailed description of each service can be found at: [www.kingsfund.org.uk/specialistcasestudies](http://www.kingsfund.org.uk/specialistcasestudies)



**Table 1 Case study key characteristics**

Imperial child health general practice hubs		Haywood rheumatology centre		Whittington respiratory service	
<b>Provider organisation</b>	Imperial College Healthcare Trust.	Staffordshire and Stoke-on-Trent NHS Partnership Trust (SSOTP).	Rheumatology services provided from a main hub that includes an inpatient ward and a day case unit, with clinics also run at different community locations. Patients assessed and treated by multi-professional teams of advanced musculoskeletal (MSK) practitioners including consultants, nurses, AHPs and GPs with a special interest in shared or pooled clinics. New roles developed within the service: a consultant in community rheumatology, consultant nurses in rheumatology and osteoporosis, and consultant physiotherapists. Various other specialist combined clinics, diagnostic and therapeutic services are provided.	Whittington Health NHS Trust.	The Whittington Integrated Community Respiratory (CORE) team comprises 3 locality-based multi-professional teams: a hospital-based team and community teams in Haringey and Islington. They work with patients with COPD and other diseases causing breathlessness, focusing on high-value respiratory care (smoking cessation, pulmonary rehabilitation). Led by integrated respiratory consultants, the CORE team include: specialist respiratory nurses, physiotherapists, clinical psychologists, respiratory pharmacist, dietician, specialist stop smoking advisor. Regular MDT meetings, led by an integrated respiratory consultant, review diagnoses and optimise care of patients in the community and in hospital. GPs incentivised to case-find and deliver evidence-based respiratory care.
<b>Date established</b>	2014 In current form (4 pilot hubs). 2005-onwards: Different parts of service developed.	2011 Service became part of SSOTP. 1970s Rheumatology service established at Haywood hospital.		2014 Home oxygen service and pharmacist role. 2012 Pathway for patients with acute exacerbations. 2011 COPD discharge bundle and stop smoking CQUINS. 2010 COPD LES and specialist stop smoking service. 2009 Integrated respiratory consultant, psychologist roles. 2002 Chronic respiratory support service. 2001 Respiratory early discharge service pilot.	
<b>Population served</b>	c 20,000 (c 4,000 children) per hub; 4 hubs currently in place across West London, Central London and Hammersmith and Fulham CCGs.	0.5-1 million (N. Staffordshire and Stoke-on-Trent CCGs)		c 0.5 million (Islington and Haringey CCGs).	

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Table 1 Case study key characteristics (continued)

	Imperial child health general practice hubs	Haywood rheumatology centre	Whittington respiratory service
<b>Location of care</b>	Outreach clinic in GP surgery; MDT meetings.	Main hub is Haywood rheumatology centre based in a community hospital; clinics also run at four other community hospitals, University Hospital of North Staffordshire (UHNS) and a GP surgery.	Patients' homes (including following discharge), GP practices, clinics and pulmonary rehabilitation venues, and hospital wards during admissions.
<b>Consultant role</b>	<p>Outreach clinics run jointly with GPs.</p> <p>Participation in MDT.</p> <p>Run education sessions at MDT meetings.</p> <p>Telephone/email helpline for GPs.</p>	<p>Run clinics.</p> <p>Attend MDT meetings.</p> <p>Ward rounds.</p> <p>Run education sessions for medical students and regional training days for specialist registrars.</p> <p>Research.</p>	<p>Medical leadership to the community respiratory team.</p> <p>Consultant-led diagnosis and care.</p> <p>Multi-professional clinical and communication skills training (eg, behaviour change).</p> <p>Strategic role in defining and incentivising high-value respiratory population care.</p> <p>Developing and evaluating new services.</p>
<b>Clinical trainees</b>	Foundation-year doctors, paediatric trainees and GP trainees on SHO rota complete 2-week blocks on integrated care, including visits to hubs and service development project.	2 specialist registrars, 1 core medical trainee, 1 foundation-year doctor.	Integrated respiratory specialist registrar - first such role in the country.
<b>Contract type/funding arrangements</b>	<p>MDTs and outreach clinic: CCG pays hourly for GP attendance (via locum costs), consultant time is part of acute trust block contract.</p> <p>CCG management of MDTs, consultants' initial development activity and consultant helpline is unfunded.</p> <p>Grants from NHS London and Health Education NW London fund practice champion project manager, initial project management of hubs, stakeholder consultation and evaluation costs.</p>	<p>Largely funded by N. Staffordshire and Stoke-on-Trent CCGs via Pbr tariff on 3-year rolling contract with 3 local variations. Some parts funded by 1 CCG.</p> <p>Small area contracts with 10 other CCGs and local authorities for certain elements of rheumatology service and NHS England contract for high-cost drugs.</p> <p>Hospital clinicians have main contract with SSOTP or Keele University, and honorary contracts with UHNS. GPs employed directly by SSOTP 1 day per week for clinic work.</p>	<p>Acute respiratory services funded by Islington and Haringey CCGs through Pbr tariff.</p> <p>4 programmed activities for integrated consultant role funded by Islington CCG.</p> <p>Stop Smoking and COPD bundle CQUIN payments (annual value £300,000-£500,000) and additional services including home oxygen service, pulmonary rehabilitation and long-term exercise classes funded by Islington CCG.</p>



**Table 1 Case study key characteristics (continued)**

Portsmouth and South East Hampshire diabetes service	Leeds interface geriatrician service	Sunderland dermatology and minor surgery service
<p><b>Provider organisation</b></p> <p>Solent NHS Trust, Southern Health NHS FT and Portsmouth Hospitals NHS Trust.</p>	<p>Leeds Teaching Hospitals NHS Trust (LHT) and Leeds Community Healthcare NHS Trust.</p>	<p>South Tyneside NHS Foundation Trust.</p>
<p><b>Service provided</b></p> <p>The service defined six patient groups ('super six') who attend hospital for their diabetes care and discharged the care of all other diabetes patients to primary care, where they are now managed by practice nurses or GPs in GP surgeries. A community diabetes team, made up of diabetes consultants and diabetes specialist nurses (DSNs), facilitate the management of these more complex patients in primary care through support and education.</p>	<p>Interface geriatricians attend monthly MDT meetings with integrated health and social care teams that consist of district nurses, GPs, social workers, occupational therapists, physiotherapists and community matrons. Geriatricians also make home visits and attend to intermediate care beds.</p> <p>Nurse-led Patient Care Advice Line (PCAL) gives GPs and community staff direct access to speciality beds and advice from Interface geriatrician.</p> <p>Consultant geriatricians also review older people presenting acutely to the emergency department five afternoons a week.</p>	<p>Service treats patients who need specialist dermatology treatment that cannot be provided in general practice. Provides diagnosis and management of various skin conditions and skin lesions; a range of treatments in nurse-led clinics, including a dedicated clinic for moderate or severe acne; minor skin surgery; advice, education and support for patients with chronic conditions, including a telephone helpline, and rapid access clinics; education and advice for wider health professionals; including telephone advice, and quarterly education sessions for general practice teams. Health care assistants, nurses (including nurse surgeon and prescriber, and advanced nurse practitioner), and GPwSI work with a consultant in the service.</p>
<p><b>Date established</b></p> <p>2012 Extended to cover Portsmouth CCG. 2011 in SE Hants and Fareham and Gosport CCG.</p>	<p>2013 In current form. 2012 In embryonic form.</p>	<p>2005 Consultant dermatologist appointed, and service located in a purpose-built primary care centre. 2002 Nursing staff appointed to support GPs and treat dermatology patients in primary care.</p>
<p><b>Population served</b></p> <p>0.7 million (c 32,000 with diabetes) (Portsmouth, SE Hants and Fareham and Gosport CCGs).</p>	<p>0.9 million (c 70,000 over 65 years) (3 Leeds CCGs).</p>	<p>c 0.3 million (Sunderland CCG).</p>
<p><b>Location of care</b></p> <p>GP surgery for most diabetes patients; hospital for 'super six' patient groups.</p>	<p>Intermediate care beds in care homes; patients' homes; MDT meetings; A&amp;E department.</p>	<p>Purpose-built primary care centre housing a range of health and social care services.</p>



**Table 1 Case study key characteristics (continued)**

	Portsmouth and South East Hampshire diabetes service	Leeds interface geriatrician service	Sunderland dermatology and minor surgery service
<b>Consultant role</b>	<p>Email and telephone support to primary care.</p> <p>Biannual visits to provide personalised advice or training to GPs and practice colleagues.</p> <p>Design and some delivery (in conjunction with DSNs) of free multidisciplinary education programme, for all area health care professionals.</p>	<p>Home visits and visits to intermediate care beds.</p> <p>Participate in MDT.</p> <p>Informal education of GPs and integrated health and social care teams.</p> <p>Patient care advice line for GPs and other community staff.</p> <p>Triage and assess older patients in A&amp;E.</p>	<p>Clinical lead for the service, including provision of clinical advice to other members of the service team.</p> <p>Initial appointments for new patients with undiagnosed conditions and follow-up for complex patients.</p> <p>Phone support for GPs and other health professionals.</p> <p>Delivery of training to primary health care teams.</p>
<b>Clinical trainees</b>	<p>Specialist trainees accompany consultants on visits to GP practices.</p> <p>GP trainees receive training from the community diabetes team (CDT) consultants and DSNs; attend hospital-based diabetes clinics, patient-structured education courses and other clinics.</p>	<p>No trainees at present.</p>	<p>Nurse students; no medical trainees.</p>
<b>Contract type/funding arrangements</b>	<p>Community diabetes team paid for via block contract that specifies email and telephone service, practice visits and education programme.</p> <p>CDT reimburses acute trust for 4 programmed activities of consultant time; consultants withdrew 4 of these from their acute trust full-time contracts.</p> <p>Pre-existing diabetes LES modified to require practices to discuss the outcome of their diabetes care reviews and receive biannual CDT visit.</p>	<p>The interface geriatricians are employed by the Leeds Teaching Hospital NHS Trust. The CCG funds 12 of their programmed activities to work with the MDT via a direct agreement with LHT, which amounts to an annual value of £200,000.</p> <p>Geriatricians in A&amp;E (5 programmed activities) and the PCAL line are not directly funded; the cost is absorbed by LHT.</p>	<p>Part of single block contract with South Tyneside CCG for all acute and community activity; Sunderland CCG for whom the service is provided, is a co-signatory of this contract. Primary care centre built with £1 million Department of Health funding in 2005. Consultant dermatologist employed by County Durham and Darlington NHS FT, and South Tyneside NHS FT reimburses them for half his time. GPs employed via service-level agreements (on a self-employed basis rather than through their practices).</p>



## 2 Key strategies for out-of-hospital working

There was no single model of care across our case study sites. The services differed in their scale and stages of development. Consultants took on different roles, delivering care in different locations and working in different ways with a range of other health and social care professionals. However, looking across these initiatives, four key strategies can be identified that are central to this type of out-of-hospital service innovation.

### Enhancing the skills of GPs and other health care professionals

Many GPs and other health care professionals do not have advanced training in the diagnosis and treatment of conditions with which the majority of their patients present. For example, between 40 and 50 per cent of GPs have had little or no paediatric training – despite paediatric cases making up two-fifths of their workload ([Department of Health 2010](#)). Similarly, there are 13 million dermatology consultations in primary care each year, but undergraduate GP training includes an average of just six days of dermatology teaching and there are no dermatology attachments available on most GP training schemes ([Schofield et al 2009](#); [Royal College of Physicians 2013](#)). This creates a skills gap in primary care, which leads some patients to miss out on care or be referred to hospital for treatment or diagnosis that could be provided in general practice if the requisite resources, training and support were in place ([Goodwin et al 2010](#)).

The services described in this report sought to fill this gap by enhancing the skills of primary and community care professionals in both diagnosis and treatment. We identified the following educational approaches.

- **Outreach clinics jointly staffed by hospital consultants and other health care professionals** in which benefits accrue beyond the patients seen in clinic, as GPs and others gain confidence to manage similar cases themselves in primary care.



- **Consultant-run email and telephone helplines** that provide advice for GPs, nurses and other health care professionals to enable them to better diagnose and treat patients in primary care or make more appropriate referrals.
- **Consultant participation in multidisciplinary team (MDT) meetings** brings specialist input into the management of patients in the community and facilitates joint learning.
- **Consultant-run education sessions;** for instance, one-to-one sessions for GP practices on topics of their choice, education sessions at MDT meetings and education sessions for GPs and other health care professionals across a clinical commissioning group (CCG).
- **Consultants supporting staff to work in extended roles.** In consultant-led intermediate care services, consultants can support nurses and other health care professionals to run clinics that would elsewhere be staffed by doctors.

These strategies represent a set of important new roles for consultants, and indicate how the hospital consultant role may evolve in the future. A key dimension of this involves the consultant spending a greater proportion of time supporting other professionals rather than working directly with patients, enabling primary and secondary health care professionals to practise at what has been described as ‘the limits of their license’ (Bohmer 2014).

### Redesigning the workforce

The health care workforce is not currently designed to staff an integrated system in which patients move seamlessly between organisations and more patients have their care managed outside hospital. Specialist knowledge is concentrated in the hospital, and moving care outside it will require a redistribution of roles and responsibilities across the health care workforce (Bohmer and Imison 2013).

In our case study sites we found examples of workforce redesign that sought to address the mismatch between patient needs and professional skills in the community, as well as the sometimes fragmented nature of service a patient receives when moving between organisations. Examples include:



- **Integrated consultant roles that span hospital and community settings** and include strategic responsibilities for service planning across sectors. These provide the capacity and drive for consultants to complete work outside the hospital on top of their usual duties.
- **New roles for nurses and other allied health professionals** in which they work at the limits of their practice. Examples included the new consultant physiotherapist and nurse roles in the Haywood rheumatology centre.
- **GPs with Special Interests (GPwSIs)** being used to treat more complex patients in their GP surgeries and within intermediate care services.

Box 1 describes how GPwSIs and new integrated consultant roles were developed in two of our case study sites.

### Development of GPwSI and new integrated consultant roles

**The Haywood rheumatology centre** uses GPwSIs in two ways: they provide in-house musculoskeletal expertise to patients in their own practices and work as advanced musculoskeletal practitioners in the Haywood musculoskeletal interface clinic. In the GP practice, they review diagnoses from other GPs and provide joint injections and medication advice to all patients within their practice. If further investigation or a referral to secondary care is needed, their knowledge of secondary care services and staff enables them to direct patients more appropriately, reducing the proportion of unnecessary referrals. At the Haywood hospital, GPwSIs work alongside nurses and physiotherapists developing advanced skills in triage and treatment that can be brought back and used within general practice.

**The Whittington respiratory service** has developed an integrated respiratory consultant role in which two specialists spend two of their programmed activities per week working across primary, community and secondary care settings, to promote the co-ordination and integration of care for respiratory patients. They provide medical leadership to the integrated community respiratory (CORE) team and other health professionals to deliver care in the community and encourage patients to manage their condition. This is done with consultant support in diagnosis and care. They also take on a strategic role developing and evaluating new services to enhance the management of patients in the community. The service has also developed an integrated specialist registrar role, which creates a career pathway for clinicians interested in working across care settings. In future the service hopes to broaden the scope of integrated respiratory physicians as long-term condition leads for patients with multiple co-morbidities.



## Redesigning the work

Before redesigning the structure of the workforce, the work that will be done in the community must be recast (Bohmer and Imison 2013). If new roles are created without changing the distribution of tasks across settings, new staff may supplement rather than replace the work completed under the previous model of care (Bohmer and Imison 2013). In this way, potential cost savings may be offset by increased utilisation and transaction costs. The approach taken by the Portsmouth and South East Hampshire diabetes service provides an example of a proactive approach to redesigning the work undertaken in primary care (*see* box below).

### Redesigning work in primary care

The **Portsmouth and South East Hampshire diabetes service** shifted the care of certain diabetes patients who were previously managed at Portsmouth Hospitals NHS Trust to general practice. They defined six patient groups who required ongoing management by the hospital because their care required a high level of diabetes expertise, multidisciplinary input or because they were inpatients. The six groups were: inpatients with diabetes; pregnant women with antenatal diabetes; type 1 diabetes patients with poor control of sugar levels; patients with complications requiring diabetes foot care; patients requiring insulin pump therapy; patients with nephropathy and receiving dialysis. All other patients with diabetes are managed in primary care. This led to more than 1,000 patients being discharged from the hospital to GPs and nurse clinics within GP practices for their ongoing care. At the same time the community diabetes team, with input from Portsmouth hospital consultants, supported primary care staff to take on this extended role.

Resistance to change from staff is a common issue during service redesigns. Within our case study sites the staff members were enthusiastic about their new way of working, but this may not be easy to replicate elsewhere. Previous experiences of staff taking on new and extended roles show that some role negotiation with others may be necessary (Walsh *et al* 2003). Our case studies show that services evolve and develop over time, as will the content and focus of the new roles created within them. Reviewing the distribution of job responsibilities periodically is one way to ensure that boundaries are clear and that duplication is avoided as roles evolve. In one of our case study sites nurses took on a new role of referring patients to the acute trust, but acute trust staff would not accept nurse-written referrals. That experience shows that discussions about new roles need to occur across the whole system rather than within a single organisation.



## Addressing patient needs along their care pathway and taking a population health-based approach

Secondary care services focus a specialist's expertise on an individual patient who presents at their hospital clinic. However, in some of our case study sites, we saw an important shift whereby consultants began to look beyond the patients in their clinic to consider the needs of their patient population at each stage of their care pathway from home to hospital. This changes the consultant role from an individual acting alone to a member of a multidisciplinary team working across sectors to deliver a package of services for their local community. This has been characterised by Atul Gawande as a shift from 'cowboy' to 'pit crew' (Gawande 2011). In our case study sites, this approach led to initiatives being established that promoted multidisciplinary team-working, and addressed access to primary care and the quality of triage at accident and emergency (A&E) (see box below).

### Working across sectors

**Leeds interface geriatrician service** is working across the local health system to help prevent unnecessary hospital admissions. A geriatrician attends A&E five afternoons a week between 2pm and 5pm. Here they triage patients and provide a comprehensive geriatric assessment before patients are admitted to the hospital. GPs and allied health professionals in the city also have access to a Primary Care Advice Line that provides advice and allows direct admission to wards. Geriatricians also attend community-based MDT meetings and may also visit patients in their homes. The geriatric team's approach was recently highlighted as an area of outstanding practice by the Care Quality Commission (CQC).

An important part of this approach is segmenting the patient population so that standard care can be provided for those with less complex needs and an individualised approach can be developed for multi-morbid patients who require more complex care. Consultants in the Portsmouth and South East Hampshire diabetes service did this by focusing their expertise on treating patients in their 'super six' groups.



The next step is to broaden the focus to a population-based health approach including prevention and active case-finding. Across the case study sites this broader population-based approach was under-developed. However, there were examples, such as the Imperial child health hub approach outlined below (*see box*) and the Whittington respiratory service, which successfully used financial incentives to promote case-finding by GPs.

### **Taking a population health-based approach to service design**

The **Imperial child health general practice hubs** team has taken a creative and comprehensive population-based approach to the care provided for children locally. They have segmented the child population into six groups and identified the issues and care needs that apply to each. This approach means their focus is not restricted to the boundary between primary and secondary care, but also addresses difficulties patients have in getting a GP appointment (hub practices have to guarantee patients have same-day access to GP advice) and a lack of parent and child capability and confidence to self-care (through their practice champions initiative, which will offer peer-to-peer support, and by linking with self-management support programmes such as Itchy, Sneezy, Wheezy). It also promotes appropriate use of health services (through theatre productions and communications campaigns).



## 3 The main challenges to developing these services

During our interviews with staff who developed, commissioned and delivered out-of-hospital services, we identified a range of factors that aided their development and a set of challenges associated with their implementation. Detail of the barriers and enablers experienced in each site can be found in our full case study profiles ([www.kingsfund.org.uk/specialistcasestudies](http://www.kingsfund.org.uk/specialistcasestudies)). Below we look across our sites and pull out some of the most common or potent factors, grouped into the following four categories:

- local context
- service design
- funding arrangements
- system-wide.

### Local context

In each case study site, the local context had a strong bearing on how the services developed. Below we outline leadership and relationships that are necessary to enable service developments and organisational and workforce issues that can hinder them.

#### Strong clinical leadership and a culture receptive to change

The pivotal role of medical leaders in effecting change is widely acknowledged in the literature (for example, [Clark 2012](#)). We were therefore not surprised to find that charismatic innovative clinical leaders were instrumental in setting up each of the services featured in this report. They were able to motivate and persuade staff to work in new ways, were prepared to work with colleagues outside their usual clinical boundaries and put in long hours – often unfunded – to get these services off the ground.



These charismatic individuals had been working to drive change in their specialty for years. Even apparent ‘big bang’ approaches had a long history. A decade or more of relationship-building between clinicians in secondary, community and primary care had often been necessary to create an environment receptive to change. This raises the issue of how service change can be implemented in a culture that is not primed for new ways of working. One of our sites felt that placing the patient voice at the centre of the case for change was an effective strategy to counteract inertia and resistance from staff.

### **Powerful partnerships between clinicians and commissioners**

Although engaged clinical leaders are an essential ingredient of service change, previous research shows that they do not always appreciate the complexities of the local context beyond the organisation that they belong to. Their influence may be most important at the inception stage of new initiatives where they can communicate changes to colleagues and persuade them to work in new ways (Walsh 2006; Locock *et al* 2000). Partnerships between managers and clinicians have the potential to be powerful pairings. Managers can complement the initial drive from a clinician by playing a critical role in the implementation and spread of new services.

Although clinicians rather than local commissioners drove the initial development of the services in our case study sites, there were examples of strong partnerships between clinicians and commissioning staff that were key to implementing the redesigns. These included managers in local CCGs and their predecessors convening local stakeholders, ensuring GP buy-in, ensuring that new service models looked across the entire patient pathway beyond the hospital’s usual purview, and working to develop integrated funding approaches.

Commissioners can also play an important role in adapting services for wider roll-out while ensuring essential core components are retained. A key enabler identified in our interviews was creating a flexible model that could be adapted for the locality.

The box overleaf describes an example of how strong relationships with commissioners aided the development and implementation of one of our case study services.



### **Local commissioner involvement in service development and implementation**

Consultants at St Mary's were piloting parts of what would become the child health general practice hub model when a children's commissioner who worked jointly for the PCT and local authority found out about the work. She drew the work at St Mary's together with other paediatric out-of-hospital work in the local area to create Connecting Care for Children - a co-ordinated strategy for connecting primary and secondary care paediatric services in North West London ([www.nwlcsu.nhs.uk/connectingcare](http://www.nwlcsu.nhs.uk/connectingcare)). The commissioner played an important role in bringing GPs into discussions about service development, co-ordinating bids for pilot funding, managing stakeholder engagement and overseeing evaluation of pilots of the model. Now that initial development is complete, staff members at the CCG are responsible for much of the ongoing management and roll-out of the service. They organise and chair the MDT meetings and education sessions, and are working to agree templates, processes and payment approaches that can be used as pilots and rolled out across the CCG.

### **A provider organisation that supports service innovation**

The provider within which a service is located can sometimes act as a barrier to its development. Consultant-led intermediate services are often located in a community trust. Shifting the location of a service away from an acute organisation and the governance structures and professional networks it provides has implications for the co-ordination of care and staff development. In one of our case study sites, issues with specialist services being located in a community trust included: a feeling that the community trust did not understand the intricacies of operating a specialist service; clinical governance and care co-ordination issues caused by an inability to access patients' acute hospital records from the community location and being located away from closely allied specialties; issues with professional revalidation and career development. Some of these issues can be overcome when a service is located in an integrated organisation that covers both acute and community care.

### **Workforce capacity**

Workforce capacity can also be a barrier to consultants who want to extend their work into the community. At least during a transition phase of establishing a



new service, the increase in work outside the hospital may not be matched by an equivalent decrease of activity within the hospital. Geriatrics offers an example of a specialty where capacity may stand in the way of this type of innovation, with many areas of the country experiencing difficulties recruiting geriatricians. The Leeds geriatric service was able to recruit additional geriatrician staff to allow them to support multidisciplinary teams in the community as well as treating patients in hospital. As hospitals move to provide consultant cover seven days a week, the issue of finding capacity for this new role will become even more acute.

The issue of workforce capacity is also a key barrier in primary care, currently under severe pressure from rising patient demand (Smith *et al* 2013). Funding arrangements that enabled GP engagement were key to overcoming this barrier in some sites (*see* financial incentives below).

### Service design

Despite there being no single service model for consultants working in the community, our interviews identified some overarching factors to be considered at the design stage of an intervention that enabled the models to be effective.

#### **A new consultant role that spans secondary, primary and community care**

Across sites, consultants took on new roles. They became educators, helping primary and community care staff to improve their skills in treatment and diagnosis, took a strategic view of the development and evaluation of services, delivered care outside hospital and became change champions making the case for service redesign. Essential to the effective working of this new role was having consultants that spanned both community and hospital settings, rather than different consultants working in each location.

A key message from consultants working across sectors was that learning ran two ways; their practice within the hospital was enhanced by their work in the community. They also provided an important link into the hospital for community staff. This has implications for future models of care where groups of GPs may employ consultants as part of a multidisciplinary accountable care organisation; to get the most out of the consultants working in the community, they still need to have links to the hospital.



## **Trainees**

To develop future clinical leaders accustomed to working across organisational boundaries and to create a career path for those clinicians seeking to work in a more integrated way, trainees need to be embedded into out-of-hospital service models. In our case study sites, some services had worries about succession planning, as consultant leaders were nearing retirement and new leaders were not emerging to replace them. However, we did find examples of trainees being embedded into these service models. Trainees also bring the benefit of being generally less resistant to new ways of working than more experienced staff who have already established a firm professional identity and pattern of working.

## **Clear clinical governance arrangements**

As services move out of hospital, clinical governance arrangements often lag behind. We saw this at a number of sites where the clinical responsibility for patients seen in the community was not clarified until after a service had been established.

## **Financial incentives**

Well-designed financial incentives can be an important part of this type of service redesign. They facilitate GP engagement and ensure consistent implementation of new care processes. General practice participation was key to the success of a number of these initiatives, but heavy workloads meant it was often difficult for GPs to take part. The Imperial child health hubs paid locum costs for one GP to attend each MDT meeting and outreach clinic, which enabled GP engagement. However, getting other GPs to attend the meetings was a challenge, as further funding was not available and taking time out of their clinic without backfill was not an option for most. The Portsmouth and South East Hampshire diabetes service used a local enhanced service (LES) payment to encourage GPs to take up consultant support with their diabetes patients. The Whittington respiratory service has also worked closely with commissioners and the local authority to develop a series of financial incentives that motivate staff inside and outside hospital to implement new care processes and case-find.

There is potential to develop further the financial incentives for integration. The Nuffield Trust has called for LES schemes and parts of the Quality and Outcomes Framework (QOF) and Commissioning for Quality and Innovation (CQUIN)



initiatives to be combined and refined to incentivise co-ordination of care and efficient transitions between hospital, mental health, community and GP services (Charlesworth *et al* 2014). However, the good design of financial incentives is dependent on the availability of accurate data to aid with the design of the incentives and the monitoring of their impact. This is particularly difficult in a community setting, where good quality metrics and outcome measures are rare.

### Evaluation

Systematic measurement and evaluation generates data on impact that can enable new service models to be refined and can help secure ongoing funding. Evaluation was not fully integrated into all of the case study sites and there were no examples of full economic evaluations of service impact. However, we found examples of services evaluating and refining interventions based on data. The team at Imperial received an NHS London Innovation grant to fund an evaluation of a pilots of their approach. They conducted a break-even analysis which allowed them to identify the reduction in referrals and admissions necessary for the model to be cost neutral over a two-year period.

To fully understand the impact of an out-of-hospital service, an evaluation must take into account the broader effects of shifting care between settings by looking across the whole system and exploring the interactions between its different parts. We did not find any cost data demonstrating the whole-system impact of this type of service innovation. To aid the development of an efficient integrated system, this type of evaluation is key.

Securing funding for research and evaluation is challenging. Time is needed to identify and apply for grants from commissioners and other external bodies. Also, research organisations willing to fund evaluations often work to different timescales and have a different focus to commissioning organisations. One route through which clinicians can embed evaluation into their service models is by working with local CLAHRCs (Collaborations for Leadership in Applied Health Research and Care – partnerships between universities and NHS organisations that conduct applied research focused on patient outcomes; see [www.clahrcpp.co.uk](http://www.clahrcpp.co.uk)).



## Funding arrangements

Across the case study sites, redesign of the funding arrangements lagged behind redesign of the services. The main challenges in gaining funding and agreeing a consolidated funding approach are outlined below.

### Agreeing a single-funding approach

Funding arrangements were often patchy, complex and in flux. None of our sites had what they felt was an ideal funding settlement. A range of payment mechanisms was often in place for different parts of the service and securing recurrent funding was a challenge in some sites. It was often difficult for commissioners to define what was within and outside the scope of the service to be contracted, in part because of the evolutionary way in which these services had developed.

A number of sites had ambitions to agree funding based on a single payment to a lead provider, such as a capitated payment to cover the whole geriatric population's care needs. Our case study sites did not provide examples of these new contracting approaches in action. The King's Fund is doing further work in this area looking at systems that have progressed these approaches (see [www.kingsfund.org.uk/projects/commissioning-and-contracting-integrated-care](http://www.kingsfund.org.uk/projects/commissioning-and-contracting-integrated-care)).

### Payment by Results

The Payment by Results (PbR) tariff was identified as a key barrier to securing acute trust buy-in to the development of out-of-hospital services. For areas concerned, the PbR tariff provides a pull to keep services in a hospital setting. Developing new tariffs and payment approaches that enable joint working across sectors will be key to wider roll-out of out-of-hospital services. In our case study sites, there were examples of payment approaches either in place or under consideration that motivated consultants to work in the community, rather than attract patients to the hospital for treatment. These included the CCG buying consultant sessions from the hospital for community work to compensate for lost PbR income, introducing a cap on PbR so that the acute trust only receives PbR payments up to an agreed limit and developing a single payment for the care of patients from a particular demographic group or disease cohort, managed by a lead provider.



## Demonstrating impact

Case studies that sought to help patients stay at home and self-care mentioned the difficulty of demonstrating the benefits of this part of their model to commissioners. Similarly, a service that sent a consultant to participate in a multidisciplinary team found it difficult to isolate and demonstrate the impact of that particular individual's input on patient outcomes. Many commissioners look for initiatives that reduce hospital admissions and generate cost savings. However, services considered in this report had more impact on quality than cost. A service may act to reduce some admissions to hospital, but unless hospital clinics are closed in response to that reduction, GPs in other parts of the system may fill the extra capacity created in hospital clinics by lowering the threshold at which they refer patients.

## Unmet demand

Both of the intermediate services among the case studies reported an increase in activity across their local health system which was in part due to uncovering unmet demand. However, fixed budgets meant that an increase in activity did not lead to an increase in overall costs. The potential to uncover unmet demand will differ by specialty (this issue is particularly acute in dermatology, for example) and location. However, commissioners should consider it when agreeing fixed-funding envelopes for community-based services.

## Scale

Difficulties demonstrating impact and the system-wide influences on referral levels point to the importance of scale when establishing these initiatives. If reductions in referrals and cost are wanted, a service needs to be of sufficient scale to, for example, allow a hospital clinic to be closed in response to activity being shifted into the community.

## Transformation funding

The need for transformation funding to pay for the initial development of out-of-hospital services and potential initial double running has been highlighted previously by The King's Fund ([Appleby et al 2014](#)). The initial development of the case study initiatives was often undertaken in consultants' own time and was unfunded. Two of the sites received grants and pump-priming funding that allowed



them to develop, pilot, evaluate and update their approaches. If the models are to be transferred elsewhere, this unfunded activity needs to be programmed into the budget and start-up funding needs to be made available by commissioners and other funding bodies.

### System-wide issues

Interviewees identified a number of challenges associated with the development of these services that were system-wide and will be familiar to practitioners across the country who have sought to integrate care across health settings.

#### Information-sharing

Difficulty sharing patient-identifiable information between organisations was a major barrier to integrated working. This included sharing information across health care organisations and sharing information between health, social care and other local partners. We heard examples of MDTs keen to discuss frequent A&E attenders and contact them to work on strategies to reduce attendances, but which were unable to identify who the frequent attenders were. Clinicians working with social care teams were also unable to share information. In paediatrics there was frustration at not being able to link health with education data. Where community and acute staff worked within an integrated provider organisation, some of these issues were overcome.

#### System incentives

Rules that promote competition in the system were also hampering development. In one site, when a CCG sought to extend an initiative developed by an acute trust across five CCGs, they were unable to continue consulting with that acute provider on the best way to roll out the initiative because of a potential future tendering exercise. In other sites, consultants mentioned that their out-of-hospital service or their input into care outside hospital was vulnerable to takeover by a private provider. If a private provider won a tender to provide consultant input into an out-of-hospital service, significant benefits from links back to the acute trust would be lost. This should be considered by commissioners alongside cost and potential other benefits when taking decisions about new service providers.



## **4** The benefits for patients and the NHS

Although there is only a small amount of data on the impact of these services for patients, our case studies show they have the potential to improve patient experience and provide quicker access to specialist treatment in a location that is often closer to patients' homes and is less intimidating than the hospital. By taking a whole-population approach to the design of their service (including initiatives that motivate case-finding in primary care and focus on prevention and the education of patients about their conditions), they also have great potential to help patients to better manage their chronic conditions and stay out of hospital for longer. The box overleaf gives examples of some of the benefits to patients of these new models of care.



## Examples of patient benefits from out-of-hospital services

In the **Sunderland dermatology service** the median wait for an appointment was 4.8 weeks, nearly two weeks less than at the local hospital service. Patient survey results from 2013 showed that 100 per cent of patients would recommend the service to others. Patients reported liking the convenience of the location (for example, easier parking); the setting being less intimidating than a hospital; and staff having more time to spend with patients.

Data from the **Whittington respiratory service** shows that following the introduction of an LES payment that incentivised GPs to find patients with COPD and provide additional care in the community, the recorded prevalence of COPD in Islington increased by 22 per cent, while there was a 16 per cent decrease in standardised hospital admissions for COPD. More patients received stop smoking services and nicotine replacement therapy following the introduction of a stop smoking CQUIN payment. The respiratory service's in-hospital mortality rate was well below the national average (1.6 per cent compared to 6.5 per cent), as was their 90-day inpatient mortality rate (2.6 per cent compared to 8.6 per cent). Attendees at the service's long-term exercise group for pulmonary rehabilitation reported a 35 per cent improvement in the COPD Assessment Test (CAT) score that measures the impact of COPD on a person's life. This compared with a 14 per cent improvement in non-attendees' score. Attendees demonstrated a clinically significant ongoing improvement in all health-related quality of life (HRQOL) domains at six months compared to the non-attendees.

Since 2011, in the **Portsmouth and South East Hampshire diabetes service**, 1,138 patients were discharged to primary care when previously they had to attend hospital for the ongoing management of their diabetes. There are indications that diabetes outcomes have improved following implementation of the new service model. The hospital's hypoglycaemia admissions fell from 224 to 198 between 2011/12 and 2013/14 and diabetic ketoacidosis admissions fell from 112 to 82 over the same period. The lower limb major amputation rate fell from 2.4 per 1,000 patients with diabetes in 2010/11 to 1.3 per 1,000 in 2012/13. This does, however, remain above the national average of 1.1 per 1,000.



Evidence on the cost implications of these models was scarce – there were no full economic evaluations of impact. Saving money was not the core aim in any of the sites, although the context of financial tightening in the NHS meant it was inevitably part of the business case for some. The cost implications were dependent on a range of factors including the structure of the service, its funding arrangements, historic service provision and the potential for a new service to uncover unmet demand. It was sometimes difficult to identify a comparator against which to assess the overall cost of the service. None of the services could provide data on their impact on the cost of care locally, although a break-even analysis outlined the potential for savings in the Imperial child health general practice hubs.



## 5 Conclusion

In an environment where patients outside hospital have increasingly complex needs and organisations across the health and social care system often fail to work together effectively, our case studies demonstrate the pressing need to develop a new role for hospital consultants. This involves specialists looking beyond the four walls of their hospital to work as part of a multidisciplinary team and develop services that address the needs of their local population at each stage of their journey from home to hospital.

To do this, specialists must become educators who dedicate time to advising and supporting primary and community staff to better diagnose and treat patients in their local communities. They must take on strategic responsibilities for service planning and evaluation across organisational boundaries and they must act as change champions, using their influence as clinical leaders to persuade staff to work in new and innovative ways. They must establish services that not only shift expertise from the hospital to primary and community care practitioners, but also shift knowledge from health care practitioners to patients by addressing their ability to self-care at home.

The potential benefits of this new way of working for patients are clear. It can improve patient experience and lead to better management of chronic conditions, more co-ordinated care and lower waiting times. It will also create powerful links between staff across sectors that are mutually beneficial for hospital consultants (who better understand the challenges their patients experience in managing their conditions) and primary and community staff (who gain skills and confidence in treating more complex patients without onward referral to hospital).

However, the ability of this type of out-of-hospital services to generate cost savings is less certain. We do not yet understand the full cost implications of shifting care and resources outside hospital. The cost implications will depend on a range of factors that include: the specialty within which a service is developed, the potential to uncover unmet demand, historic service provision, the specifics of the service's design, the payment arrangements and the scale of each initiative. For this reason,



improving quality rather than reducing cost should be the core aim of this type of service redesign.

Developing these services requires motivated consultants to provide strong clinical leadership. However, consultants cannot and should not do this on their own. They must form effective partnerships with commissioners, who have a key role to play in consulting with stakeholders, acting as a bridge between organisations and adapting models for roll-out at scale. To be effective, commissioners will need to take risks to pilot new approaches, accepting that these will likely need to be adapted as their impact becomes clear. They must take a broader view of value by funding services that improve quality without increasing cost, rather than simply seeking service innovations that generate cost savings in the short term.

Realistic goals for the service must be clearly agreed in advance, and for many a reduction in hospital admissions will not be the best indicator of good performance; patient experience and – in the longer-term – health outcome measures may be more appropriate. Commissioners must also recognise the importance of transition funding to allow services to be piloted where appropriate, evaluated and refined, and to facilitate some amount of initial double running of services when necessary.

A key message from this research is the lack of robust economic evaluation data on the impact of out-of-hospital service models. Commissioners have the power to insist that new service developments include robust evaluations that look at the impact of a service redesign across the local health system. This will allow continuous quality improvement in the design and delivery of these services and will enable robust payment approaches and well-designed financial incentives to be developed. Academic researchers and evaluation scientists are the third important partner working with clinicians and commissioners in developing these new service models.

Incentives in the health system are not currently designed to promote integration. The PbR tariff can act as a key barrier to this type of innovation, and local and national commissioners must work to develop new joint tariffs, financial incentives and collaborative funding models that motivate hospitals to keep activity out of their clinics rather than pulling it in. As initiatives such as the Better Care Fund lead commissioners to pull money out of the acute sector, hospitals will increasingly be motivated to work with community colleagues to maintain market share.



This new way of working also has important implications for the development of our health care workforce. First, in many areas there may not be capacity in the consultant workforce to add a community-based element to their role. This problem will be intensified as the policy of seven-day working is implemented in acute and emergency care. In particular, specialists involved in older people's, respiratory and diabetes care who are also general physicians may be asked to staff acute services at the weekend, reducing the time they have available in the week to dedicate to community-based work. Ring-fencing consultant time for this important out-of-hospital work will be difficult in this climate, but is essential if the vision of a more integrated NHS is to be realised.

Second, the career pathway for specialists does not currently prepare them to work in an integrated care system. As new models of care emerge, they must offer placements and training posts and create roles that work across sectors at each point along the career pathway.

Finally, the findings have major implications for the primary care workforce, who will be asked to take on extended roles and provide more specialist care in their surgeries. General practice is currently under severe pressure from increasing patient demand and recruitment issues that have left some parts of the country vastly under-resourced. As activity shifts out of hospital, resources must be made available to fund extra capacity in the community. This requires the scale of an initiative to be sufficient to allow – for example – hospital clinics to be closed in response to the increase in care outside hospital.

Following the initial investment, initiatives that help GPs manage the more complex cases in their workload may eventually relieve capacity pressures on primary care by helping clinicians get their treatment and diagnosis right first time. Although the services profiled in this report go some way towards filling the skills gap that currently exists in general practice through consultant support, this is only a short-term solution. More fundamental change will also be needed to the medical curriculum to reflect the case mix and complexity of GPs' workloads.



This report has shown that there is huge potential in consultants becoming part of a multidisciplinary team, working with primary and community care professionals to help them diagnose and treat patients outside hospital. It has also highlighted the undeniable challenges of implementing this type of service innovation in an environment where budgets are constrained, the acute care workforce is focused on delivering consultant cover in hospital seven days a week and general practice is functioning under severe pressure. However, despite this context, if visionary clinicians team up with commissioners and academic researchers, they have the opportunity to design, implement, evaluate and refine out-of-hospital service models that do more than ‘drag and drop’ clinics from the hospital to the community. By placing education at their core they can develop services that address the full range of their local population’s needs and bring great value to patients and the NHS.



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## Acknowledgements

Many individuals contributed to this work. Firstly, we would like to thank the staff from our six case study sites who kindly took time out of their busy schedules to show us around their service and talk to us about its development – without their support we would not have been able to write the report. We are also grateful to Ros West at The King's Fund for her organisation and logistical planning to make sure the visits and interviews ran smoothly.

Special thanks to Dr Martin McShane, NHS England, who made comments on an early draft of the report. His input provided a new perspective on our findings and helped enormously in their interpretation. So did comments from six clinical experts, who kindly peer-reviewed the individual case study write-ups. Numerous individuals working in similar services who we spoke to during the project also helped considerably.

Thank you to colleagues Chris Ham, Nicola Walsh, Candace Imison and Richard Murray, who provided advice throughout the research process, and to Nigel Edwards, who was at The King's Fund during the initial design of this project and is now Chief Executive of the Nuffield Trust. Thank you also to James Thompson at The King's Fund for his analytical support.

We would also like to thank the clinicians, commissioners, academics and policy experts who attended a roundtable event held at The King's Fund in September 2014 to discuss emerging findings from this work. Their insight helped us understand the wider application of our findings to the NHS as a whole. Finally, thank you to Alison Jury for administrative support with that event.



**Published by**

The King's Fund  
11-13 Cavendish Square  
London W1G 0AN  
Tel: 020 7307 2568  
Fax: 020 7307 2801

Email:  
publications@kingsfund.org.uk

[www.kingsfund.org.uk](http://www.kingsfund.org.uk)

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First published 2014 by  
The King's Fund

Charity registration number:  
1126980

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ISBN: 978 1 9090029 39 2

A catalogue record for this  
publication is available from the  
British Library

Edited by Anna Brown

Typeset by Liaison Design,  
[www.liaisondesign.co.uk](http://www.liaisondesign.co.uk)

Printed in the UK by  
The King's Fund

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Demographic change, technological advances and the changing pattern of disease are pushing up the number of patients with complex needs who require treatment in the community. But the resources and expertise are often not available to treat them outside hospital, and patient care can be disjointed as different parts of the system fail to understand each other.

How can hospital consultants help? Some specialists in England are developing services where they deliver or facilitate care outside hospitals. Their work is spreading consultant expertise outside hospital walls and into the community.

*Specialists in out-of-hospital settings* presents the findings from six such services across England. The report identifies key characteristics, strategies and lessons from those services in a bid to inform and inspire others.

By interviewing consultants, primary and community staff and reviewing relevant documents, the report's authors discovered:

- great potential for these services to help patients better manage their chronic conditions and to improve patient experience, care co-ordination, and waiting times
- education and training - advising and supporting primary and community staff in diagnosis and treatment - are a central part of the consultant's new role
- strong partnerships between consultants and commissioners and transition funding are key to getting new initiatives off the ground.

The report offers clear pointers for commissioners, clinicians, researchers and policy-makers to play their part in getting more specialists working in out-of-hospital settings. It recognises the challenge in doing this when budgets are constrained, the acute care workforce is focused on delivering consultant cover in hospital seven days a week, and general practice is functioning under severe pressure. However, doing so offers enormous benefits to patients and brings the vision of a more integrated NHS that bit closer.

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