KINGS FUND RESPONSE TO WHITE PAPER ON CARE OUTSIDE HOSPITALS

Introduction

This paper is a response by the King's Fund to the Care Outside Hospitals White Paper consultation. The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding others. We are a major resource to people working in health and social care, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

Summary

The White Paper offers an unprecedented opportunity to redesign community health and social care services. The White Paper consultation exercise revealed strong public support for more accessible, convenient services in local settings and better integrated care - particularly for people with complex needs and long term conditions.

Given the rich findings from the consultation exercise, the temptation for the DH will be to devise specific policies to improve access to various types of services. But this may risk yet more micro-management of the service against specific targets. Instead it would be worth spending time reflecting on why the service is not responding regularly enough to these demands/suggestions by patients and devising better incentives to prompt more innovation and responsiveness. In short the DH in our view should concentrate not on the what but on the how, with particular reference to:

- Maintain choice
- Ensure quality
- Encourage innovation in the design and organisation of services/tolerate diversity
- Minimise disruption to ongoing developments between health and social care for long term conditions
- Manage demand
- Ensure value for money

With these goals in mind, this paper recommends the following as particularly important for achieving the vision for *Care Outside Hospitals*

- Design new incentives to stimulate change rather than introduce policies that result in micro-management of the NHS through targets. The incentives will need to act across generalist and specialist service providers

- Proceed with caution in developing a 'market' in accessible minor ailment/illness services and other fragments of general medical services and in allowing dual registration. Both approaches could create problems with respect to fuelling demand for minor problems and reducing value for money
- Develop a clear vision for commissioning at all levels of the NHS and a regulatory framework that supports good governance, preserves choice and enhances quality
- Support the development of market forces in out-of-hospital care in ways that avoid the emergence of monopolies and encourage innovation. We recommend many different ways in which to stimulate competition and innovation.
- Regarding long term conditions, ensure that incentives exist to bring together generalists, specialists and other health and social care professionals in ways that build on recent developments in partnership working and integration. There is scope to encourage independent providers of services for long term conditions where *locally* relevant, but not as part of a national procurement exercise.

Introduction and context for policy development

The *Care Outside Hospital* White Paper provides an opportunity to weave together changes in primary, community and social care services in ways that address a number of long standing policy challenges. Key among them are the need to improve access to GPs and reduce variation in standards of care; to meet public demand for better preventive, and diagnostic services; to manage demand for acute services; to improve the organisation and delivery of community nursing and therapies; to improve services for long term conditions and reduce avoidable hospitalisation and to ensure closer integration between health and social care.

With growing interest in the relocation of selected hospital services into community settings –supported by many of the participants in the national consultation events – expectations about what the White Paper might deliver are running high. Parallel changes in hospital care (including reduced lengths of stay; minimal access technologies, anaesthetic agents that allow more day surgery; drug developments and early discharge support schemes) support the transfer of care to community settings.

Yet the history of secondary to primary substitution – which picked up pace in the early 1990s (following publication of the Tomlinson Report on Health Services in London) – is not particularly impressive. Few 'Tomlinson' pilot services became self sustaining and the impact of significant investment in general

practice in London was limited.[1] Hospital at home schemes established at the time were not shown to be cost effective although they were popular and may have improved quality[2], and evidence for the cost – effectiveness of other substituted services is thin. But despite limited evidence, there is considerable pressure to enhance primary and community services in order to counter the financial incentives on acute trusts to maximise their workload.

With the perceived failure of primary care trusts (PCTs) to act as effective commissioners, attention has now turned to GPs to restrain demand for acute hospital care. Practice-based commissioning creates incentives to reduce hospital referrals and admissions and to develop cost-effective services in-house. Yet here too evidence to date is weak. Research into GP fund-holding (where similar incentives existed) reported a mixed effect on hospital utilisation with no significant reduction in referrals for elective care from fund-holding GPs reported by Surender et al[3] but a 3.3% reduction in elective admissions reported by Dusheiko et al[4]. Evaluations of specialist outreach clinics in the GP practices reported that they were popular but not cost-effective.[5] And research on Total Purchasing Pilots that are, in many ways similar to emerging commissioning practices, showed that many groups achieved only marginal changes in services at considerable managerial effort and typically lacked the support needed to become more effective.[6] However the crucial point to make is that the incentives environment in the NHS today is very different to that in the 1990s. In theory at least, there are far stronger incentives on primary care to reduce avoidable admissions, in particular because of Payment by Results.

The emerging vision for Care Outside Hospitals is increasingly focused on clusters of GP practices coming together to provide general medical and enhanced services and in some cases a range of additional diagnostic and specialist services. At the same time, partnerships forged at PCT level between health and social care service for the benefit of those with complex needs must be preserved and enhanced and brought into the practice-based commissioning arena. For GPs to be more effective as commissioners than their 1990's counterparts, there need to be far stronger incentives on them to become engaged meaningfully in practice-based commissioning. So far very few GPs are engaged, and if this continues effective commissioning and in particular cost effective demand management simply will not happen, regardless of PCT and supra PCT developments to streamline commissioning functions. If that continues there will be inappropriate haste to seek solutions from the private sector.

Challenges for the White Paper

The White Paper on *Care Outside Hospital* must juggle these various pressures, pulling together learning from the last 15 years to produce recommendations that :

- build and improve on past efforts to transfer services from secondary to primary care;

- respond to changing public expectations of health services;
- reflect the current choice agenda
- strengthen the commissioning function and demand management
- preserve newly formed partnerships in health
- harness developments in medical and information technology
- build on recent work on long term conditions and reducing avoidable hospitalisation
- build on recent efforts to improve co-ordination between/integrate health and social care.

Chief among the problems with primary care to be tackled by the white paper are:

- Evidence from the White Paper public consultation that people want:
  Better access to primary care services at more convenient times
  Drop in services to fit with busy life styles
  More preventive services, regular health checks (MOTs) and a focus on mental wellbeing
  Extra investment for those at greatest risk of poor health
  More care provided in community settings
  More support for carers

- The weakness of current commissioning (by PCTs) and the urgent need for practice-based commissioning (PBC) to counter the incentives on acute trusts to maximise activity in hospital settings
- The need to respond to demand from people with long term conditions for high quality local services and more joined-up services from different health and social care providers
- The potential benefits of extending choice into primary and community services are matched by potential problems (particularly increased demand and discontinuity)

Questions arise about the how to organise and incentivise care outside hospital in order to address these problems. Section 1 of this paper will consider four themes related to the re-design/re-organisation of community based health and social care (and in some circumstances, other services), highlighting strengths and weaknesses in relation to the problems described above and identifying key challenges that must be addressed by the white paper. Section 2 will pull together issues identified in section 1 to make recommendations about options for re-designing care outside hospitals.

1. Four themes underpinning the re-design of care outside hospitals

1.1. The organisation and scope of general practice:

PBC has the potential to drive GP practice mergers or networks and stimulate the evolution of 'super-practices'. This is starting to happen on an *ad hoc* basis through arrangements ranging from rapid expansion of existing partnerships to associations between clusters of smaller partnerships. In some circumstances, clusters of GP practices may link with specialist clinics, diagnostic services, minor surgery units, social services, forming 'poly-clinics' (see below). This raises various questions about which organisations (PCTs, GP partnerships, acute trusts, private companies, joint ventures) will or should drive such developments and the beneficial and perverse incentives associated with different models. The potential benefits of this trend in relation to the problems outlined above are:

- responding to public demand for more services to be provided in community settings
- economies of scale around commissioning with the *potential* for greater strength (through larger size) in commissioning although evidence for this is weak.
- incentives for demand management and - if registered patients remain stable over years - for preventive work
- opportunities to work together across practices to improve patient responsiveness through, for example, longer clinic hours/wider range of services, (although there is little evidence to date that this will happen in the absence of incentives to do so)
- a larger population base for which to develop enhanced, specialist and preventive services, (in response to public demand)
- opportunities to develop specialist clinics for long term conditions - either through GP or nurse specialists or by commissioning specialists to provide services in community locations. The 'community locations' could be within existing GP practices or within new polyclinic facilities combining any or all of diagnostics, outpatients, minor surgery, general practice and community nursing and therapy services. Again, this would respond to public demand for accessible and convenient local services.

Potential problems associated with such moves are:

- The evaluation of the Total Purchasing Pilots showed smaller TPP groups achieved more than larger groups in the first few years of their operation.
- Development of in-house specialist and preventive services could restrict patient choice unless regulations are developed to 'manage' in-house referrals and preserve choice
- Evidence from research on outreach clinics associated with GP fundholding reported them to be inefficient though popular with patients.

- Recent research on GPs with specialist interests found that clinical governance for GPSI clinics was under-developed, raising questions about quality assurance for GPSI and other enhanced services[7]
- GP super-practices or networked practices could become monopoly providers in an area, removing incentives to improve the quality and responsiveness of services.
- Good quality /like-minded practices group together and leave a group of less high quality practices to serve some patients in the area.
- Inner city practices/groups with high patient turnover may loose the incentive to undertake preventive work - a phenomenon seen in many US HMOs[8]
- PCT led 'polyclinic' developments could be slow to get of the ground while GP-led, private sector-led or joint-venture type developments could create conflicts of interest and jeopardise choice

In the light of these observations, questions arise about

- Whether and how to regulate the formation of GP practice clusters
- Whether and how to regulate ownership of 'polyclinics'
- What guidance is needed on the development of specialist services in the community to ensure quality

1.2 Choice, contestability and incentives in primary and community services

In line with current policy to increase choice in public services, the White Paper must ensure that proposed changes in primary, community and social care maintain and enhance current levels of patient choice rather than reduce it. Choices about care outside hospital may take place at many points, including:

- Choices made within clinical consultations about drug or treatment regimes
- Choice of provider for the management of minor illnesses and ailments including GP, pharmacist, Walk In Centre, NHS Direct
- Choice between GPs (more of a theoretical than a real choice at present)
- Choice of provider at point of referral for investigation and/or specialist care

Options for maintaining and extending choice include

- increasing clinician and patient skills in supported self-management to ensure patients participate actively in choices about their own care plans

- stimulating a market in primary and community services; encouraging new providers of personal medical services
- increasing choice of commissioner
- stimulating a market in specialist care and services for long term conditions
- extending the market in elective surgical care and diagnostics

Initiatives to enhance **self-management support** have been launched through recent policies on long term conditions. Currently focused on widening provision of the expert patient programme, a recent Kings Fund review of patient preferences around self management[9] concluded that other developments are urgently needed. Of particular importance are enhancing clinician skills to support self-management and patient participation in clinical decision-making; improving information and signposting about local services and increasing the flexibility of services to enable people with long term conditions to fit contact with health professional into their daily lives. The need for better signposting and access to information about services has also been highlighted in the *Who Supports and Helps Me* White Paper task group

Opportunities to extend the use of **market forces into primary care provision** already exist through A PMS and S PMS arrangements but few providers or PCTs have capitalised on these opportunities. The national White Paper consultation confirms public support for longer hours of access to GP services and for diversifying the location of primary care providers although recent King's Fund research using focus groups revealed the problem of stoking demand through such services. [1] In theory at least, a competitive market in primary care could stimulate greater patient responsiveness in relation to opening times and convenience of access to primary care services.

On a related note, if monopoly clusters of GP practices emerge in response to practice-based commissioning (see 1.1 above) this risks limiting choice and reducing responsiveness to patient preferences, but could also stimulate improvements in quality associated with organisational efficiencies (economies of scale) and an improved infrastructure for monitoring and improving performance. King's Fund research into high performing US HMOs concluded that, among other things, it was the competitive pressure on these organisations that kept them responsive to patient

[1] Recent focus groups to explore public views on choice asked specifically about increasing choice around GP-type services. People were frustrated by the lack of choice of different GPs and enthusiastic about locating primary care/GP-type clinics in new settings (shops, pharmacists etc) but reported being more likely to use such services for minor ailments than for long standing or serious problems. Pharmacists were also highly respected sources of advice about health problems but for serious problems, people wanted continuity of care from a doctor (typically a GP) that not only had their full medical record but also knew about them as an individual. (Rosen, Curry and Florin 2005).

preferences, financially efficient and able to change and respond quickly to external pressures. Furthermore this pressure helped to unite the efforts of clinicians and managers. Questions remain about whether the further use of standards and targets could be used to achieve a similar level of responsiveness. Also how realistic will it be to establish competing GP groups in areas outside big cities?

The idea of new, **independent providers of service for long term conditions** has also been raised. This received a mixed reception at the focus groups described above with some in favour of specialist providers and others concerned about fragmentation and duplication of existing general practice services. [2] Overall many people wanted to improve and extend access to current services as much as, if not more than wanting to develop new providers and recognised that there were opportunity costs associated with encouraging new providers into the market.

Extending choice at the point of referral to specialist providers has been the cornerstone of recent health policy and could be seen to be jeopardised by the changes in general practice described in section 1.1 above. Incentivised by potential savings from commissioning budgets, GPs may choose to develop in-house services (see point 1 above), encouraging patients to seek specialist opinions from practice-linked clinicians rather than offering a full and free choice of other local providers.

These observations raises three key questions that must be addressed in the White Paper:

- Given existing constraints (eg the national GP contract, financial incentives in acute trusts to maximise activity, GP and other clinician shortages in many areas etc) how exactly might market-style incentives improve responsiveness *and* maintain quality?
- If so, what form should such a market take?
- How should ownership and referral arrangements be regulated to preserve patient choice, support multiple providers and minimise perverse incentives?

1.3 Strengthening commissioning of and in primary care

At present there is no national vision for commissioning. This is a glaring lack. How will supra-PCT arrangements being developed across England link with newly restructured PCTs or with practice-based commissioners? What should be the roles of each?

[2] Opinions about telephone based disease management were mixed with many stating they already had a good relationship with the specialist nurse or doctor within their own GP practice that they would not want to disrupt. Others were concerned that generalist clinicians couldn't keep up to date with knowledge about long term conditions and liked the idea of care from a highly specialist provider).

There is limited evidence from which to infer that under PBC, GPs will be better commissioners than PCTs. In the absence of clear guidance to date about how savings from commissioning will be allocated, what they may be used for and what support will be provided for management and skills development, we do not know how strong will be the PBC incentives to demand manage and change services. Furthermore, evidence from GP fund-holding and the national TPP evaluation shows that most participating groups achieved limited changes in the three years in which they operated, although mostly within primary and community services rather than in hospital care. The current aspiration is for wholesale change and transfer of specialist care to the community. In some health economies, PCTs are using the opportunity of rebuilding a DGH to achieve whole-system change and introduce more community based services, but most are not. Furthermore, the incentives acting on acute (and Foundation) trusts run counter to this vision.

If groups of commissioning GPs are to act as stronger commissioners than PCTs and achieve this vision of increasing care in community settings, a number of conditions will have to be met:

- Support for the development of basic commissioning skills through investment in IT and data analysis skills and of management skills for commissioning.
- A timely transfer of management budgets between PCTs (once their functions are scaled down) and PBC groups. It is hard to envisage many GPs will be willing to make up front investments in PBC management when the potential gains remain unclear
- Effective incentives are needed for commissioning GPs to succeed. These may be positive incentives (eg a share of savings) or negative incentives (sanctions) such as the possibility of take over of the commissioning function by an external group if minimum standards for commissioning are not met
- Given that effective 'commissioning' (as opposed to contracting) requires changes in clinical behaviour, effective clinical leadership will be essential within groups of commissioning GPs.
- A regulatory framework to ensure quality and financial probity and preserve choice
- Minimum standards for commissioning will be required to ensure the incentives for demand management do not overshadow other requirements such as the provision of preventive services or services for vulnerable groups.
- Inclusion of practice-based commissioning into the new GP contract to create a legally binding obligation on participating GPs to adhere to local standards for commissioning

What role for the private sector and foundation trusts?

A number of roles have been postulated for the independent sector in primary care and commissioning. First that they take over the commissioning function in a health economy (eg in Oxfordshire) -acting in effect as a for-profit or not-for-profit, networked HMO. Second that they provide 'commissioning services' that could be purchased by PBC groups or PCTs to inform their planning and commissioning activities. Third is that they are brought in to take over failing GP practices or PBC groups to act as combined commissioners and providers.

Early experiences of independent providers of NHS primary care have been broadly positive but there is no real evidence yet on which to judge their ability to achieve change. If the broad goal is to transfer significant portions of acute care into the community, they will need to lead change in clinical behaviour - either as providers that employ GPs or as commissioners that lever change from a network of local primary care organisations. Evidence from the US following the 'managed care backlash' suggests how hard this will be and King's Fund research on this issue in relation to long term conditions found that constructive relationships between payer (commissioner) and provider were important. Policy in this area will need to encourage different forms of engagement between the independent sector and GPs. Effective collaborative working will be essential - be this through contractual or employment arrangements, joint ventures or new forms of partnership.

Alongside a potential role for independent providers, foundation trusts have expressed the intention of taking over general practices and community health services, creating the possibility that they too have a stake in commissioning. Here too, a regulatory framework will be needed to ensure that any 'top down'vertical integration of acute and primary care does not result in restrictions on patient choice.

When addressing these issues, the White Paper will have to be mindful of the following issues:

- Preserving patient choice of both primary and specialist providers
- The potential benefits - as evidenced by learning from US HMOs (see Dixon et al) - of competition between commissioners
- Achieving change through commissioning requires changes in clinician behaviour. This in turn requires strong clinical leadership, good alignment between clinician and commissioner goals and appropriate incentives. Initiatives to develop new commissioners are likely to be more effective if they address these issues
- There is a limited primary care workforce so the capacity to develop competing PBC groups is limited.

1.4 Out of hospital care for long term conditions

Policy on long term conditions over the last two years has triggered numerous developments to improve services in this area. Building on the risk-pyramid model of long term condition management, the new 'PARR' risk-stratification algorithm developed at the Kings Fund,[10] community matrons, case management arrangements and *ad hoc* local developments between health and social care providers are all working to improve out of hospital care for patients with particularly complex problems.

The developments described above in terms of new alignments between PBC groups and the opportunities these create to develop 'polyclinics' offering diagnostic facilities and specialist care in community settings are also highly relevant and respond to calls from patient groups for earlier diagnosis and good local services. Such developments might, over time, start to replicate the kind of multi-speciality health system delivered by Kaiser Permanente. However, the extent to which well integrated services develop may vary between locations depending on who leads the development of new facilities and services (GPs or PCTs); the willingness of GPs to open up their partnerships to other specialities and the range of service that are pulled together. While this kind of 'integrated delivery system' could mimic some of the characteristics of leading US HMOs, a multi-speciality organisation that both commissions and provides care could restrict patient choice (unless there was sufficient supply of similar organisations to compete for patients) and jeopardise standards in the absence of necessary regulation.

Developments to support self-management (discussed in 1.2 above) are perhaps more patchy and remain strongly linked to the EPP, which in our view is of limited effectiveness because it is not integrated with mainstream clinical practice. Calls from patients (Corben and Rosen), and patient groups (17 million reasons) for better access to information about services have been echoed in the work of at least one of the White Paper task groups (who cares for and looks after me) in relation to carers. There are more fundamental questions as to whether 'lay-led' programmes to increase self management are as effective as professionally-led programmes.

In relation to people with complex needs, emerging partnership arrangements between PCTs , local authorities and, in some places, voluntary sector groups and other agencies are starting to produce results. The re-organisation of PCTs risks destabilising these partnerships and it remains unclear the extent to which PBC groups will attempt to re-create them or to develop their own equivalent services. For example, the aspirations of some commissioning GPs to employ directly teams of community nurses should not jeopardise developments seen in areas such as Kingston where community nursing services have started to employ generic health workers to undertake joint health and social care tasks. Equally, innovative commissioning groups may develop in-house social care to promote integration between different workers.

With these observations in mind, the White Paper should aim to address the following:

- Ensure that quality standards for community-based specialist services build on those already developed between the RCGP and other Royal Colleges in relation to GPSI clinics
- Stimulate the development of 'Kaiser- style' multi-speciality providers in the community, and develop the need for effective regulation and governance arrangements to maintain quality and patient choice
- Encourage polyclinics to act as centres for information and advice to support people with long term conditions and their carers
- Be mindful of efforts to date to integrate health and social care provision for people with complex long term conditions and the risk that new PBC arrangements could disrupt progress
- Clarify what will be effective mechanisms for investment in the facilities needed to support a new model of LTC in the community?

2. Options for the White Paper

The White Paper consultation has unsurprisingly revealed public enthusiasm for improved access; better preventive care; services provided closer to home; closer integration of health and social care and a focus on people with greatest needs. Drawing on the above discussion, there are many ways possible ways to respond to these findings but the challenge will be to

- Maintain choice
- Ensure quality
- Encourage innovation in the design and organisation of services/tolerate diversity
- Minimise disruption to ongoing developments between health and social care for long term conditions
- Manage demand
- Ensure value for money

With these goals in mind, the following approaches are recommended for the white paper:

Focus on designing new incentives

Focus on designing new incentives to stimulate everyday improvement on the ground, rather than designing policies which seek to micro-manage the NHS through targets and performance management.

The incentives will need to act across generalist and specialist providers if they are to encourage hospital based specialists to undertake more care in community settings.

Improve timing and convenience of care

Proceed with caution in expanding primary care provision into new 'convenient' locations. While popular, the balance between meeting unmet need and fuelling additional demand is hard to predict, as are the opportunity costs of providing such services. Increasing capacity in existing GP and primary care services (including pharmacists) linked to competition between different providers (or clusters of providers) would be an alternative way to improve responsiveness to patient preferences about access.

While dual registration offers one way of increasing access to established services. We do not favour this approach at this stage. It is hard to envisage a remuneration system that would reward those providing increased access without a significant opportunity cost on wider service provision. It may also make efforts to manage demand appropriately harder.

Develop a vision for commissioning with the service

The vision must set out what might be the roles of supra PCT organisations, PCTs and practice-based commissioning and how they are linked.

Develop a regulatory framework for practice-based commissioning and enhance commissioning skills

A regulatory framework is urgently required for commissioning practices that will establish financial rules and accountabilities of commissioning groups, ensure quality and protect patient choice. Of particular importance will be guidance about referral behaviour and ownership of facilities and services. Along side this, credible management allowances, and IT and data support are needed to facilitate PBC, as is an effective skills development programme for commissioning GPs. This could come from within the NHS or from private providers.

Developing market-incentives in Care Outside Hospital

Having cautioned against stimulating a market in easy-access minor illness/ailment primary care services, there are other ways to encourage new providers of a combination of GMS, specialist or enhanced services and social care and which develop market-style incentives to encourage change. This may be through

- competing clusters of commissioning GPs;
- outsourcing various functions of commissioning (eg back office functions)

- allowing independent organisations to bid for tenders to commission in areas where commissioning is seen (by a regulator) to be failing
- new (independent) providers of GMS or S PMS services;
- Kaiser-type multi-speciality partnerships;
- joint ventures between new providers and established GP practices;
- community based services provided by acute and foundation trusts

Whatever the model for extending provision, the White Paper should ensure that local monopolies do not form. An element of competition between different providers of care outside hospitals will be important to maintain choice, drive efficiency and improve responsiveness to patients.

Develop services for long term conditions

The proposals described above – if suitably regulated – will stimulate the development of high quality specialist care in the community. Groups of commissioning GPs will be able to develop special clinical interests, take on specialist partners, buy-in additional services for long term conditions or commission specialist care from other local providers. With some PCTs currently organising joint health and social care teams around GP practices, PBC need not, necessarily, disrupt these recently formed relationships. But it will be essential to ensure practice development plans for people with long term conditions to not destabilise strategic planning for the wider population.

There is scope to encourage more providers into the NHS 'market place' *at their own risk* – not as part of any central procurement plan. For example community therapies (particularly dietetics and chiropody) are in short supply despite their key role in the management of diabetes. Disease management services may also have a useful role to play but should not be imposed upon local health economies as part of a national plan. The introduction of payment by results and practice based commissioning allow for such services to be commissioned locally as needed.

Finally, the White Paper creates an opportunity to stimulate closer working between generalists (GPs) and specialists (acute sector consultants), nurses, therapists and social care providers. The King's Fund review of evidence on case management suggested that the most effective case managers were embedded in teams or services from which they could obtain the services needed by individual patients. While no single model has emerged for managing high risk patients a cluster of different arrangements are coming to the fore. Locality specific health and social care teams (which may be aligned to GP practices); GP practice based case management; and 'virtual' integration between nursing, intermediate care and social care services working to shared standards and eligibility criteria in a single PCT. These models typically lack *formal* specialist input and depend on good relationships between team members and hospital

consultants to ensure rapid patient access to specialist advice. Formalising specialist input into emerging services targeted at people at high risk of hospital admission would be helpful. This could be through outreach work by hospital consultants (as in the old community mental health services), specialists joining GP commissioning clusters (as partners or employees) or through managed network arrangements with pooled budgets.

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