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Ideas that change
health care

Acute hospitals and integrated care

From hospitals to health systems

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Summary

A core part of the vision laid out in the *NHS five year forward view* (Forward View) involves acute hospitals becoming more closely integrated with other forms of care. If the health and social care system is to respond to the changing needs of the population, and also address the financial challenges it faces, acute hospitals will need to play a fundamentally different role within local health economies. This will involve:

- moving from an organisational focus to a system-wide perspective

- working more closely with local partners, including primary care, social care and community services

- developing integrated service models that span organisational boundaries

- providing services through horizontal networks with other acute hospitals.

This report explores the role that acute hospitals can play in integrated care, drawing on learning from five case study sites in England where acute hospital providers have engaged actively with the integration agenda.

Building shared governance arrangements across the local system

Effective partnership structures between acute hospital providers and other local stakeholders can support the development and rapid implementation of integrated service models drawing on resources and expertise from across the local health system. The critical ingredients in building a sense of shared accountability across the system include:

- a shared vision and strategy for integrated care

- a governance structure that makes it clear which organisations are accountable for each aspect of delivery

- agreeing system-wide metrics for defining success, and monitoring performance against these regularly.

One of the most significant challenges has been engaging primary care within whole-system governance structures. In areas where more substantial progress has been made, acute hospital leaders have invested considerable time and energy in building relationships with general practice. A number of facilitating factors were identified, including:

- direct contact between senior hospital leaders and general practitioners (GPs), for example, through regular practice visits, or via engagement with GP federations where these exist

- a history of joint working between the acute trust and primary care

- strong clinical leadership in general practice

- employing people with a primary care background at a senior level within the acute provider

- joint educational sessions for GPs and consultants.

Horizontal networks between hospitals

In addition to closer vertical relationships with community partners, integrated care can also involve neighbouring acute hospitals finding new ways of collaborating to improve the service delivered to patients. It is becoming increasingly common for some acute care services to be delivered jointly by two or more acute hospitals working together, allowing local access to be maintained at the same time as realising economies of scale. This includes the use of approaches recently described by the Dalton review, such as joint ventures, visiting services or service-level management franchises.

In the future, these kinds of approaches are likely to be used for a growing range of services, particularly in smaller hospitals, including for services that are currently considered to be 'core' acute hospital services.

Breaking down the silos within combined acute-community trusts

Many acute hospital providers in England now also provide community services, but the degree to which there has been successful integration at the clinical and service level within these organisations varies. Providing community, and in some

cases adult social care services, appears to have encouraged some acute trusts to shift their focus and engage in conversations about strengthening out-of-hospital care. However, it is clear that this transformation has not taken place consistently across all combined acute and community trusts in England.

A number of practical measures can help in overcoming the barriers between acute and community services, including:

- establishing effective internal governance systems that support integration across business units

- creating opportunities for interaction and mutual learning between acute and community professionals

- developing job roles that span acute and community settings

- using tangible service changes and early wins to demonstrate to staff the benefits of integrated models of care for patients.

In some cases, there was evidence that integration at the organisational level had facilitated the implementation of integrated models of care. Interviewees argued that organisational integration had made it quicker and easier to agree new service models that draw on resources from multiple service segments. However, it is also possible to achieve many of the same benefits through successful partnership working between organisations.

The impact of integrated care involving acute hospitals

In most of our case study sites, robust evaluation of integrated service models is still needed. However, some of the results reported so far are impressive and give an indication of what may be possible when acute hospitals take a more proactive role in integrated care.

- The High Risk Patient Programme delivered by Northumbria Healthcare NHS Foundation Trust and partners has been associated with a significant drop in avoidable admissions and emergency readmissions.

- In Sheffield, an upwards trend in preventable bed usage appears to have been reversed. Since the Right First Time programme was initiated there has been a drop in bed usage among people with ambulatory care-sensitive conditions.

- The use of Discharge to Assess in South Warwickshire was associated with a 33 per cent reduction in length of stay, a 15 per cent drop in new admissions to nursing homes post-discharge, and a 15 per cent drop in mortality.

- Provision of telehealth to care homes by Airedale NHS Foundation Trust was associated with a 37 per cent drop in hospital admissions and a 45 per cent reduction in accident and emergency (A&E) attendances from affected care homes.

The acute hospital of the future

A growing consensus suggests that acute hospitals will in future be fundamentally different from today, with a greater proportion of care delivered beyond the hospital walls, and an increased role in prevention and population health. These changes will be supported by the development of new care pathways, workforce arrangements and organisational models.

A contentious issue is whether the growth of out-of-hospital care will translate into reductions in bed numbers in acute hospitals. There was a strong consensus among the hospital leaders involved in our research that radically reducing the number of beds in acute hospitals in the short or medium term was not a realistic prospect. Rapid growth in demand for hospital care has meant that integrated service models have provided a means of managing growth within existing bed capacity, rather than achieving any significant reductions in bed numbers. This has important financial implications as it reduces the ability of commissioners to realise 'cashable' savings in the short or medium term.

We describe three scenarios for the future of acute hospitals:

- **hospitals as islands:** the worst-case scenario, a retreat to a 'fortress mentality' in the face of mounting service and financial pressures

- **hospitals as part of integrated care systems:** the scenario present in our case study sites, working with local partners to provide co-ordinated care to patient groups with greatest need, including through horizontal or vertical integration

- **hospitals in population health systems:** the best-case scenario, going beyond the integration of *care* services for *patients* to focus also on improving the broader *health* of *the local population*.

Who will lead integrated care?

Some have suggested that the move towards integrated care will need to be provider-led, arguing that this is where the necessary expertise is based. However, the policy expectation is that commissioners act as system leaders in their local area, and there are a number of examples of commissioner-led integration.

We argue that neither extreme is desirable, and that a simple dichotomy between provider-led and commissioner-led integration is unhelpful. Instead, collective leadership is needed, bringing together acute sector leaders with other providers and commissioners to improve outcomes for patients and populations. Acute hospital leaders should avoid pursuing integrated care through unilateral action, but instead should invest time in building a consensus with local partners.

As part of this collective approach, it is important that leadership is shared between clinicians and managers. Clinical leaders in the acute sector can play an indispensable role in building relationships and trust with GPs and other professionals working beyond the hospital. Professional inertia within the hospital's own clinical workforce can create a significant barrier to change, and medical directors and other leaders need to see part of their role as being to build enthusiasm for new ways of working. Clinicians will need to be supported in this leadership role by managerial colleagues and professional leaders at the national level.

Implications for the *NHS five year forward view*

The Forward View introduces a number of new models of care involving acute hospitals and their local partners, including primary and acute care systems (PACS) and multispecialty community providers (MCPs). Our research has a number of implications for implementation of these models of care.

• The experience of organisations involved in our research highlights just how ambitious the Forward View vision is. Implementing the PACS model in particular will involve tackling issues that have been significant barriers in our case study sites and even the most advanced areas are currently some distance from the scenario described in the model.

- The successes seen in leading areas have only been achieved after several years of sustained effort. There is a need for realism regarding the pace of implementation, and the necessity of doing the 'ground work' before embarking on a process of transformative change.

- In many cases local system leaders argue that the best option for their health economy will be a blend of models such as MCPs and PACS.

- Care should be taken to resist oversimplifying discussions regarding MCPs and PACS models as being a binary choice between 'primary care-led' and 'hospital-led' integration – this is unlikely to foster the collective forms of system leadership that are needed.

What should happen now?

Our primary recommendation is that acute sector leaders should be encouraged to take a leadership role in their local health systems, working with local partners to develop more integrated models of care, and taking greater responsibility for prevention and public health. If this is to be achieved, supporting actions at a number of levels will be needed, including:

- developing a new regulatory model with greater emphasis on whole-system performance

- ensuring that competition law does not create barriers (real or perceived) to constructive dialogue and partnership working between commissioners and providers

- continuing to develop a range of alternative payment systems and support local commissioners in moving away from activity-based tariffs for hospital care

- introducing a transformation fund that ensures that all areas of the country are able to cover the costs of transitioning to more integrated models of care

- creating more flexible job plans for acute care professionals that emphasise continuity across settings and joint working with other professionals

- developing more flexible contracting models for general practice to make it possible for acute hospital providers to take a greater role in primary care provision.

The recommendations section of the report describes specific actions that will be needed from acute hospital leaders, local commissioners and national bodies including NHS England, system regulators, professional bodies and the Department of Health.

1 Introduction

The case for change

Acute hospitals in England and around the world face significant challenges as a result of demographic change, rising demand and a limited supply of some professional groups. The changing needs of the population make it increasingly important that acute hospitals are able to provide high-quality care for people with multiple chronic conditions and complex needs, including but not limited to the growing numbers of frail older people. To respond effectively to these changing needs, health and social care services must be capable of providing ongoing support over time, anticipating and preventing deterioration and exacerbations of existing conditions, and supporting a person's multiple needs in a well-co-ordinated way. At present, the system often fails to do this, with divisions and gaps between different agencies and professionals meaning that patients and families experience a fragmented service.

Integrated care is the response to this failure, and represents a fundamental transformation in the way that health and social care services are delivered. A core part of integrated care concerns the interface between acute hospitals and community-based services. There are at least two reasons why this interface is critically important. First, hospitals will need to work closely with community partners in order to prevent avoidable hospital admissions and enable people to remain safe and healthy in their own homes. Second, it is at the point of discharge from hospital to the community that care is often most fragmented. Integrated care therefore involves a focus on both the 'front door' and 'back door' of acute hospitals.

There are also financial reasons for critically examining the role of the acute hospital in the health system of the future. If demand for hospital care continues to grow at the rates observed over recent years, the mismatch between costs and revenue is likely to widen over time. The intense financial pressures currently experienced in hospitals make the need for change in the acute sector more urgent than ever.

The effects of budgetary constraints are made greater still by increasingly demanding expectations around quality, safety and seven-day working. These

expectations have important implications in terms of the workforce needed within acute hospitals. There is currently a considerable undersupply of some acute hospital professionals, with recruitment and retention issues among nursing and medical staff now representing a significant risk for acute hospital providers in many parts of the country.

Taking these factors together, it is clear that for many acute hospitals, the current model of care is no longer sustainable. The Forward View recognises that radically different models of care will be needed if acute hospitals are to meet the challenges they face successfully (**NHS England** *et al* **2014a**). Crucially, these new models of care rely on better integration of acute hospitals with surrounding out-of-hospital services. For example, the primary and acute care system (PACS) model envisages new organisational forms that would combine general practices, other community services and acute hospitals in a single entity – achieving a degree of vertical integration not previously seen in the NHS. However, the Forward View is also clear that no single model will apply across the NHS, with the leadership for integration potentially coming from different parts of the system in each local health economy. This question of leadership for integration – and where in the system it will come from – is an important issue addressed throughout this report, and particularly in **section 9**.

The need for change in the acute hospital sector is further supported by the findings of the Royal College of Physicians' Future Hospital Commission, which argued that hospitals of the future will need to be more outward-facing if they are to remain sustainable, with all physicians and specialist medical teams expecting to spend part of their time working in the community alongside primary, community and social care colleagues.

The dominance of hospitals in the current system is often seen as an impediment to achieving integrated care. It is sometimes assumed that integrated care – with its emphasis on strengthening community-based provision – is intrinsically opposed to the organisational interests of acute hospital providers. The examples described in this report demonstrate that this assumption is wrong, and that integrated care can and must include acute hospitals as a critical part of co-ordinated systems of care.

About this report

This report explores the role that acute hospitals can play in integrated care, drawing on learning from five case study sites in England where acute hospital providers have engaged actively with the integration agenda. Although integrated care remains a work in progress across the NHS, elements of the future can be seen today in some of the innovative practices developed within local health economies. The report is based primarily on case study research conducted with the following organisations and their local partners:

- Northumbria Healthcare NHS Foundation Trust

- Sheffield Teaching Hospitals NHS Foundation Trust

- Airedale NHS Foundation Trust

- Yeovil District Hospital NHS Foundation Trust

- South Warwickshire NHS Foundation Trust

These sites were selected as examples of acute hospital providers that have made encouraging progress in developing more integrated models of care. They are not intended to be representative of all acute trusts in England. The report describes the progress made in these sites, explores the barriers that local leaders have needed to overcome and distils lessons for other local areas and for national policy-makers.

The research process involved 39 in-depth interviews, site visits and an expert seminar held in January 2015 with participants from our case study sites plus representatives of other local health economies and national organisations.

The forms of integration covered by the report include:

- vertical integration, including through closer working with primary care, social care and other community partners (section 3)

- horizontal integration, including networks between acute hospitals (section 4)

- integration within a single organisation, for example, in the case of trusts providing both acute hospital and community services (section 5).

Our primary interest is in integration at the clinical and service level, in line with the

evidence that this is what has greatest impact on patient experience and outcomes (Curry and Ham 2010). However, we also explore the role of organisational merger in facilitating integration at the clinical and service level (*see* section 5).

② The role of acute hospitals in integrated care

It will be increasingly difficult for acute hospitals alone to meet the challenges laid out in the previous section. Hospitals will need to develop new ways of working that span traditional service and organisational boundaries – including working more closely with other hospitals (for example, through alliances and partnerships), and strengthening connections with community-based services such as primary care, social care, community services and mental health. This points towards hospitals playing a more outward-facing role in their local health system, in which they shift from an organisational focus to a system leadership role, and play a more active part in preventing illness and promoting health in local communities.

> *We now see ourselves as trying to run a system rather than running an institution.*
> Acute trust chief executive

This change resonates with messages from major transformations seen in international health systems such as the Veterans Health Administration (VA) in the United States. Ken Kizer, who led the changes in VA in the late 1990s, describes the organisation as having the realisation that the business they are in is health, rather than hospitals. This shift in focus is well under way in some acute trusts in England, but even in those areas that have made the greatest progress, there is a recognition that the journey is far from complete. In the five case study sites examined for this report, it was clear that while acute hospitals have made encouraging progress in terms of integration with community services, social care and in some cases primary care, significant barriers remain.

The focus and drivers of integrated care

Acute hospital providers saw their principal role in integrated care as being to support out-of-hospital service providers (which often include services within their own organisation) in safely managing care for patients with higher levels of risk in the community. Their goal is to allow people to remain independent in their

own home for longer, or to be discharged from hospital at an earlier stage in their recovery. By strengthening the interface with community-based support, hospital leaders aim to manage demand and improve patient flow through the hospital in a way that will be of mutual benefit both to patients and to the hospital as an organisation. Previous research has highlighted that working in community settings can also create important learning opportunities for hospital consultants that can lead to perceived improvements in clinical practice (**Robertson *et al* 2014**).

The active involvement of the acute hospital in integrated care was seen as a highly positive development in each of our case study sites. However, there was often a suggestion from local stakeholders that this involvement had come at a price, with several remarking that the leading role played by the acute hospital had shaped the focus of integrated care in their area.

Many acute hospitals are under extreme financial pressure – and it was clear in our research that this is having at least some effect on the focus of integrated care activities. Acute hospital leaders often cited financial pressures, alongside quality improvement, as one of the key drivers for the hospital's work on integrated care. Integrated care was seen as an important part of the solution to the financial challenges facing hospitals, although rarely as the whole answer. There is a consensus among acute hospital providers that internal efficiencies can only deliver part of the productivity improvements needed, and that the remainder will need to come from system-wide transformation and working with local partners in innovative ways.

> *We cannot rely on our partners to manage the demand we face – we have to be involved in this ourselves, albeit by working in partnership.*
> Acute hospital chief executive

Increasingly urgent concerns about the financial sustainability of acute hospitals have made it imperative that the efficiency of discharge processes in particular is improved. As a consequence, discharge from acute hospital care has often been a major focus of integration programmes, and has been a dominating concern both for hospital providers and commissioners alike. Discharge to Assess pathways have been used successfully in South Warwickshire, Sheffield and elsewhere, and a range of other integrated service models have been developed that support more co-ordinated working between acute, community and social care at the point of discharge. We discuss these models in greater depth in **section 6**.

Facilitated early discharge is an important and appropriate focus for integrated care, as discharge is often a point at which care is highly fragmented. However, the focus on the 'back door' of the hospital has sometimes meant that less progress has been made on other parts of the patient pathway, in particular prior to hospital admission. All of the hospitals involved in our research were working with community partners to find ways of preventing avoidable hospital admissions among high-risk groups. However, there was a perception in some areas that less emphasis had been placed on upstream work, for example, on preventing deterioration among people with long-term conditions, or promoting community resilience.

Commissioners in some areas also reported that acute hospital leaders risk trying to push the integration agenda too quickly, without building sufficient consensus among local partners. Again this was seen to be related to the urgency of the financial pressures facing acute hospitals and the need among acute sector leaders to meet their own organisational imperatives. Conversely, there was often a sense of frustration among hospital leaders that partner organisations were unable to move at the kind of pace demanded by the current contextual challenges. The danger is that by attempting to drive integration at pace, acute hospital providers risk being seen as expansionist or self-interested by local partners. This underlines the importance of working in partnership and building a shared vision for integrated care (*see* section 3).

In all of our case study sites, integrated care is being targeted largely at the highest-risk patient groups, with a particular focus on frail older people, and in some cases on people with multiple long-term conditions regardless of age (for example, in Yeovil). Some areas are looking to extend their focus to other patient groups where fragmentation of care has been found to be a significant problem, for example, children and young people (in Northumbria). We have previously argued that while focusing on high-risk groups is an appropriate place to start, the next step for integrated care will be to incorporate a population-health perspective into integrated care which takes account of the needs of the whole population (Alderwick *et al* 2015). We develop this argument further, particularly in relation to the role of acute hospitals, in section 7.

③ Building shared governance arrangements across the local system

Providing high-quality services to patients and communities increasingly requires acute hospitals to work in partnership with other local organisations, including social care, primary care and other community-based services. As described in the previous section, the hospitals involved in our research saw partnership working not only as a foundation of high-quality care, but also as a key strategy in securing the sustainability of the hospital.

Developing effective structures to support partnership working has been an important focus in all of our sites. Regular meetings are held bringing together the leaders of all the key health and social care organisations in the local area. In the most successful examples, these meetings have gone beyond being merely a forum for discussion and strategic co-ordination, and have evolved into more sophisticated whole-system governance arrangements in which all partners are held jointly accountable for delivery against shared performance metrics. The critical ingredients in building a sense of shared accountability across the system include:

• a shared vision and strategy for integrated care, so that the individual projects stemming from partnership working have a strategic coherence to them

• a governance structure that makes it clear which organisations are accountable for each aspect of delivery

• agreeing common metrics for defining success, and monitoring performance against these regularly.

In Sheffield, the Right First Time programme has provided a highly effective platform for partnership working across the city, including health and social care. Senior leaders report that after some time, programme board meetings began to have the character of executive meetings of a single organisation, rather than

multi-agency meetings. The strength of this relationship is supported by the fact that the partner organisations involved all cover roughly the same geography, and by the stability of leadership and high-level relationships in the city. At its best, the Right First Time partnership has enabled organisations in the city to agree and implement rapid service changes involving close co-ordination of inputs from health and social care that interviewees believed would have taken a year or more of negotiation under previous arrangements, and may never have happened at all. Further information on Right First Time is given in the box, .

The use of shared metrics as a way of assessing whole-system performance is a key feature of partnership working in the two areas covered by Northumbria Healthcare NHS Foundation Trust – Northumberland and North Tyneside. In addition to 18 metrics used internally within the acute trust for measuring integrated care, eight system-wide metrics have been agreed for use across the two areas. Progress against these metrics is monitored in each area through a bi-monthly integration board meeting involving commissioners, NHS providers and social care. The eight system-wide metrics are:

- total bed days

- non-elective admissions in the last 100 days of life

- hospital admissions for ambulatory care-sensitive admissions

- patient health status (assessed using the EQ-5D tool)

- experience of co-ordinated care (patient- and carer-reported)

- ability to self-manage care

- provision of anticipatory care plans

- care home admissions.

Airedale also provides an example of well-developed governance arrangements for partnership working. All local partners, including NHS organisations and the local authority, have signed up to a five-year Right Care strategy, which emphasises overcoming organisational boundaries, a more proactive approach to care, a focus on health and wellbeing as well as illness and supporting more people at home. The senior leadership of local commissioning and provider organisations attends a monthly integration and change board, which is accountable to the health and

wellbeing board. The integration and change board sets the strategic direction and has developed a shared five-year plan. Beneath this are two transformation and integration groups, chaired by the two local clinical commissioning groups (CCGs), responsible for implementing the plan in their respective geographical areas. Local system leaders have also developed the concept of a Bradford and Craven mutual as a way of encouraging partner organisations to think of themselves as leaders of the whole system and to act as if part of a single organisation. There is no current proposal to form a single mutually owned organisation, but the concept is used to foster system leadership behaviours.

A number of lessons can be learnt from the experience of building partnerships in our case study sites. First, a common theme across these examples is that they demand a new model of leadership based on shared accountability for collective performance. In section 8 we discuss the kind of acute sector leadership that will be needed if hospitals are to play an active part in integrated care, and the importance of supporting the development of these forms of leadership across the health and social care system.

Second, where collective system leadership is most advanced, this has been the culmination of relationship-building activities that have taken place over several years. Developing the necessary trust and a common understanding of the future was a long journey in all of our sites, requiring sustained commitment and effort.

Third, while several areas have succeeded in agreeing a shared strategic plan supported by all of the main local partners, implementation can be more challenging. Roles and responsibilities have to be clarified; there is a tendency for some acute hospital providers to assume that they will be leading the development of integrated models of care and in some areas we observed a risk that this could deter GPs and other community providers from engaging.

Fourth, integration of mental and physical health care was often identified as a significant opportunity that had so far not been given sufficient emphasis in partnership arrangements. Although mental health providers were often included in these arrangements, and there have been some specific projects targeting this aspect of integration (for example, work in Sheffield focusing on the physical health of people with serious mental illnesses), it was widely considered that there remains significant scope to do more on this, particularly in relation to patients with multiple

co-morbid conditions. Several interviewees argued that the next phase of their work locally should include a focus on mental health integration, for example, increasing psychological input to multidisciplinary teams supporting people with long-term conditions.

The Right First Time partnership in Sheffield

Right First Time is a city-wide partnership established in 2011 bringing together commissioners and providers on an equal footing. It includes the local acute trust, mental health trust, children's trust, CCG and local authority, all of which cover roughly the same geographical footprints.

The Right First Time board includes the chief executives of these organisations and meets quarterly to discuss system-wide challenges. These meetings create a neutral space in which commissioners and providers can work together, and were reported to have supported very open and transparent (and at times challenging) dialogue.

In addition to the board, there are a number of other points of connection between partner organisations. A partnership executive group reporting to the board meets on a more regular basis, and weekly meetings were established for senior leaders from across the system to discuss patient flow in and out of the acute hospital.

Those involved said that the Right First Time partnership gives local organisations a way of managing across the system and responding to pressures in a rapid and flexible way. At its best, system problems are solved 'almost as easily as if we were part of one organisation'. For example, a significant shift of resources towards intermediate care and community re-ablement was agreed and implemented over a period of just two months.

The trust and relationships developed through Right First Time have allowed partner organisations to align systems and experiment with different approaches to integration, for example, involving the transfer of staff from the local authority to the acute hospital trust.

In its first three years, the partnership also involved the delivery of a programme of work structured around 4 key project areas and approximately 20 work streams. This collaborative work is overseen by a programme director equally accountable to all five sponsoring organisations.

Its governance arrangements are currently evolving, with the creation of a new integrated commissioning programme and a separate joint provider executive. The two bodies will have distinct responsibilities in terms of delivery of the Right First Time projects. The

integrated commissioning programme will be responsible for commissioning the projects using a pooled budget, with these then being provided either by the joint provider executive (working collaboratively), in some cases by the individual organisations involved, or potentially by other providers outside this group. These new arrangements were seen as being more compatible with competition law.

Under these new arrangements, joint working between commissioners and providers will focus specifically on those things that commissioners and providers need to do together, for example, improving information sharing, but will not include any contractual discussions.

The Sheffield joint provider executive is currently an informal partnership but could evolve into something more formal over time – for example, some form of integrated care organisation or accountable care organisation. The purpose of the executive is to deliver an integrated provider response to the integrated commissioning agenda.

Engaging GPs in the Right First Time governance structure has been an important and ongoing challenge. A GP provider board is currently being established which will sit alongside the Right First Time structures. In addition to this, there is the potential in future for federated forms of general practice to join the joint provider executive or any integrated care organisation that evolves from this. The four GP provider companies in Sheffield, dating back to practice-based commissioning, are currently engaged in discussions about creating a single trading voice for primary care in the city, which could then enter into joint ventures with the three foundation trusts.

Outcomes are monitored through a monthly dashboard, which is shared across organisations. Data indicates a number of successes since Right First Time was initiated, including a reversal of the upwards trend in preventable bed usage, with a significant drop in bed usage among people with ambulatory care-sensitive conditions observed in both 2012/13 and 2013/14.

For more information contact: Stephen Haigh (**stevenhaigh@nhs.net**), Sheffield Joint Provider Partnership Lead and Director of GP Provider Board.

Working in partnership with primary care

The missing link in many of the most successful examples of partnership working is primary care. Acute hospitals in our research reported encountering major difficulties in engaging primary care at scale, with this being consistently identified as a priority for the future. This mirrors the experience of local system leaders involved in the Department of Health's 16 integrated care pilot sites, many of whom

described engaging general practice as one of the most significant barriers to progress (Ling *et al* 2012).

> *We need to abolish the primary/secondary distinction and replace it with a continuum of care.*
> Acute trust chief executive

An important message from our research was that there is often no alternative to building relationships on a practice-by-practice basis, and many of the acute hospitals involved in our research have invested considerable resources in doing so. For example, senior hospital leaders in Yeovil and Airedale reported spending a significant amount of time visiting local practices and attempting to strengthen relationships, including a 'closing the gap' programme in Airedale which aims to bring primary and hospital-based care closer together.

GP provider groups or federations represent one level at which an acute hospital provider could build a relationship with general practice. However, these are still at an early stage of development in many areas of the country, and where they do exist it is not always clear that they are sufficiently cohesive to represent local practices and have leverage over them. A lesson from our case study sites was that while the presence of a local federation may be helpful, it does not necessarily remove the need for practice-by-practice engagement.

To varying degrees, the acute providers in most of our case study sites have attempted to stimulate and support the formation of GP federations. Northumbria Healthcare in particular has been highly active in this role and has offered significant support to primary care. The trust is a formal member of two of the four federations in its local area, and has had some involvement in the development of all four (to varying degrees) – *see* box, **pages 25-26**, for further information about partnership working between Northumbria Healthcare and primary care. The trust's leaders identify federated general practice as a key enabler to integrated care – however, it should be noted that considerable groundwork had been done in building relationships with individual practices prior to federations being established.

In some of our case study sites acute hospitals and other providers had attempted to engage with the local CCG, seeing this as a route into primary care. While it

is clearly important for acute providers to have a close relationship with CCGs, the lesson from our sites was that these cannot function as an adequate proxy for primary care – as the role of the CCG is fundamentally about commissioning rather than provision.

Despite the resources invested in engaging primary care, most areas reported that there was still a long way to go in terms of the relationship between acute hospitals and GP practices. Hospital leaders often felt that the best tactic was to focus on those practices where the relationship was strongest and where there was a willingness to explore new ways of working, in the hope that successful innovations would then spread to other practices.

Part of the challenge in building partnerships between acute hospitals and primary care is the need for trust and understanding of each other's perspectives. In many cases, acute hospitals attempting to engage local primary care providers have been met with concerns about 'empire building'. Even in areas where acute trusts have been highly proactive in engaging general practice, overcoming these sentiments remains a challenge. The most progress has been made when acute hospitals have been able to frame their offer to primary care in terms of helping to lift some of the pressure off GPs. Other enablers reported included:

- direct contact between senior hospital leaders and GPs, for example, through regular practice visits, or via engagement with GP federations where these exist

- a history of joint working between the acute trust and primary care

- strong clinical leadership in general practice

- employing people with a primary care background at a senior level within the acute provider

- telephone advice lines for GPs staffed by acute hospital staff

- joint educational sessions for GPs and consultants

- working groups including primary and acute care professionals as part of local programmes on integrated care

- inviting feedback from GPs by email on pathways developed by consultants

- 'going with the energy' – for example, piloting new care models with one or two supportive practices before extending the offer to others.

Working with primary care – Northumbria Healthcare

Northumbria Healthcare NHS Foundation Trust has a long history of partnership working with primary care. Among other factors, this has been supported by the strong presence of GPs in senior leadership roles at the trust, as well as longstanding collaboration over clinical decision-making.

Today, the trust supports joint working with primary care in a number of different ways. At a clinical and service level, the trust works with primary care through a range of programmes developed to integrate services for older people and patients with complex needs – most notably the High Risk Patient Programme described elsewhere in this report (*see* box, **pages 41-43**).

The trust also provides specialist services on-site in a small number of general practices. For example, since 2006 the trust has worked with a local primary care provider, Ponteland Medical Group, to deliver specialist clinics in the Ponteland Primary Care Centre — including orthopaedics, gynaecology, gastroenterology, podiatry and basic day-case surgery. The trust and the medical group now work together to provide these services through a joint venture, called Pointnorth Community Interest Company, pooling primary and secondary care expertise for local patients.

Some GP services are also delivered at Northumbria's hospital sites. Two general practices are hosted on-site at Hexham hospital, and others are exploring how they can do the same as part of the organisation's reconfiguration plans (*see* **page 31**). The trust has also established a number of joint posts with general practices to share expertise and offer new career options, including jointly held positions for GPs who split their time between general practice and one of the trust's hospitals.

The trust is also taking on responsibility for the delivery of general medical service (GMS) and personal medical service (PMS) contracts in two general practices through Northumbria Primary Care Ltd – a new company set up by the trust to provide support to primary care. Under this model, GPs at these two practices have subcontracted the delivery of their GMS and PMS contracts to Northumbria Primary Care Ltd, which now directly employs these GPs and other practice staff.

Over time, all of the support that the trust provides to primary care will be delivered through Northumbria Primary Care Ltd – including the range of 'back office' support services that the trust already provides to many general practices, such as payroll, human resources and occupational health functions. It is expected that a number of other practices will work with the trust through Northumbria Primary Care Ltd to support the direct delivery of primary services over the coming years.

The trust has also supported broader primary care development in a number of ways. For example, the trust has actively supported its local practices to develop into federations – for example, through contributing legal fees and other set-up costs – and is a member of two out of the four GP federations that now exist in Northumberland and North Tyneside. The trust also recently established a series of one-day training events for local GPs and practice staff called the Excellence Through Collaboration programme, which offer a chance for GPs to receive training, share learning with hospital consultants and build relationships with acute care staff. Three of these events took place in 2014, attended by more than 650 GPs.

Barriers to partnership working

It was clear from our research that the current financial climate has often put local partnership arrangements under considerable pressure. Even the strongest partnerships are tested when resources are scarce – and in all of our case study sites we heard examples of providers adopting protectionist behaviours and retreating into their organisational silos when competition for funding became most extreme (for example, in relation to system resilience monies). This was often exacerbated by the scale of the cost improvement programmes that many trusts were seeking to deliver, which typically focused on care delivered within the organisation rather than care delivered in partnership with others.

In some areas, acute hospital leaders felt that the structural reforms initiated by the Health and Social Care Act 2012 made it necessary for them to take a leadership role on integrated care. Acute trusts were seen as having provided leadership at a time when primary care trusts and strategic health authorities were in the process of dissolution and while CCGs were still finding their feet. As CCGs begin to assert themselves, this leadership role is now being contested. We saw some examples where the CCG's view of the best pathway towards integrated care is beginning to diverge from the acute providers', even where there is a shared vision of the end destination. This will undoubtedly be a thorny issue in some local areas. In **section 9** we discuss whether the system leadership needed for developing integrated care needs to come from commissioners, providers or both.

4 Horizontal networks between acute hospitals

In addition to closer working with primary care, social care and community services, integrated care can also involve neighbouring acute hospitals in finding new ways of collaborating to improve the service delivered to patients. It is becoming increasingly common for some acute care services to be delivered jointly by two or more acute hospitals working together. The review of future organisational options recently conducted by Sir David Dalton envisages acute hospitals working together to a much greater extent in future, in order to spread good managerial and clinical practices and to ensure that struggling providers receive the support they need to improve (Department of Health 2014).

The networking arrangements developed in the NHS so far are varied and our case studies reflect the guiding principle of the Dalton review that 'one size does not fit all' when it comes to new organisational models. This section examines the horizontal networking arrangements that have developed in our case study sites.

The benefits of collaboration between neighbouring trusts were clear to the organisations involved in our research. These include:

- maintaining local access to clinical services which might otherwise not be sustainable due to workforce shortages or increased staffing demands related to new clinical standards

- achieving economies of scale through sharing functions that need not be limited to a single site.

Small hospitals in particular could benefit from networking arrangements. Monitor's recent review of the future of smaller acute trusts found that many of these will continue to face significant pressure from increasingly demanding clinical guidance, greater specialisation in the medical workforce and perverse incentives created by existing payment systems (Monitor 2014b). The King's Fund's research on reconfiguration found that networked solutions were used infrequently in the

English NHS during acute clinical reconfiguration processes, with trusts instead opting to close or 'downgrade' services rather than seek partnerships with other acute trusts that might have sustained them (Imison *et al* 2014).

There are a number of networking models that could help in promoting the sustainability of acute hospital services, most of which were in use in our case study sites. These are summarised in Table 1 and described below.

Table 1 Examples of networking models in acute hospitals

	Intra-organisational networking	Inter-organisational networking
Same service(s) provided across the network, with shared workforce	**Rotation of clinical staff** across different hospitals in multi-site trusts, eg, Northumbria Healthcare	**Joint ventures** for pathology in Yeovil and Northumbria Healthcare
		Visiting services for ENT and neurology at Yeovil District Hospital, or for elective vascular surgery in South Warwickshire
		Service-level management franchise arrangements eg, for ophthalmology services at Yeovil District Hospital
Different service provided by each site in network	**Reconfiguration of emergency care** services across hospital sites within Northumbria Healthcare	**Regional networks** for specialist cardiovascular services and major trauma, as seen across England
		Risk-tiered networks in maternity or paediatrics, as recommended by Monitor (2014a)

Joint ventures

Some trusts have set up joint ventures to run clinical support services or 'back office' functions on a shared basis. This involves two or more organisations pooling sovereignty into a separate legal entity to manage a particular service, in order to realise the economies of scale that would otherwise be beyond the reach of individual organisations. For example, pathology services are being run through joint ventures with neighbouring trusts in several of our case study sites, including Yeovil and Northumbria Healthcare. Airedale NHS Foundation Trust is part of a joint venture, Immedicare, with a commercial technology company. Immedicare is used as a vehicle for delivering telehealth services to care homes, prisons, private homes and other settings across England (*see* box, **page 66**).

Visiting services

Workforce-sharing arrangements between organisations have also become more common across the NHS in England. Yeovil District Hospital hosts visiting services for two specialties from two different neighbouring NHS trusts. Clinicians from Dorset County Hospital operate ear, nose and throat (ENT) clinics and a neurology team based in Taunton also operate their clinics at Yeovil. This enables patients to access services on the Yeovil site, rather than having to travel to other hospitals located further away. Similarly, elective vascular surgery is provided in Warwick Hospital by a visiting surgeon from the regional centre in University Hospital Coventry.

Service-level management franchise

A growing number of hospital services are provided through management contracts where an external organisation operates a set of services in a trust's hospital facilities. Many of the hospitals in our case study sites provided some services on this basis, particularly smaller hospitals in rural areas. For example, Yeovil District Hospital credits its ability to continue provision of ophthalmology services on-site to the three-year arrangement reached with Circle Bath, an independent care provider. Circle provides operational management for the care on the Yeovil District Hospital site and also provides remote access to clinical specialists. The consultants delivering the service are employed by the NHS trust.

Networks within multi-site trusts

While the above models are based on collaboration between separate organisations, networking arrangements can also exist within a single trust. Some multi-site trusts have a sufficient number of hospital sites to allow them to realise the benefits of horizontal networking by promoting collaboration between sites, and then differentiating and co-ordinating the services provided in each. Northumbria Healthcare NHS Foundation Trust provides one example of an organisation that is moving towards this kind of approach (*see* box, **page 31**), facilitated by workforce sharing across sites and clinicians being contracted to the trust rather than to particular hospital sites.

Regional clinical networks for specialised services

Major national reconfiguration programmes have resulted in most acute hospitals in England becoming part of clinical networks for specialist cardiovascular services, major trauma services and hyper-acute stroke treatment. Perhaps the most high-profile example is the reconfiguration of major trauma services, where patients who have major injuries are directed immediately to a regional specialist major trauma centre, bypassing closer but smaller units. These arrangements are common in our case study sites as elsewhere in England.

Risk-tiered networks

In some service areas, it is possible to assess the level of risk patients face during treatment with a sufficient degree of confidence to treat them in a less intensive environment or using an alternative, narrower skillset. In a risk-tiered network, some provider sites focus on low-risk patients, with standardised protocols for prompt escalation or transfer to other sites when necessary. None of our case study sites were currently using this approach, but some discussed the potential to use risk-tiered networks in future to sustain local access to maternity and paediatric services. The recent work by Monitor (2014a) exploring international models of acute care concluded that there is significant scope for risk-tiered networking in the United Kingdom, and emphasised the importance of clearly defining the boundaries of the roles played by each site when using these kinds of networks.

The future of networking in the acute hospital sector in England

As outlined above, horizontal networks are now common for the delivery of more specialised hospital services in England. Our research suggests that in the future, these kinds of approaches are likely to be used for a growing range of services, including services that are currently considered to be 'core' acute hospital services, including paediatrics, maternity and general surgery. None of our sites had plans to reconfigure these services in the immediate future, but hospital leaders reported that a number of factors will make it increasingly likely that these kinds of options will be explored in the near future. The drivers for this include financial pressures, workforce recruitment issues in some areas and increasingly taxing clinical standards. Networks may offer opportunities to maintain local access to services in the face of these pressures and to improve the efficiency with which patients can be treated.

A networked hospital system in Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust plans to develop a networked hospital system that will separate emergency acute services from elective services. The hub of the network will be a new specialist emergency care hospital at Cramlington, due to open in June 2015. Serving a population of around 500,000, this will be the first hospital in the NHS dedicated exclusively to emergency care.

The hub will be surrounded by three 'base sites', based on the existing acute hospitals at Hexham, Wansbeck and North Tyneside. The trust plans to use the space created by removing urgent care services from these hospital sites to provide a wider range of services within the hospital, including GP services, social care services, post offices and other community facilities – transforming these buildings into 'health campuses'. The base sites will continue to provide elective surgery, rehabilitation and step-up and step-down services (providing an intermediate level of support between acute care and less intensive forms of community support).

One of the ways that the trust facilitates the emerging network approach is by employing clinicians as employees of the trust, rather than as employees of specific hospitals. This enables them to create job plans involving roles in multiple sites and instils the expectation that clinical staff may be needed to travel and spread their time across several locations if patient needs are best served by this.

Northumbria's hospitals will continue to operate as part of larger regional clinical networks. It already has processes that direct patients to neighbouring centres in other trusts for major trauma, vascular surgery and some specialist paediatric services.

The policy drive to provide seven-day services in acute care is expected to prompt greater use of networks. In particular, it may cause some trusts to seek out networked arrangements for clinical support services such as diagnostics or pathology. However, it is also possible that the policy may encourage some trusts to consolidate and retain their workforce rather than share staff with neighbouring organisations, to ensure that they are able to operate throughout the week on their own sites.

Trusts pursuing networked options will need to co-operate across organisational boundaries to co-ordinate care in different locations, particularly when employing and deploying the clinical workforce. Some of the trusts involved in our research

reported concerns that smaller organisations tend to lose out in arrangements like this. For example, staff shortages can mean that services are temporarily cancelled. When this happens, the services provided by the 'junior' partner are reportedly more likely to be affected. This underscores the importance of developing robust workforce-sharing agreements that mean the response to staff shortages depends upon the interests of patients seen across the network, rather than on the interests of the dominant provider. Joint appointments of key members of the workforce or even whole teams might help to facilitate this more equitable partnership working by formalising the responsibilities of both parties.

5 Breaking down the silos within combined acute-community trusts

The previous sections have examined how acute hospitals are attempting to give patients a more integrated experience of care by building shared governance structures and networks with other organisations. The focus of this section is change within rather than between organisations. This is particularly relevant in the case of combined acute and community trusts. A significant minority of acute hospital providers in England also provide a range of community services, having taken over responsibility for providing these services from 2009 onwards as a result of the Transforming Community Services programme.

The stated aspiration of combined acute-community trusts has often been to integrate the two parts of their portfolio so that service users requiring both hospital and community care experience better co-ordination and smoother care transitions. Curry and Ham (2010) have previously argued that organisational merger is neither necessary nor sufficient for integration to take place at the clinical and service level – reflecting research evidence that organisational mergers in health care often fail to deliver the intended results (Fulop *et al* 2002). The findings of our research support this conclusion, but also highlight some of the benefits that can potentially follow from integration at the organisational level when this is supported by a sustained focus on bringing services together at the clinical level.

Although the focus of this section is on integration within combined acute-community trusts, similar issues apply in all acute trusts, where integration within the organisation includes changes within the hospital itself to improve patient flow and co-ordination between departments. The experience of our case study sites was that this contributes significantly to some of the improvements achieved, such as reduced length of stay. A description of efforts to improve patient flow in South Warwickshire and Sheffield is provided by the Health Foundation (2013).

Stretching beyond the hospital campus through organisational integration

In four of our five case study sites, the acute hospital provider also provides community services previously run by primary care trusts. In the case of Northumbria Healthcare, the trust also provides adult social care services for parts of the area it covers. A very strongly held view among a number of interviewees – including people inside and outside the acute trusts – was that providing community and social care services had encouraged acute trusts to shift their focus and engage in conversations about strengthening care out of hospital. While this had not necessarily happened immediately, the widespread perception was that the provider's view of their role had changed so that trust leaders now saw themselves as having a much wider role in their local health system. In short, they saw themselves as an integrated care organisation rather than an acute hospital provider with community services 'bolted on'.

> *Being an integrated community and acute provider means that it's completely in our interests to decrease our dependence on acute beds.*
> Acute trust medical director

It should be noted that this transformation may not have been mirrored in all of the acute trusts across England that now provide community services. Our sites were selected as innovators rather than being a representative sample, and other research has indicated that some combined trusts still have a considerable distance to travel before community services receive the same amount of board-level attention as acute services (**Foot** *et al* **2014**).

Where integration of acute and community services appears to have been most successful, staff report that teamworking (particularly at the point of admission and discharge) is becoming 'bread-and-butter'. Many of those working within combined acute-community trusts argued that organisational integration has made it quicker and easier to redesign services and improve co-ordination and continuity of care. Often the basis of these statements was the 'natural experiment' created by the comparison between two geographies covered by the organisation. For example, South Warwickshire NHS Foundation Trust provides community services for the whole of Warwickshire, but is the acute provider for only the south of the county. Interviewees from the trust argued that discharge processes are now significantly smoother in the south as a consequence of organisational integration.

A similar natural experiment exists in the case of Northumbria Healthcare. In Northumberland, Northumbria Healthcare provides adult social care services alongside acute and community services, whereas in North Tyneside social care services are still provided by the local authority. The perception of senior leaders in Northumbria Healthcare is that integration of health and social care at the clinical and service level is easier and quicker to bring about in Northumberland as a consequence of organisational-level integration.

> *[Organisational integration] means that you can just do stuff so much quicker.*
> Acute trust medical director

The argument that integration at the organisational level can deliver a number of benefits received some support from the integration metrics monitored in Northumberland and North Tyneside. As an area, Northumberland appears to be starting to outperform North Tyneside against some of these metrics, for example, emergency readmission to hospital within 30 days for patients aged 75 years and over. However, multiple factors may be involved in this difference and causality is difficult to prove without more detailed analysis.

Realising the benefits of organisational integration

Whatever the potential benefits of organisational integration, it is clear that the successes reported above were not achieved as an automatic consequence of organisational change. Instead, they represented the culmination of sustained effort aimed at nurturing a single organisational culture and integrating care at the clinical and service level, often over several years. A number of practical measures were described that helped in breaking down cultural and practical barriers between acute and community services. A common theme is the importance of building individual relationships between professionals working in different services, and the power of face-to-face communication in this. For example, in Sheffield the following were identified as important:

- having someone at a senior level within the organisation with a background in community services

- creating opportunities for personal contact between acute and community nurses to build relationships, including by encouraging senior

acute nursing and midwifery staff to conduct frequent community visits, for example, shadowing community staff

- joint consultation events bringing all staff groups together to discuss new proposals using a 'big room' approach

- ensuring representation from acute and community services in work streams developing new models of care

- focusing on improvements in patient care, using tangible changes and 'early wins' to demonstrate the patient benefits of integration

- regular communication and updates informing teams about strategic priorities and integration programmes.

Clinical leaders within the trust had been instrumental in all of the above. Perhaps as a result of these measures, staff engagement levels in the community services directorate at Sheffield Teaching Hospital are now higher than in the trust's other directorates.

Effective governance structures are important in bringing together acute and community services. In Northumbria Healthcare, an internal governance system has been developed to support integration across the trust's five business units, led by an integration committee. Business units operate with a high degree of autonomy, including budgetary responsibilities and their own board that is held accountable for performance. The integration committee is responsible for strategic oversight of all integration work across the business units. There is senior representation on the committee including non-executive directors. The committee tracks progress by monitoring 18 metrics that measure the impact of integration across the whole organisation and produces an annual report to the trust's board.

Research on specialists working outside hospitals has highlighted that developing job roles that span acute and community settings can also serve as an important way of integrating services in combined trusts (**Robertson** *et al* **2014**).

The limitations of organisational integration

Despite these efforts and their perceived successes, it was clear that integration of community and acute services is an incomplete and ongoing process in all of

our case study sites, and cultural barriers and an implicit hierarchy often remain. For example, representatives of the local authority in one area remarked that they still observe a hierarchy within the acute trust, with community service leaders rarely challenging their acute sector colleagues when working out operational issues. Mindset shifts in an organisation's senior leadership are not necessarily reflected at all levels in the clinical and managerial workforce, and new values take time to diffuse through the organisation. Some felt that further changes to medical and nursing education are needed to ensure that new trainees do not replicate longstanding professional divisions, for example, between acute and community nursing. Differences in reimbursement models also continue to have an impact, with community services typically on block contracts and acute services on activity-based Payment by Results.

It was also clear that although organisational integration may help facilitate service transformation in some situations, it is also possible to achieve many of the same benefits through successful partnership working. There were a number of examples in our case study sites of integrated working involving teams of professionals employed by separate organisations (*see* section 6). While some acute hospital leaders felt that further organisational integration would be helpful, there will always be a need to work in an integrated fashion with other organisations, and to understand how to do this effectively.

> *It doesn't matter who owns the service but it definitely does matter how they collaborate.*
> Integration programme director

6 Integrated service models

The organisational- and system-level innovations described so far in this report are of little value unless they translate into integrated service models at the clinical level that deliver better outcomes and a more co-ordinated experience for patients. In this section we summarise some of the main successes in our case study sites in terms of developing integrated models of care.

There are a number of examples of improved co-ordination and integrated teamworking across our case study sites. The main text of this chapter describes common elements frequently found in these service models, with the details of five specific examples in the boxes, .

Common elements of integrated service models

Although different models have been developed in each of our case study sites, there were a number of common elements. These are summarised in Table 2 and described in greater detail below.

Table 2 **Common elements of integrated service models developed in case study sites**

Pre-admission	Pre-discharge	General
Risk profiling of the population	Early comprehensive geriatric assessment	Support for self-care
Multidisciplinary teams	Trusted common assessment	Use of new technologies
Locality focus aligned with general practice	Discharge planning and 'man marking'	
Rapid response teams for patients at high risk of admission		

Risk profiling of the population

The integrated service models in operation in our case study sites were targeted largely at frail older people who are at highest risk of acute hospital admission or who require significant support to remain in their own homes. Most sites were focusing on the top 0.5 per cent to 2 per cent of patients most at risk of hospital admission – 'the very tip of the pyramid', in the words of one interviewee. All sites anticipated widening the scope of their activities beyond the top 2 per cent over time.

Multidisciplinary teams with input from a wide range of professionals

Community-based multidisciplinary teams were commonly used to co-ordinate inputs from a wide variety of professionals. Exact team composition varied between sites, but often included:

- community nurses

- occupational therapists

- physiotherapists

- social workers

- specialist input from acute services

- community psychiatric nurses

- GPs

- non-professional generic workers who performed strictly delegated tasks.

These teams offer holistic assessment of patients' health and social care needs, with team members then co-ordinating and often directly providing the care to meet those needs. Team members were not always employed by the acute trust, and the reported effectiveness of teamworking varied across sites.

Locality focus aligned with general practice

A successful strategy for areas operating risk stratification was the alignment of multidisciplinary teams with groups of local GP practices, allowing interventions

agreed at the team meetings to be co-ordinated with GPs across the local area. In Northumbria, consultant geriatricians are allocated to support each locality, creating a link with the acute services. In Sheffield, the multidisciplinary teams provide 'virtual wards' in each local area for the 20 per cent of patients at highest risk of admission.

Rapid response teams for patients at high risk of admission

Another strategy used to reduce avoidable admissions was a team who could respond rapidly to requests for help from GPs. These generally feature health and social care staff who deliver care and support and initiate the process of arranging longer-term support. For example, in South Warwickshire, community emergency response teams attend patients' homes within two hours of a request from local GPs. In Sheffield, GPs can use a single point of access to seek the advice of multidisciplinary teams and request support from community-based health and social care professionals who are able to visit patients in their own homes.

Early comprehensive geriatric assessment

Case study sites with enhanced pathways for frail older patients all operated some form of consultant-led geriatric assessment at an early stage during the patient's hospital stay. The importance of a holistic assessment of patient needs is emphasised by Oliver *et al* (2014). This assessment informs the planning of care throughout the patient's hospital stay and (importantly) after discharge. Interviewees stressed the benefit of setting a realistic discharge date based on this assessment as soon as possible.

Trusted common assessment across health and social care

Some of our case study sites had invested significant effort in ensuring that assessments of patients' needs were universal, and would be accepted by all professionals, regardless of their employing organisation or professional background. This meant implementing common protocols, shared information platforms and encouraging the workforce to recognise the skills and backgrounds of other professionals. This removes duplication and means that patients only need to be assessed once.

Discharge planning and 'man marking' through the hospital

Teams with responsibility for arranging support for patients after discharge were a common feature across the case studies. These teams work to move patients along the discharge pathway as soon as possible, following the patient through the acute hospital and into the community. They place patients in residential or nursing homes, or in their own home, and arrange and provide the necessary support for those patients. The teams tend to be integrated health and social care teams, led by nurses from community services. In South Warwickshire, the teams have access to beds in the community associated with the Discharge to Assess programme.

Use of new technologies

Several of our sites use new technologies in innovative ways. The Airedale telehealth hub is particularly noteworthy (*see* box, **pages 66-67**). It delivers clinical benefits by enabling senior acute care nurses to support residential and nursing home workers and patients in their own homes. Nursing staff help those using the service to deal with problems or exacerbations that could lead to admission. Their 'Gold Line' service gives palliative care patients a telephone or video link from their own home to nurses at the hospital who provide support and advice.

Support for self-care

A focus of activity in many areas is providing better support for patients to look after their health and manage their own conditions. For example, Airedale's Right Care strategy involves a number of measures designed to help patients look after themselves better, including self-management training delivered through multidisciplinary teams. There is also a plan to provide a digital workspace through which patients can monitor their condition, communicate with peers and professionals, and connect to Airedale's telehealth facility in the event of an exacerbation in their condition.

> #### High Risk Patient Programme in Northumbria Healthcare
>
> The High Risk Patient Programme focuses on co-ordinating services for older people and people with long-term conditions at high risk of hospital admission in Northumberland and North Tyneside. The programme has been running since 2012 and involves integrating

services across primary, community, secondary and social care though locality-based multidisciplinary teams working in general practices and aligned with hospital services.

The key service processes of the programme include:

- identifying high-risk patients in general practice

- creating a practice high-risk register

- carrying out an initial nursing assessment for these patients

- holding regular practice-based multidisciplinary team meetings

- assigning a 'key worker' for each patient

- undertaking care planning and tailored reviews

- holding complex case conferences as necessary.

The core make-up of the locality-based multidisciplinary teams includes community nurses, social workers, consultant geriatricians and pharmacists, working alongside general practices. The programme initially aimed to reach the top 0.5 per cent of the population at risk of hospital admission, but this target group has been extended to 2 per cent as a result of the unplanned admissions enhanced service specification for general practices in 2014/15 (this asks practices to use risk stratification to identify a minimum of 2 per cent of the practice's adult population to case-manage proactively).

In 2014, all 74 general practices across Northumberland and North Tyneside were signed up to deliver the programme, although its implementation and success have varied significantly.

In Northumberland, the programme is co-ordinated by a dedicated board, which reports into Northumberland's whole-system integration committee. Programme partners have established 'clinical testing panels' to periodically assess the service and identify opportunities for improvement. Each quarter, general practices are asked to produce two written examples of cases where the programme has or has not worked well. A selection of these cases are then analysed by multidisciplinary clinical panels, and key issues are identified and communicated to relevant parts of the system. A similar process is also carried out with patient groups.

Evaluating the impact of the programme has been difficult for local partners for a number of reasons – not least because of the range of overlapping interventions across the system aimed at improving care for this population group. Recognising these limitations, Northumbria Healthcare's internal evaluation between 2012/13 and 2013/14

suggested that the programme contributed to a reduction in non-elective admissions for this group of the population, as well as savings for commissioners of around £4 million as a result. However, these reductions in non-elective activity appear to have been reversed in 2014/15. Formal evaluation of the programme has been commissioned by Northumberland Clinical Commissioning Group (CCG).

Active Recovery Pathway in Sheffield

In Sheffield, patients needing rehabilitation support after discharge from the acute hospital are referred into an active recovery pathway. This is delivered by an integrated service bringing together health and social care professionals (including therapies, care support workers, community nurses and others).

The service consists of two components – a short-term intervention team (provided by social care) and a community integrated care service (provided by the NHS). Although health and social care staff are still employed by separate organisations, they work under a single management structure, and integration at team level is widely perceived to be excellent.

Generic assessments are conducted by nurses, occupational therapists or physiotherapists, requiring mutual trust and recognition of each other's skills. All professionals contribute to a single set of patient notes.

Since the Active Recovery Pathway was established, the accessibility of home-based rehabilitation after discharge is reported to have improved dramatically. Delays of one to two weeks have been replaced by maximum waits of a single day. It is also perceived to have been highly successful in bringing about cultural change and helping acute, community and social care professionals to better understand each other's skills and values.

The experience of the Active Recovery Pathway has been that highly effective integrated working is possible at the team level even when team members are employed by separate organisations. An advantage of setting up the team in this way is that it was significantly quicker than trying to transfer staff into a single organisation through transfer of undertakings arrangements.

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Collaborative care teams in Airedale

Enhancing intermediate care is an issue that has been given significant emphasis in Airedale. A single point of contact for all intermediate care services has been established and can be reached on a 24/7 basis. An important part of the approach being taken towards intermediate care is the development of collaborative care teams.

Airedale collaborative care team was initially established through practice-based commissioning, with a second team for the Craven area being set up on the same model more recently.

These are multidisciplinary teams that provide patients with step-up and step-down care, the majority of this being delivered in patients' own homes. They also support some patients in intermediate care beds delivered in nursing homes.

The team is predominantly led by district and community nurses, with input from occupational therapists, physiotherapists, social workers, community psychiatric nurses, specialists from the acute hospital and generic workers. Advanced nursing practitioners play a pivotal role in collaborative care teams, and there has been a significant investment in recruiting more nurses at this level.

Individual professionals are employed by their 'home' organisation and in governance terms remain accountable to that organisation. Nonetheless, teamworking is reported to be highly effective and Airedale collaborative care team is widely perceived to be one of the best examples of successful collaborative working in the area.

The balance of the teams' work is currently more on step-up support than step-down (with the exception of bed-based support which is mainly step-down). The local commissioner would like the collaborative care team to take a less reactive role, for example, doing more to prevent as well as manage acute exacerbations of chronic conditions.

Commissioners have chosen to expand the capacity of collaborative care teams – particularly in terms of the home care aspect of their work – as this has been found to be more effective and efficient than increasing the number of intermediate care beds.

The success of Airedale's collaborative care team is partly attributed to the fact that it was designed by the clinicians who would be involved in delivering the service.

Commissioners fund the whole team collectively, with funds then being distributed among the constituent providers as appropriate.

Multi-morbidity care model in Yeovil

Yeovil is implementing a multi-morbidity care model developed as part of the Symphony project. The approach is based on an economic analysis of local linked data conducted by the Centre for Health Economics in York, which showed that co-morbidities were the primary factor in demand for care resources, rather than age. As the number of conditions we have tends to rise with age, this still means the majority of patients will be older people, but a significant minority of younger multi-morbid patients (roughly 20 per cent) exists alongside them. Yeovil aspires to meet the needs of all patients with multiple conditions, applying the same principles for care across this group.

The model has three key components: the provision of care, self-management support and co-ordination of all this. It will initially cover a single cohort of patients with multiple morbidities in a geographic area based on clusters of GP practices. Within each of these clusters, there will be a hub – which could be based in a GP practice, community hospital or other facility – co-ordinating care across the patient population. The team for a given cluster will include a skilled generalist doctor (either a GP or a generalist physician from a hospital), care co-ordinators and health coaches. The hub team will work closely with GP practices, the hospital, community services and social care. The model puts emphasis on team members building long-term relationships with patients.

The hub doctor will work with the patient's GP, carers and other professionals, gaining knowledge of both the health and social factors in patients' lives in order to enable more personalised care for their long-term conditions. A care co-ordinator will manage the patient's transition from traditional pathways to the new one. Key workers will provide health coaching, helping people to care for their own long-term condition where possible. The intense support is intended to help to detect crises early and put in place measures to support people in the community, rather than result in an admission.

The leadership of Yeovil District Hospital expects the transition to the new care model to be costly in the near term, and projects deficits for the acute trust over the next three to four years. However, the long-term outlook would be a return to surplus as a result of more efficient use of resources across the health economy and significantly reduced activity in the acute setting.

Discharge to Assess in South Warwickshire

South Warwickshire NHS Foundation Trust, community care partners and social care worked together to develop the Discharge to Assess (D2A) programme that seeks to integrate acute and post-acute care.

After admission, patients undergo early, comprehensive geriatric assessment, visible to and trusted by all organisations involved in the pathway. They are placed on one of three pathways according to need:

- **Pathway 1** serves patients assessed as able to return home. They are provided with community rehabilitation care for up to six weeks supported by community emergency response teams, with ongoing support from primary care. Patients are also directly admitted to the social care re-ablement service without being re-assessed, as the services share a trusted assessment system.

- **Pathway 2** serves medium-high complex rehabilitation needs patients. Those with the most complex needs are discharged to a community hospital. Those with slightly less complex needs are discharged into a special D2A 'moving on' bed in a residential nursing home. Patients receive post-acute care and undergo further assessment. Medical cover is provided by commissioned GP practices. If it is possible for the patient to return home after this, this can be followed up by community re-ablement (as in Pathway 1) and then continuing primary care and social care.

- **Pathway 3** serves patients with the most complex needs, assessed as likely to need a long-term care home placement. Patients are discharged from acute settings into nursing home beds with supportive care provision for two to six weeks. This is then followed by ongoing residential social care, nursing home care or continuing health care.

A key enabler of the D2A model was employing discharge co-ordinators in the acute hospital setting. These co-ordinators work from early in the patients' stay to achieve smooth and safe discharge by ensuring a bed-and-care package is in place. Importantly, they have early conversations with the patient and their relatives to help them understand how important getting out of hospital is for the patient's health and the options for support outside hospital.

The team explained that the clarity of the pathway and the increased level of provision in community and social care it provides has been vital in improving care. Key achievements attributed to the D2A programme and other measures include:

- increasing throughput (discharges per bed per annum) and reducing average length of stay by one-third

- reduced mortality by 15 per cent

- reduced readmissions to acute care by 3 per cent

- reduced the number of patients discharged to nursing homes after living in their own home before admission by 15 per cent.

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⑦ The acute hospital of the future

For a number of years it has been recognised that to provide high-quality, co-ordinated care for patients and populations there needs to be fundamental changes to the way that acute hospitals work and to the way they connect with other services. Most recently, the Forward View outlined a number of new models of care that involve hospitals working in new ways with partners across their local systems (*see* box, **page 49**). The work of the Future Hospital Commission also called for a more outward-facing role for acute hospitals, with specialists working across hospital and community settings (Future Hospital Commission 2013).

As the examples described in the previous sections of this paper illustrate, significant changes are already under way in some parts of England, with more care being delivered in partnership with others across traditional service boundaries. This section builds on these examples to examine different scenarios for the future of acute hospitals within more integrated systems of care. It begins by summarising the perspectives of the acute hospital leaders involved in our research, who described to us how their hospitals, and the services provided within them, will need to work differently in future as integrated care becomes a reality. We then outline three future scenarios for acute hospitals in the context of integrated care.

NHS five year forward view models of care

The Forward View describes seven new 'models of care':

- multispecialty community providers

- primary and acute care systems

- viable smaller hospitals (including through use of chains and franchise models as described in the Dalton review)

- enhanced health and care homes

- urgent and emergency care networks

- reconfiguration of specialised care

- modern maternity services.

The initial stages of implementation will focus on the first four of these in particular, with prototypes being developed and tested in selected 'vanguard sites'.

For further details see: **www.kingsfund.org.uk/projects/nhs-five-year-forward-view**

Perspectives from our case study sites

The acute hospital leaders we interviewed as part of our research described a number of changes that they envisaged taking place in order to deliver more integrated, sustainable services in the future. We summarise these changes below under four headings:

- delivering more care beyond the hospital walls

- the future size and shape of acute hospitals

- an increased role in prevention and population health

- new organisational models with local partners.

These changes will also have important implications for the acute hospital workforce of the future, as discussed in **section 8**.

Delivering more care beyond the hospital walls

A common theme across our hospital sites was ensuring that specialist expertise traditionally concentrated in hospitals is used to support the delivery and co-ordination of care outside hospitals, which was also consistent with the recommendations of the Future Hospital Commission. This type of working is starting to emerge in a number of parts of the country, as consultants develop new models of care that link their expertise with the work of other professionals across primary, community and social care services. Evidence from six case studies reviewed by Robertson *et al* (2014) suggests that this has the potential to improve patient experience and access to care, particularly when changes in the location of services are accompanied by the development of new care pathways and innovative workforce arrangements.

While a small number of examples of consultants working in out-of-hospital settings were emerging in our case study sites – for example, in Northumbria, where consultant geriatricians work as part of practice-based multidisciplinary teams (*see* box, pages 41–43), and where specialists deliver clinics in primary care settings (*see* box, pages 25–26) – this type of working was far from being the norm across these hospitals. Technology was seen as a key enabler to support new ways of working outside the hospital walls in the future, and has been deployed with particular success in Airedale NHS Foundation Trust (*see* box, pages 66–67).

The future size and shape of acute hospitals

While there was agreement that more care traditionally provided in hospitals should be delivered in out-of-hospital settings in the future, there was also a consensus among the hospital leaders in our case study sites that radically reducing the number of beds in acute hospitals in the short or medium term was not a realistic prospect. In Airedale, non-elective activity was reported to be growing by between 4 per cent and 7 per cent annually (depending on specialty), and similar growth in demand was reported across other sites. Average bed occupancy levels in acute hospitals in England were more than 88 per cent during the first half of 2014/15, with winter pressures taking this well beyond 90 per cent during the third quarter (NHS England 2014). In this context, while some of our hospital sites had been successful in achieving modest reductions in their bed base over recent years, leaders saw the challenge for the immediate future as finding ways of managing growing demand within existing bed capacity (and to hold on to these reductions), rather than attempting to manage with significantly fewer hospital beds.

In the longer term, there remains a possibility that radically different models of care could allow capacity to be taken out of acute hospitals. The history of service transformation in mental health could be taken as illustrating how significant reductions in bed numbers are achievable when out-of-hospital care is completely redesigned – although important contextual differences mean that direct comparisons between mental health and the acute sector risk oversimplification (Gilburt *et al* 2014). However, international examples of large-scale transformation illustrate that even the most concerted efforts do not necessarily permit contraction in the acute sector. For example, integrated models of care developed in Canterbury, New Zealand, appear to have helped avoid the need for any expansion in bed numbers in acute hospitals to meet growing demand, and have enabled the system to control bed occupancy levels more effectively, but have not led to a substantial reduction in acute beds (Timmins and Ham 2013). It is also important to acknowledge that the scale of the opportunity may be lower in the United Kingdom than in some other countries – the number of hospital beds per 1,000 people in the United Kingdom already being among the lowest in Europe (OECD 2014).

While the future size of acute hospitals is uncertain, it is likely that there will be significant change in terms of the portfolio of services offered at some hospitals. For example, Northumbria Healthcare plans on redefining the function and purpose of their acute hospital sites as part of broader service reconfiguration plans for emergency care. Under these plans, provision of urgent care will be concentrated on a new specialist emergency care hospital in Cramlington, while existing acute hospitals will be maintained to provide elective care and step-up and step-down services in a networked hospital system. These hospital sites will evolve into 'health campuses' providing a wide range of services within the building, including GP services and social care (*see* box, page 31, for further details on these plans). Although the details will vary according to local circumstances, this kind of evolution in focus is expected to be seen elsewhere, for example, with smaller hospitals in some areas choosing to concentrate their work on specific service areas or population groups.

An increased role in prevention and population health

Echoing experiences elsewhere in England, the main focus of integrated care in our case study sites to date has been on bringing different parts of the NHS closer together, as well as co-ordinating services across health and social care. These

efforts have mainly been focused on co-ordinating care services for older people and those with complex needs, rather than improving the *health* of the broader populations served by these organisations (Alderwick *et al* 2015). While this is in line with national policy initiatives and the emphasis placed on co-ordinating care for frequent users of health and care services, leaders in our case study sites envisaged a far greater role for acute hospitals in prevention and population health initiatives in the future, working with a range of organisations to improve people's lifestyles and living environments across all age groups in their communities. This means broadening the focus of integrated care to pay more attention to prevention and the wider determinants of health. In a number of our sites, population-based capitated budgets linked to shared outcomes were seen as important mechanisms to help enable this shift towards population health improvement (*see* 'New ways of contracting for services', section 8), creating a stronger incentive for investment in prevention and health improvement across local systems.

New organisational models with local partners

In all of our case study sites, greater integration of services at both a horizontal and a vertical level was expected in the future. This is unsurprising, given the emphasis placed on integrated care in each of these areas. However, the focus of these plans differed depending on the size of the hospital and the characteristics of the local system.

In terms of horizontal integration, a number of sites envisaged significant extension of existing networking arrangements with neighbouring hospitals as a way to maintain acute service portfolios and to share expertise across different hospitals (*see* section 4). This is particularly relevant for smaller acute hospitals in rural areas. The leaders of these expected the scope of services directly provided by their organisations (ie, not in partnership with others) to shrink in future to focus increasingly on a core set of services around care for older people and those with complex needs. In this sense, horizontal integration was seen as an important way for these smaller hospitals to remain viable in the future.

In terms of vertical integration, all of our case study sites planned to extend integrated working with primary, community and social care services, as well as working more closely with mental health services, and were exploring various options for both 'real' and 'virtual' forms of integration to support these plans.

① ② ③ ④ ⑤ ⑥ **7** ⑧ ⑨ ⑩

In many cases, these plans are closely aligned with the primary and acute care system (PACS) model described in the Forward View. For example, Northumbria Healthcare plans to become increasingly involved in the delivery of primary care services in the future through Northumbria Primary Care Ltd (*see* box, **pages 25–26**). In their most developed form, these arrangements will involve the trust effectively running some general practices as part of their organisation's service portfolio. Other areas were exploring the use of joint ventures and new contracting models to align incentives between hospitals, primary care and other community-based services (*see* box, **page 61**).
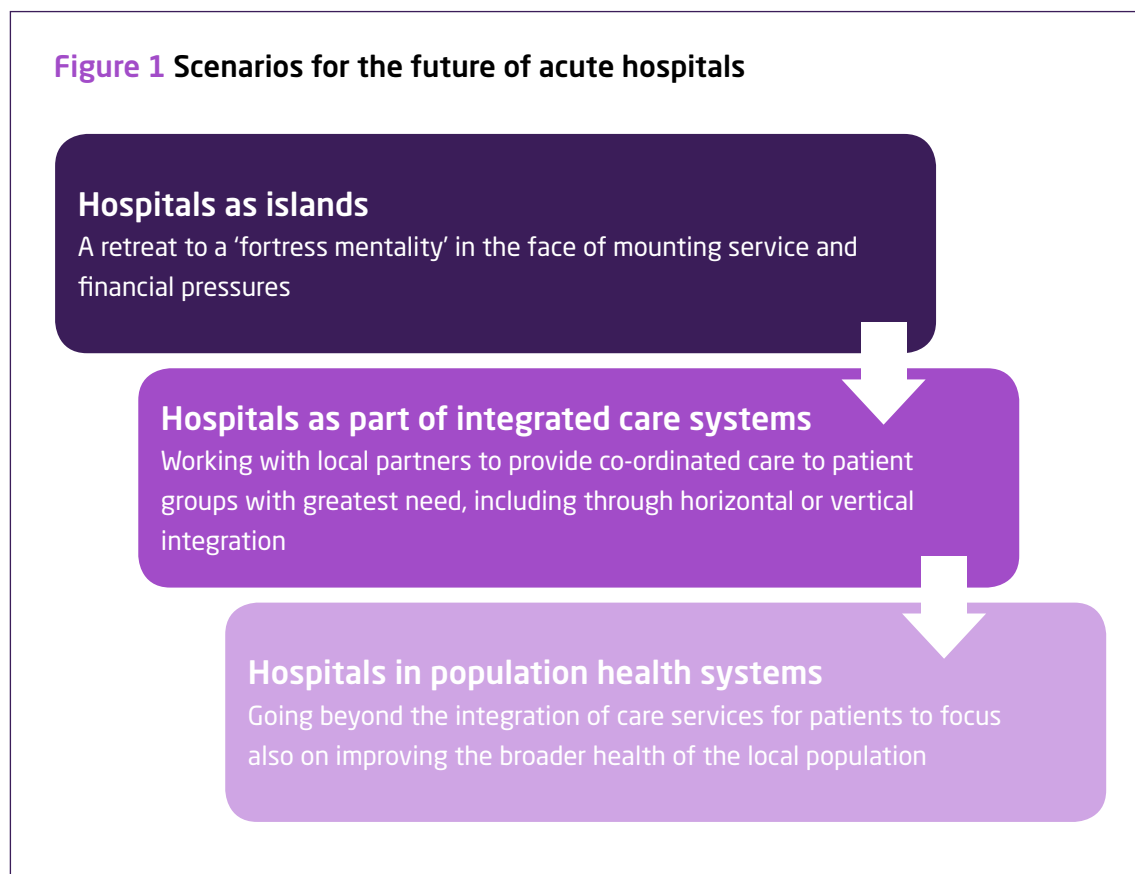
In the longer term, hospital leaders anticipated the development of more ambitious forms of integrated working covering large population groups – for example, through the creation of accountable care organisations or integrated care organisations responsible for delivering all health and social care services in their local areas. These terms were used to describe various forms of integration, ranging from single vertically integrated providers to more nuanced virtual arrangements based on collaboration between separate organisations.

Since the publication of the Forward View, acute sector leaders have been seeking to understand the degree of alignment between local plans and the seven models of care described in the box, **page 49**. As we will explore in **section 9**, local strategies do not always map precisely on to any single model, and many leaders involved in our research argued that a blend of different models will be most suitable for their local area.

Scenarios for acute hospitals in integrated care

The acute hospitals involved in our research have been actively involved in efforts to develop integrated care services in their local areas – often for a number of years. This experience has not always been echoed elsewhere in England. Based on our research, we suggest three broad scenarios for the future of acute hospitals in integrated care, with the most likely scenario in each area depending on local circumstances. Figure 1 outlines the three scenarios.

Figure 1 Scenarios for the future of acute hospitals

Hospitals as islands
A retreat to a 'fortress mentality' in the face of mounting service and financial pressures

Hospitals as part of integrated care systems
Working with local partners to provide co-ordinated care to patient groups with greatest need, including through horizontal or vertical integration

Hospitals in population health systems
Going beyond the integration of care services for patients to focus also on improving the broader health of the local population

- Hospitals as islands
  In the face of mounting service and financial pressures, one scenario for acute hospitals is to develop a 'fortress mentality', prioritising organisational survival above broader system interests and the development of new models of care. In many ways, this scenario describes a rational response to a perverse set of financial and regulatory incentives, which too often treat hospitals in isolation rather than emphasising their role in systems of care. However, it represents the worst-case scenario for the future sustainability of NHS hospital services, as well as for local patients and populations.

- Hospitals as part of integrated care systems
  A second scenario is for acute hospitals to work with other organisations across their local systems to integrate services for patients and groups who most need co-ordinated care. Broadly, there are two main ways that acute hospitals can do this, which are not mutually exclusive.

   –   Horizontal integration – Hospitals working with other (small and large) hospitals in networks to provide high-quality and co-ordinated acute care (*see* section 4).

   –   Vertical integration – Hospitals working with out-of-hospital services to co-ordinate care for patients across traditional service boundaries (*see* section 3).

•   Hospitals in population health systems
The final scenario is for acute hospitals to see themselves as part of broader population health systems. As described by Alderwick *et al* (2015), this transformation would require hospitals to work with a wide range of organisations across their surrounding area – including local authorities and voluntary and community organisations – to go beyond the integration of *care* services for *patients* to focus also on improving the *health* of the broader *populations* they serve. This means working together across services to keep people healthy in all population groups, as well as focusing on the distribution of health outcomes within these groups.

Alderwick *et al* (2015) argue that the third of these scenarios represents by far the most promising future, both from a patient and population perspective and in terms of the sustainability of the health and social care system. However, it will also involve the most radical departure from the current model of acute hospital care.

The case studies described in this report provide good examples of hospitals working with partner organisations to co-ordinate care for those in greatest need – ie, the second of the three scenarios. Even reaching this level involves significant work and will require acute hospitals to overcome a number of systemic barriers. These barriers and perverse incentives mean that acute trusts are all too often pushed into the first scenario. The following section describes what actions are necessary to overcome these barriers and to support movement towards scenarios two and three.

8 Making change happen

To achieve the best-case scenario described in the previous section, supporting actions at a number of levels will be needed. This section describes the key barriers to change, and how these can be overcome, including by:

- supporting a new model of leadership in the acute sector

- regulating systems as well as organisations

- providing financial support for providers through the transition period

- encouraging collaborative working between commissioners and providers

- supporting the use of new contracting models

- harnessing data and technology

- strengthening the hospital workforce and deploying it creatively.

A new model of leadership

Many of the participants involved in our research argued that the critical ingredients for success were the will, capability and commitment of local leaders, and a shared determination to plan and act as a system. A recent report examining learning from 'integrated care discovery communities' in north-west England argued that 'system leadership needs different knowledge, skills and behaviours to those of effective leaders within an institutional hierarchy', adding that both institutional and system leadership skills will be essential in delivering integrated care (Fillingham and Weir 2014, p 37).

The box below describes the characteristics of effective system leadership identified in our research. These attitudes and behaviours will be important if acute hospitals are to play an active role in integrated care. Many of these characteristics are already becoming established in some areas of the country – in other areas developmental support will be needed to help bring about the necessary culture change.

> ### Key characteristics of effective system leadership for integrated care
>
> • Taking a wider role in the local health system and accepting shared responsibility for the sustainability of the local health economy.
>
> • Promoting collective leadership within and between organisations, creating a culture of collaborative working across the hospital and with external partners.
>
> • Shifting from a hierarchical focus ('looking upwards') to a place-based one ('looking outwards').
>
> • Agreeing shared metrics of success with local partners, against which leaders can hold each other mutually accountable.
>
> • Taking a role in public health, prevention and wellbeing.
>
> • Fostering relationships with local partners that are capable of sustaining collaboration alongside competition.

Integrated care will also require new forms of organisational leadership, particularly where a single organisation provides acute, community and/or social care services across multiple settings. Attention will need to be paid to the leadership and management model used within these organisations, for example, the extent to which control is decentralised across business units or sites. In Northumbria Healthcare, separate business units operate with a high degree of autonomy, but with oversight from a central integration committee (*see* **section 5**). A similar function is performed by eight care groups in Sheffield Teaching Hospitals NHS Foundation Trust which are responsible for much of the decision-making regarding operational management.

Integration at the clinical and service level will need to be led by clinicians, with support from managerial colleagues. Strong clinical leadership is often needed to overcome 'professional inertia' and resistance to change – something that was seen as a very real barrier in some of our case study sites. A high level of clinical involvement in strategic leadership, and clinical ownership of the integrated care agenda specifically, was seen to be a critical enabler. Conversely, partner organisations were concerned where they perceived that the clinical workforce in the local acute trusts did not necessarily share the same vision as the executive team.

Particular support is needed for leadership in primary care. As emphasised in section 3, building strong relationships between acute hospitals and GPs is often cited as one of the most significant enablers of integrated care. Acute hospital leaders have a role to play in supporting primary care leadership and, where necessary, facilitating the development of federations.

Regulating systems as well as organisations

Regulation and performance management in the NHS is primarily focused on ensuring that individual organisations are well led, financially sustainable and deliver high-quality care. However, delivering integrated care relies on systems rather than organisations acting alone. There is a significant risk that the sharing of responsibility and accountability across local health and care systems is actively discouraged by existing approaches to regulation, which can reinforce a focus on the survival of individual organisations rather than system-wide sustainability. Too often, current reporting requirements compel organisations to concentrate on keeping their own organisation safe and sustainable rather than taking action which will be in the mutual interests of the local health economy.

The regulatory approach of Monitor, the NHS Trust Development Authority (TDA) and the Care Quality Commission (CQC) must strike a balance between organisational and system performance if acute trusts and others are to be encouraged to invest in developing integrated care. For example, risk ratings conducted by Monitor, the TDA and CQC should include metrics assessing whether acute hospitals and other providers are playing a sufficient role in supporting system-wide sustainability.

Where performance is below the required standard, recovery plans should include a focus on the sustainability of the local system. An encouraging development here is the announcement that a whole health economy diagnostic will be central to the new 'success regime' being developed by NHS England, Monitor and the NHS TDA. These three organisations will then work together to decide what resources they can collectively put in place across a local area to improve system performance.

Moving towards a whole-systems approach to regulation entails a significant shift from the current governance model for foundation and NHS trusts. The Department of Health will need to give regulatory bodies a clear mandate to take further steps in this direction.

Providing financial support through the transition period (the transformation fund)

The journey from fragmented to integrated care is rarely linear, can take a number of years and will often require up-front investment before the benefits of new models of care can be achieved. Put simply, integration often 'costs before it pays' (Leutz 1999). Several of the acute trust leaders in our research argued that their organisation would need to be permitted to go through a period of deficit over two to four years while transformations are under way, before reaching a position where new models of care will deliver net savings. This resonates with lessons from the history of service transformation in mental health, where additional financial support during the process of moving to community-based care was a key enabler of change (Gilburt *et al* 2014).

Appleby *et al* (2014) made the case for a 'transformation fund' to cover costs associated with the transition to more integrated models of care, for example, double-running costs. The announcement of £200 million for 2015/16 in the Chancellor's 2014 autumn statement to help establish new care models illustrates that this proposal is gaining traction. Planning guidance for 2015/16 indicates that this additional funding will be reserved largely for 'vanguard sites' and those areas taking part in the new 'success regime' for trusts in need of improvement (NHS England *et al* 2014b). It seems likely that the fund will need to be expanded significantly if it is to be used to support change at scale across England. Forthcoming work by The King's Fund and the Health Foundation will explore this in greater depth.

Helping organisations to make the transition to integrated models of care is not solely a question of financial support, but also relates again to regulatory models. Monitor will need to ensure that reporting requirements do not restrict providers from planning over a longer time horizon. Limited flexibility to plan for short- and medium-term deficits was consistently mentioned as a key barrier to change in our case study sites.

Encouraging collaborative working between commissioners and providers

Although this report has concentrated on the role of provider organisations in integrated care, it is clear that commissioners also have a critical role to play. The examples of successful partnership working in our case study sites point to the benefits that can be gained by commissioners and providers working together. However, these partnerships also raise fundamental questions about the 'rules of engagement' and the respective responsibilities of commissioners and providers in planning service change. In some areas, there was significant anxiety that collaborative working between providers and commissioners might be in violation of competition rules.

It is important that competition law does not create barriers (real or perceived) to constructive dialogue and partnership working between commissioners and providers. National system leaders will need to articulate what the commissioner–provider split will mean in the context of integrated care – including being clear that collaborative system governance groups are not in violation of competition rules, provided that these groups are inclusive and transparent. The relationship between commissioners and providers should encompass and permit collaborative thinking and planning, although clearly once discussions reach decisions about contracting, separation would be necessary. Local leaders seeking greater clarity on the appropriate boundary between commissioning and provision are advised to contact Monitor for guidance.

New ways of contracting for services

New contracting models and risk-sharing arrangements are being developed in different parts of the country that enable commissioners to hold providers collectively accountable for system outcomes (*see* Addicott 2014 for a summary). Various options were being enthusiastically discussed in our case study sites – including alliance contracts, prime contractor and prime provider models – but in most sites only minimal progress had been made in implementing these new approaches in practice. A key barrier had been the difficulty in getting multiple local partners to agree to collective risk-sharing agreements within a timeframe that would be acceptable to all parties involved. The box below gives examples of some of the contracting models developed in our case study sites.

A further attraction of these alternative contracting models is that they are often

used as a way of giving providers a longer-term financial settlement lasting several years, creating a more stable platform for innovation and investment, in place of annual contracting rounds. This type of approach is already being explored in a number of parts of the country, where commissioners are letting multi-year contracts to providers to support investment in new models of care (**Addicott 2014**).

Commissioning and contracting models

In all of our case study sites, commissioners and providers were exploring new models of commissioning and contracting to support the closer integration of services and the delivery of more outcome-focused care.

At a large scale, the main approaches being explored were prime contract and alliance contract models, focusing on care for specific diseases, service areas or broader population groups, in line with developments elsewhere in England (**Addicott 2014**). However, progress in developing and implementing these new contracting models was generally limited.

In Yeovil, commissioners from the clinical commissioning group and the local authority are working with their NHS England local area team to develop a new contracting approach, with payments for providers linked to the delivery of shared outcomes. The acute hospital and local partners are currently working together to understand the different options for responding to this approach – including establishing a joint venture between the acute trust and general practices.

At a smaller scale, acute trusts in Northumbria and South Warwickshire have worked with individual system partners to develop risk-share agreements to share financial gains or shortfalls associated with particular elements of their integration work.

For example, in Northumbria, an agreement was put in place between Northumberland Clinical Commissioning Group (CCG) and the acute trust to share financial benefits associated with reductions in non-elective activity, resulting in savings of around £4 million being shared between the CCG and the acute trust in 2013/14. This saving was attributed to a collection of initiatives across the health and care system, including the High Risk Patient Programme (*see* box, **pages 41–43**). Under this risk-share agreement, the acute trust had also agreed to absorb some of the financial 'pain' if non-elective activity increased. A similar agreement has been put in place for 2014/15, although similar savings are not expected as non-elective activity has increased at the acute trust in line with growing pressures across the system.

Contractual innovation will need to be supported by alternative payment systems that align incentives across organisational and service boundaries. At a national level, NHS England and Monitor have recently outlined plans for reform of NHS payment systems following the Forward View, including plans to develop a menu of payment systems that local areas can adopt to support different models of care (Monitor and NHS England 2014a; Monitor and NHS England 2014b). However, transition from 'old' to 'new' payment approaches will be neither quick nor easy, and support should be given to local areas already developing new payment approaches as part of their integration efforts.

Our research suggested that there is a particular need for contracting for GP services to become more flexible if the intention is to make it easier for hospital providers to become involved in the delivery of these services. Although organisations such as Northumbria Healthcare have taken a growing role in the delivery of GP services, the contracting and organisational arrangements needed to allow this to happen have been complex, time-consuming and costly. The arrangements described in the box, pages 25-26 have involved the trust creating a new organisational vehicle (Northumbria Primary Care Ltd) to act as subcontractor for existing GMS and PMS contracts held by two practices in Northumberland, and working with the NHS England area team to allow these arrangements to take place. After the subcontracting arrangements were formally agreed, the GPs and staff from these practices then transferred their employment to the new organisational vehicle. Given the scale of the barriers involved, it is unlikely that the primary and acute care systems (PACS) model described in the Forward View will become more widespread without a significantly more flexible approach to contracting for GP services.

Strengthening the workforce and redesigning professional contracts

As the core business of acute hospitals shifts to encompass a growing role in the management of long-term conditions, parallel changes in the workforce will also be needed. There is an increasing need for roles that cut across traditional professional and service boundaries to support this shift in focus (Imison and Bohmer 2013).

> *We won't necessarily be getting rid of people, but there will be a new workforce model in five years' time.*
> Acute trust deputy chief executive

Workforce shortages in some areas risk holding back the development of new models of care unless we are prepared to reconsider the roles and responsibilities of different professional groups. In some geographical areas, national shortages are compounded by specific local issues, for example, difficulties in recruiting and retaining hospital consultants in some rural areas.

These challenges make a number of changes necessary, including:

- More flexible job plans for acute care professionals – for example, through more specialist services being provided beyond the hospital (*see* **Robertson *et al* 2014**). Similarly, delivering more hospital services on a networked basis may require consultants and others to work across several sites and potentially several organisations. Overly rigid application of job planning guidance can create a significant barrier to these sorts of changes.

- An increased emphasis on generalism in the hospital workforce – both in the sense of expanding the numbers of generalist professionals and of ensuring that all medical, nursing and allied health professionals have adequate generalist skills to allow them to see the 'bigger picture' and to work closely with other professionals. A serious challenge to this is the national shortage of geriatricians and other hospital-based generalists. In some areas these gaps have been bridged through use of nurse consultants.

- A greater role for 'care co-ordinators' to help join up services across boundaries – for example, in arranging and planning discharge from hospital and continuing to support patients at home and in the community.

- New roles in primary care with closer links to services provided in acute hospitals and other care settings.

A critical and contentious issue is the question of whether contractual changes will be needed in order to achieve progress on the above. Many leaders in our case study sites argued that changes to the consultant contract will be needed to enable workforce innovation. In some cases the local workforce was reported to be open-minded about new ways of working, but there was concern that national negotiation of contracts sometimes creates excessive rigidity. This raises the question of whether more varied national solutions are needed to give local providers a range of options to draw upon when negotiating consultant job plans.

Harnessing data and technology

Integrated IT and data systems were seen as one of the greatest potential enablers of service transformation. Several of our case study sites had already made considerable investments in shared IT platforms. Although there was often a sense that these had not yet delivered on their full potential, considerable progress is anticipated over the next few years. For example, in the areas covered by Airedale CCG and Bradford Districts CCG, most local partners are now using (or are in the process of moving to) a common IT system, and it is expected that this will underpin the development of shared electronic records within two years (*see* box below). In South Somerset, the Symphony project has brought together data from Yeovil NHS Foundation Trust, primary care, social care and the local care trust, allowing a ground-breaking economic analysis to be conducted that has provided the partner organisations with an in-depth understanding of resource use and cost drivers across the whole system.

All of our case study sites emphasised the importance of being able to share information about patients across providers. However, technical and information governance barriers often slow down implementation or prevent this happening across all settings. Some of the barriers to developing integrated IT platforms could be dealt with by addressing the issue collectively across a local health economy. This is one area where the potential power of joint governance structures bringing together local commissioners and providers is clear. Enabling the development of integrated IT systems should be a priority issue for discussion in these system-wide forums.

Telehealth and telecare technologies are also a potential enabler of integrated care, allowing different groups of professionals to interact and communicate in new ways, and supporting more care to be delivered in community settings. Airedale NHS Foundation Trust has been a leading innovator in telehealth, and has seen significant reductions in demand for acute hospital services among the groups provided with telehealth devices (*see* box,).

Developing a shared IT platform across primary, secondary and social care in Airedale

In the Bradford and Airedale region, there has been significant progress in developing a common IT platform shared by local partners. Airedale NHS Foundation Trust, Bradford District Care Trust, Bradford Metropolitan District Council and local commissioners worked on this agenda collectively, supported by £6 million funding from the Integrated Digital Care Technology Fund. This money has been invested across the health economy in a series of specific developments, primarily focused on installing SystmOne as the clinical IT system for all providers. The following entities are now using the common platform or are in the process of adopting it, enabling them to share the same patient records:

- almost all GP practices locally

- Airedale NHS Foundation Trust

- community services provided by Bradford District Care Trust

- social care teams provided by Bradford Council.

Airedale emphasised that comprehensive and accurate data for analysis of the whole system's activity will bring huge benefits for the trust, allowing them to understand the demand growth and fluctuations that they face and how they can help other organisations to control demand.

In addition to better intelligence on population needs, the shared IT platform creates a significant opportunity to make improvements in patient care, resulting from all professionals working with a patient having access to the same information. In primary care, this would mean being able to instantly access detailed accounts of why a patient was admitted to hospital and what treatment they received. In hospital, access to GP-maintained care records would provide crucial information about existing conditions, allergies and current medication – helping to improve decision-making and reducing the risk of harm from drug interactions.

Barriers still remain, particularly in terms of integrating mental health information into the shared system. Other challenges relate to the human factors involved in using the system. For example, there was concern among some clinical leaders that not all clinicians are currently using the system to its full potential. Further progress is expected on this in the future.

Telehealth in Airedale

Airedale NHS Foundation Trust has been a leading example of using telehealth technologies to support integrated care outside the hospital environment. The trust currently supports at least 6,000 people in this way across England and has seen impressive reductions in use of hospital services among targeted groups.

These technologies have been used particularly effectively for linking care homes to expert advice. Care home staff can speak to senior acute care nurses based in the trust's telehealth hub via a secure video connection available on a 24/7 basis, for example, in relation to a health problem currently being experienced by a resident. Nurses can draw on additional expertise from specialists if necessary. As of February 2015, the trust was contracted to provide this service to more than 300 care homes in locations that extend well beyond the hospital's own geographical catchment area.

Admissions from care homes receiving the service have dropped by 37 per cent, while accident and emergency (A&E) attendances have fallen by 45 per cent. Reductions in length of stay have also been observed. The trust estimates that savings to the CCG through avoided hospital activity are in excess of £1 million.

People living in private homes are also supported remotely in a similar way, with the video connection being delivered either through their own computer or tablet, or through a bespoke device provided by the trust. The recipients of this service are usually either patients with long-term conditions, or people approaching the end of life.

The same technology has also been deployed in prisons so that specialists based in the hospital can conduct remote outpatient or urgent care appointments. In around 50 per cent of cases, the recipient can be helped there and then without needing a highly expensive transfer from prison to hospital – again pointing to the potential for significant cost savings.

Service users report that the presence of the system in itself 'makes them feel reassured' because it is available 24/7. Hence someone who might previously have arranged a GP appointment on a Friday afternoon because they were worried their health might deteriorate over the weekend may no longer feel the need to do so. Patient satisfaction with the service is very high.

The set-up costs for the telemedicine hub were considerable, and were covered in part by innovation funds from the former strategic health authority. The trust now sees expansion in this area as an important source of future revenue and is exploring the options to supply telehealth services to new groups, including children, drug and alcohol services, and potentially the private market.

For more information see: **www.airedale-trust.nhs.uk/services/telemedicine/**

(9) Discussion

The achievements made so far by the organisations included in this report illustrate that much is possible within the existing system, despite the barriers outlined in the previous section. Our research highlights the variety of roles that acute hospitals are already playing in different parts of the country to support the development and delivery of integrated care. These case studies demonstrate the progress that can be made when partnership working and integration is prioritised and supported by local leaders.

Who will lead integrated care?

A critical question is where the leadership for integrated care will come from. For the purposes of this research, we deliberately selected areas where acute hospitals have played a leading role in integration. Some have suggested that the move towards integrated care will necessarily be provider-led, arguing that this is where the necessary expertise is based. However, elsewhere in the country there are examples of commissioner-led integration, and there is a clear policy expectation that commissioners act as system leaders in their local area.

The answer may be that neither extreme is desirable, and that a simple dichotomy between provider-led and commissioner-led integration is unhelpful. Instead, collective leadership is needed which brings together acute sector leaders with other providers and commissioners to improve outcomes for patients and populations. The potential benefits of acute sector involvement in integrated care are clear, and it is important that whether or not they are in the driving seat themselves, acute hospital leaders are encouraged to take responsibility for the systems around their own organisations, and to become involved in setting the strategic direction for their local health economy. However, leaders of acute hospital providers should avoid pursuing integrated care through unilateral action, and should instead invest time in building a consensus with local partners. This will be important to ensure buy-in from organisations and professionals working in the community.

As part of this collective approach, it is also important that leadership is shared between clinicians and managers. Clinical leaders in the acute sector can play

an indispensable role in building relationships and trust with GPs and other professionals working beyond the hospital. Medical directors and other leaders need to see part of their role as being to build enthusiasm for new ways of working in the hospital's own clinical workforce, for example, in relation to taking a more proactive role in population health. Clinicians will need to be supported in this leadership role by managerial colleagues and professional leaders at the national level.

A striking characteristic of our case study sites was the length of time that senior leaders in provider and commissioning organisations had been in their leadership roles, and the maturity of relationships between them. This stability and maturity has been previously identified as a key ingredient for success in health systems that have undergone major transformations, for example, in the Canterbury district of New Zealand (Timmins and Ham 2013). The implication is that patients in England may not be best served by the prevailing model of improvement that emphasises replacing senior management teams as the default response to under-performance.

The areas of the country where it may be most difficult to make progress are those where no organisation is stepping up to take a leadership role – whether commissioner or provider. In these circumstances, external help may be needed to support local leaders. The 'success regime' recently outlined by NHS England and national partners will be critical in this regard (NHS England *et al* 2014b).

Moving towards the *NHS five year forward view* models of care

The Forward View sets an ambitious agenda for transforming local systems and building integrated models of care. Our research raises a number of implications for the implementation of the Forward View vision, particularly in relation to the new models of care and the role of acute hospitals in these.

First, the experience of organisations involved in our research highlights just how ambitious the vision is, and the complexities that will be involved in developing new models of care such as primary and acute care systems (PACS) or multispecialty community providers (MCPs). One of the most difficult challenges consistently encountered in our case study sites was the reported lack of leadership in general practice and the challenges that this presents in terms of ensuring general practice is an active and equal participant in local system governance arrangements. Where the greatest progress has been made in terms of the relationship between acute

hospitals and general practices, this has required significant investment of time and resources, and even the most advanced areas are still some distance from the scenario described in the PACS model. Implementing the PACS model in practice will involve tackling the blockages that have been most problematic in our case study sites, potentially including renegotiation of the GP contract if PACS are to take the form of integrated organisations rather that 'virtual' networks of providers.

The MCP model will also involve addressing the lack of scaled-up primary care in some parts of the country. An additional concern regarding this model – although not an unsurmountable one – is the risk that the focus on primary and community service integration in this model could leave acute hospitals isolated and outside the critical conversations regarding the local strategy for integrated care. Our contention is that this would be a mistake, and that it will be important for emerging MCPs to actively engage with local acute providers to ensure that integration does not neglect what will remain a major part of the local health economy.

A second implication of our research relates to the timeframes for implementation. The successes seen in our case study sites had not been achieved overnight, but only after several years of sustained effort, with significant time spent on building relationships, developing shared governance structures to enable partnership working, agreeing a strategic vision for integrated care and finally identifying specific priorities for improvement. This is not to suggest that other areas cannot repeat this journey, but it does highlight the need for realism regarding the pace of implementation and the necessity of doing the 'ground work' before embarking on a process of transformative change. The concern that policy-makers and others may expect 'too much, too soon' is a common refrain in recent evaluations of integrated care programmes, for example, in north-west London (**Curry *et al* 2013**), and our research gives further support to this.

A third message is that in some cases the best option for a local health economy will be a blend of models such as MCPs and PACS. In our case study sites, the models of care being discussed were typically more closely aligned with the 'hospital-led' PACS model, but did not always fit that model exactly. In some areas, primary care networks were developing alongside hospital-led models of integration, and future models of care were likely to involve 'virtual' forms of collaboration between hospitals and these primary care networks rather than the development of single integrated providers – not least because of the significant cultural, organisational

and contractual barriers referred to above. This suggests that thinking about PACS as virtual entities rather than (or as well as) single merged organisations may be useful. Leaders in some sites explicitly challenged the applicability of any single national model to their local area, arguing that while '1,000 flowers blooming' would not be the best approach, greater diversity is needed than the two main models currently receiving most attention (MCPs and PACS). On this view, the models of care described in the Forward View should be seen as a starting point for local discussions rather than a definitive menu of options.

Related to this, care should be taken to resist oversimplifying discussions regarding MCPs and PACS models as being a binary choice between 'primary care-led' and 'hospital-led' integration. A reductive debate conducted along these lines is unlikely to help foster the collective forms of system leadership that will be needed in developing integrated care. Whatever model is chosen in a given health economy, neither primary care nor acute hospital providers should see themselves as leading integration alone – instead, all of the main providers and commissioners should be involved in leading change and shaping the strategic direction to be taken locally. Local leaders should focus their efforts on how integration will be delivered at a clinical and service level before considering the best organisational and contractual form to support the development of these services.

The final implications of our research relate to the wider system barriers that will need to be removed. The NHS England planning guidance for 2015/16 outlines the national-level strategy for encouraging the widespread adoption of the new models of care (NHS England *et al* 2014b), with three main components:

- focused support for leading 'vanguard' sites to move ahead with implementation of new models of care

- a more top-down approach to implementation in challenged areas through the new 'success regime'

- a more permissive national approach to encourage adoption of new models of care across the country.

The last of these measures will be particularly important if integrated care is to be implemented widely. Our research would suggest that steps taken by national system leaders should include a shift to whole-systems regulation, more flexible payment

mechanisms with longer-term financial settlements and a pragmatic approach to competition that avoids creating unnecessary barriers to change. There should also be a focus on building system leadership in all local health economies, not only in the vanguard sites.

The following section provides a complete list of recommendations for both national and local leaders.

10 Recommendations

Our central recommendation is that acute sector leaders should be encouraged to take a leadership role in their local health systems, working with local partners to develop more integrated models of care. This will involve taking greater responsibility for prevention and public health.

If the best-case scenario described in section 7 is to be achieved, supporting actions at a number of levels will be needed. Many of these recommendations will be important for any coherent and comprehensive approach to integrated care, regardless of the role of acute hospitals within it.

Acute hospital leaders

- Ensure that there is collective leadership of integrated care across the local system, build consensus and avoid taking a unilateral approach that risks alienating partner organisations.

- Agree system-wide success metrics with local commissioners and providers, and review collective performance against these.

- Develop more flexible job roles for the hospital workforce that emphasise continuity across settings and joint working with other professionals beyond the hospital walls.

- Empower clinical leaders to lead the development and implementation of integrated models of care. For example, medical directors and other clinical leaders need to take responsibility for championing new ways of working and overcoming professional inertia and resistance.

- Clinical leaders in acute hospitals will also need to invest time in building trust with GPs and other local partners.

- Develop training placements that span sectors and give hospital professionals the opportunity to work in community settings.

Local commissioners

- Work together with acute hospital and other local providers in developing a shared strategy for integrated care, using whole-system governance structures to do so.

- Create financial incentives (for example, using Commissioning for Quality and Innovation payments) based on whole-system performance, with shared goals that encourage collaborative working across acute trusts and other providers.

- Make use of new co-commissioning arrangements to promote integrated working between primary and acute care, for example, through incentive payments for GPs or by redesigning alternative provider medical services (APMS) and personal medical service (PMS) contracts.

- Support the development of integrated IT platforms that allow information sharing between acute hospitals and other local providers.

- Explore the issuing of longer-term contracts to providers where this will support the development of integrated care, including through new contracting models and risk-sharing agreements that hold providers collectively accountable for system outcomes.

Department of Health, NHS England and system regulators

- Ensure that competition law does not create barriers (real or perceived) to constructive dialogue and partnership working between commissioners and providers.

- Develop regulatory approaches that place greater emphasis on whole-systems regulation. For example, risk ratings conducted by Monitor, the NHS Trust Development Authority (TDA) and the Care Quality Commission (CQC) should include metrics assessing whether acute hospitals and other providers are playing a role in supporting system-wide sustainability.

- Introduce a transformation fund that ensures that all areas of the country are able to cover the costs of transitioning to more integrated models of care.

- See the models of care in the Forward View as a starting point for discussion rather than a definitive menu of options. Permit and encourage local solutions that combine elements of multiple models, and commission formal evaluation of these.

- Continue to develop a range of alternative payment systems and support local commissioners in moving away from activity-based tariffs for hospital care where appropriate.

- Develop more flexible contracting models for general practice to make it possible for acute hospital providers to take a greater role in primary care provision.

Health Education England, royal colleges and other professional bodies

- Support the development of flexible staffing models that allow staff to work across hospital and community settings. Ensure that the need for flexible working arrangements is reflected in training and educational curricula for health and care professionals.

- Ensure that contracts for consultants, nurses, GPs and other professionals do not create barriers or disincentives to working across multiple organisational settings.

Appendix A: Site profiles

Sheffield Teaching Hospitals NHS Foundation Trust	
Key characteristics	
Services provided	Acute and community (provides 80 per cent of community services in Sheffield)
	Specialist services for cancer, spinal cord injuries, renal care, neurosciences, cardiothoracic surgery and a number of other services
	Major trauma centre
Hospital portfolio	2 large acute hospitals (1 with A&E)
	1 purpose-built maternity unit
	1 dedicated cancer hospital
	1 specialist dental hospital
Population size	550,000 (approx)
Workforce	15,000 (approx)
Budget	£933 million
Historical details	Formed from a merger of several acute trusts in 2001 and established as a foundation trust in 2004
	Community services acquired in 2011
Financial situation	£7.3 million surplus in 2013/14, expected to break even or generate a small surplus in 2014/15
	Position for 2015/16 appears to be more challenging
Local context	
Rural/urban	Urban
Population characteristics	Variable population characteristics in different parts of the city:
	• high deprivation and cultural diversity in the north, with multiple morbidities and high rates of mental health problems, and poor access to primary care
	• age, frailty and social isolation are the major challenges in the south-west of the city
Commissioners	Sheffield CCG
	Sheffield Council
	Biggest Better Care Fund in the country – £280 million pooled budget
Primary care	88 GP practices, 16 GP federations under development
Other providers	Sheffield Health and Social Care NHS Foundation Trust
	Sheffield Children's NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust	
Notable features	All major providers and commissioners largely co-terminous
Key innovations in integrated care	
Pre-admission	Single Point of Access to integrated health and social care support
	Virtual wards wrapped around general practice
	Major investment in risk profiling
Post-admission	Active Recovery Pathway for rehabilitation post-discharge
	New models of intermediate care (including bed-based)
	Discharge to Assess
Other	Reorganised district nursing around general practice

Airedale NHS Foundation Trust	
Key characteristics	
Services provided	Acute and community
Hospital portfolio	1 acute hospital (with A&E)
	3 community hospitals
Population size	238,000 (approx) locally, plus a national population of more than 6,000 supported via telemedicine in nursing and residential care homes and private homes, and a further population of 8,000 in prisons
Workforce	3,000
Budget	£145 million
Historical details	Through the Transforming Community Services programme, took over community services for Craven area but not for other parts of its catchment area
Financial situation	Small deficit (£1,000) for 2013/14
	Subsequent years expected to be more challenging
Local context	
Rural/urban	Predominantly rural
Population characteristics	Older demographic than national average
	3 distinct areas – Airedale, Wharfedale and Craven
	Low population density, particularly in Craven area
	Also serves neighbouring populations in East Lancashire and Bradford Districts
Commissioners	CCGs
	• Airedale, Wharfedale and Craven CCG (main commissioner)
	• Bradford Districts CCG (10–12 per cent)
	• East Lancashire CCG (10–12 per cent)
	Local authorities
	• Bradford Metropolitan District Council
	• North Yorkshire County Council
Primary care	17 GP practices in Airedale, Wharfedale and Craven
	8 GP practices in East Lancashire
	9 GP practices in Bradford District
	The trust is also working with emerging GP federations

Airedale NHS Foundation Trust	
Other providers	Bradford Teaching Hospitals NHS Foundation Trust
	Bradford District Care Trust – provides mental health across the patch, plus community services in Airedale/Wharfedale
	Nearest tertiary centre – Leeds
Notable features	Reputation for innovation, particularly in relation to technology
	Complex pattern of overlapping provider/commissioner geographies

Key innovations in integrated care

- Major investment in telehealth and digital technologies
- Shared electronic patient record
- Collaborative care teams delivering enhanced intermediate care
- Intermediate care hub with a multidisciplinary team from across health and social care co-ordinating step-up, step-down care
- Ambulatory care pathways based on Map of Medicine
- Ambulatory care unit
- Long-term conditions management model stressing self-care
- Integrated end-of-life care via the Gold Line single point of access, using Gold Standards Framework and advanced care planning
- Exploring implementation of extensivist model for most intensive users of system resources

Northumbria Healthcare NHS Foundation Trust	
Key characteristics	
Services provided	Acute and community services in Northumberland and North Tyneside
	Adult social care in Northumberland
Hospital portfolio	3 acute hospitals
	6 community hospitals
	1 major emergency site to be opened in 2016
Population size	500,000
Workforce	9,282 headcount; 7,044 WTE
Budget	£470 million
Historical details	Became foundation trust in 2006
	After transforming community services in 2011, Northumbria has been responsible for community services in North Tyneside and community and adult social care services in Northumberland
Financial situation	Strong financial position; on track to deliver surplus of approx. £21.5 million in 2014/15
Local context	
Rural/urban	Urban areas in North Tyneside and highly rural areas in Northumberland
Population characteristics	Diverse population with varied needs between remote, sparsely populated rural areas and more densely populated urban communities
	Large differences in life expectancy within the population, both in Northumberland and North Tyneside
Commissioners	CCGs:
	• Northumberland CCG
	• North Tyneside CCG
	Local authorities:
	• Northumberland County Council
	• North Tyneside Council
Primary care	74 GP practices
	4 primary care federations covering all practices – 3 in Northumberland and 1 in North Tyneside
Other providers	Northumberland Tyne and Wear Foundation Trust (Mental health and disability services)
	Large neighbouring acute provider – Newcastle upon Tyne Hospitals NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust	
Notable features	Local GPs in senior leadership positions
	Long history of partnership working with general practice
	Provides adult social care services in half of its patch (Northumberland)
	Close links and shared learning with Kaiser Permanente since 2000
Key innovations in integrated care	
	• Close working with general practices through locality integrated networks
	• High Risk Patient Programme for older people and those with complex needs, including multidisciplinary working
	• A wide range of integration initiatives, including hospital-to-home teams and integrated end-of-life services
	• Risk-sharing agreements with local CCG
	• Investment and active involvement in primary care development
	• New professional roles spanning organisational and service boundaries
	• Involvement in the delivery of primary care through Northumbria Primary Care Ltd

South Warwickshire NHS Foundation Trust	
Key characteristics	
Services provided	Acute and community
Hospital portfolio	1 acute hospital (with A&E)
	3 community hospitals
Population size	550,000 (approximate community services catchment area)
	270,000 for Warwick Hospital
Workforce	3,430 WTE / 4,140 headcount
Budget	£226.8 million revenue (2013/14)
Historical details	Through transforming community services, took over community services for the whole of the Warwickshire area
	Attempt to acquire the George Eliot Hospital in 2013/14 unsuccessful
Financial situation	£2.1 million surplus in 2013/14
	Smaller surplus of £500,000 forecast for 2014/15 at Nov 2014
Local context	
Rural/urban	Mainly small towns and rural areas – with no major urban areas
Population characteristics	Older and more affluent population than the national average
	Small but significant minority ethnic populations, with Asian groups being the largest among these
Commissioners	CCGs
	• South Warwickshire CCG (approx. 70 per cent of income)
	• Coventry/Rugby CCG
	• North Warwickshire CCG
	Local authorities
	• Warwickshire County Council
Primary care	56 GP practices in South Warwickshire area
Other providers	University Hospitals Coventry and Warwickshire NHS Trust
	George Eliot Hospital NHS Trust
	Warwickshire County Council – providing social care
	Coventry and Warwickshire Partnership Trust (acute and community mental health care)
Notable features	An integrated acute–community provider in the south of the county
	Close proximity to a very large urban area (Coventry)
	Highly transparent relationship with local council – 'just short of open book accounting'

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South Warwickshire NHS Foundation Trust

Key innovations in integrated care

- Discharge to Assess – early geriatric assessment, discharge planning and post-acute care – in partnership with County Council
- Community emergency response teams working with GPs to identify patients at risk of admission
- Development of GP post in Warwick Hospital with responsibility for clinical care in Stratford Hospital
- Exploring 'social triage'

Yeovil District Hospital NHS Foundation Trust	
Key characteristics	
Services provided	Acute
Hospital portfolio	1 acute hospital (with A&E)
Population size	185,000 (approx.)
Workforce	2,200 (approx.)
Budget	£117.9 million (2013/14)
Historical details	Became a foundation trust in 2006
Financial situation	£200,000 underlying surplus in 2013/14
	Substantial deficits forecast for 2014/15 and 2015/16
	Long-term financial projection of increasing deficits if no change from local health economy status quo
Local context	
Rural/urban	Mostly rural with one small town
Population characteristics	Age profile older than national average
	Population rise expected among older age groups (>65s expected to increase by 30 per cent over 2011–2021)
	More affluent on average and higher-than-average life expectancy
Commissioners	CCGs:
	• Somerset CCG
	• Dorset CCG
Primary care	75 GP practices in Somerset, 19 in the hospital's 'catchment' area part of a federation
Other providers	Dorset County Hospital NHS Foundation Trust (neighbouring acute)
	Taunton and Somerset NHS Foundation Trust (neighbouring acute)
	Somerset Partnership NHS Trust (community and mental health services)
	Somerset County Council (social care)
	Nearby private providers: Circle Bath, Shepton Mallet NHS Treatment Centre, Nuffield Hospital, Taunton, BMI Winterbourne Hospital
Notable features	Small acute-only provider

Yeovil District Hospital NHS Foundation Trust

Key innovations in integrated care

- Symphony project partnered with other local organisations and the York University Centre for Health Economics to produce comprehensive analysis of health and social care spend and develop multi-morbidity models of care.

- Development and pilot of multi-morbidity care model working in partnership with primary care – influenced by extensivist care model

- Exploration of different organisational models (eg, joint ventures) and contracting options to support new care models

- Use of horizontal networking arrangements to enable other organisations to provide services on Yeovil site

- 15-year strategic estate partnership to fund and manage new 'health campus' development

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Ideas that change health care

A core part of the vision in the *NHS five year forward view* is a fundamentally different role for acute hospitals. Hospitals in England and elsewhere face significant challenges as a result of rising demand and the changing needs of the population, and will not be able to meet these challenges by working alone. Instead, acute trust leaders will need to work increasingly closely with primary care, community services, social care and others to achieve common goals.

Acute hospitals and integrated care: from hospitals to health systems explores the evolving role of acute hospitals, as clinical and managerial leaders move from an organisational focus to a system-wide perspective. The report focuses on lessons from five case studies where acute hospitals are working collaboratively with local partners to build integrated models of care. It assesses the achievements made so far, and distils lessons for other local health economies in terms of how to:

- build a sense of shared accountability across the system

- strengthen connections with primary care

- break down barriers between acute and community service professionals.

This research has important implications for the implementation of the care models envisaged by the *NHS five year forward view* – not least the need to recognise the ambitious scale of its vision. Despite the advances already made, further progress will be needed to involve primary care more in integration and to broaden thinking to include population health and prevention. Clinical and managerial leaders in the acute sector have an important role to play in relation to both these goals.

To support its broad recommendations, the report lists specific actions that will be required from local commissioners and national bodies, such as NHS England, system regulators, professional bodies and the Department of Health.