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The path to integrated care

At a glance

Internationally, many hospital services are already at full capacity or are rapidly approaching their limits. The evidence shows that in order to relieve increasing pressure on hospitals – and community-based services – a whole-systems perspective is needed, adopting an integrated approach that recognises the 'real world' complexities of modern health care

Finding ways to successfully integrate health services is becoming more urgent as demand for health services grows, with an increasing prevalence of people with multiple morbidity, and increasing complexity of health care requiring strong collaboration between hospitals and community-based services.

When initiatives to integrate services are planned and implemented well, they can improve the quality and effectiveness of services and reduce rates of hospital admissions. But many attempts at integrating services have not produced the hoped-for results. There are various reasons for this, including a lack of long-term investment, over-ambitious political expectations in short-timeframes; poorly prepared environments, including staff shortages, for establishing the conditions for change; and poor understanding of what is required to implement innovative change in complex adaptive systems, including poorly informed attempts to integrate services from top-down directives.

There is no 'one size first all' model for integrating services because integration can take many forms and the requirements for implementing change is determined largely by local context, including the diversity of populations served, existing health policies and political environment, geographical issues, differing philosophies of care, advances in biotechnology, and funding mechanisms, among others. However, there are common elements that are critical for success. These include:

- Upfront and long-term investment, recognising that it takes time to produce measurable and sustainable benefits.
- Working from the 'bottom up' in a highly organic and adaptive process.
- High levels of ongoing dialogue, debate and discussion at all levels to achieve shared understanding about quality problems and solutions. This requires collective leadership; that is, leadership that is not focused on a few 'heroic' individuals in formal leadership roles but is shared and distributed as a collective responsibility.

Successful initiatives to improve communication across organisations and different parts of the system, including IT and the quality and efficiency of referrals between community and hospital services, are a product of collective leadership.

The 'Canterbury Initiative', which includes many of the features considered important to successful integration, has been recognised internationally as an example of how to implement changes to achieve better community-hospital care integration. Similar to experiences overseas, however, the Canterbury District Health Board's (DHB's) initiative is constrained by funding and staffing shortfalls.

Introduction

Hospital use continues to rise higher than the population growth rate, strongly influenced by the rapidly growing number of patients with multiple, chronic health conditions.[1] These patients often need access to multiple health and social care services but often experience fragmented and poorly coordinated care, which can draw them into a vicious circle of increasing or repeated use of hospital care.[2 3 4]

As a result, many hospital services are running at full capacity or are rapidly approaching their limits. A common response internationally has been to focus on policies to strengthen community care. However, the evidence shows that in order to relieve increasing pressure on hospitals – as well as community-based services – the focus cannot be on community care alone; a whole-systems approach is needed because with the introduction of interventions in community care there will often be implications for hospital care, and vice versa. A systems perspective adopting an integrated approach has been identified as becoming increasingly important in dealing with and understanding 'real world' complexities of modern health care.[5 6 7]

Integrated care, an umbrella term to describe initiatives which aim to address fragmentation of care between and within public services, has been an aspiration in many countries.[8] In New Zealand it has been a policy goal in various ways since the establishment of area health boards in the 1980s, in the market-oriented system in the 1990s (including both negative and positive effects on incentives to integrate care), and continued with the current health system model of district health boards (DHBs) from the 2000s, with a particular emphasis on integrating community health care.

But while the notion of integrated care intuitively makes sense, for policy makers and providers both here and around the world it has until relatively recently doggedly remained an elusive goal. There is a growing understanding internationally of how to achieve successful integration with examples, including the 'Canterbury Initiative' at Canterbury DHB and some health care trusts in the United Kingdom (UK), that have brought about significant service improvements.

This paper considers the potential for integrated, patient-centred care approaches as a response to the mounting pressures on New Zealand's hospitals, learning from the lessons given in the literature and particularly from the internationally recognised achievements at Canterbury DHB.

For clarity, integrated care is defined in this paper as:

> *The provision of seamless, effective and efficient care that reflects the whole of a person's health needs; from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family. It requires greater focus on a person's needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home.*[9]

The growing urgency for integration

Life expectancy across the Organisation for Economic Co-operation and Development (OECD) is increasing and studies show that around half the gains in recent decades stem from improved health care.[10] The effect of this success in part is that chronic illness and mental health needs have become more prominent and are increasing as the population ages, exacerbated by public health problems such as obesity. In New Zealand 20%-30% of the years of life gained over last 25 years are lived in poor health; the use of Mental Health and Addiction Services (MHA) has increased well beyond the rate of population growth in recent years; and stark inequalities exist in health outcomes by ethnicity and socioeconomic deprivation.[11] [12]

In addition, multimorbidity is one of the biggest challenges facing New Zealand's health system, as is the case internationally, as multiple disease care, not single disease care, becomes the norm in an aging society. In New Zealand, multimorbidity has been estimated to affect about one in four adults, which is consistent with findings in many other countries. [13] Multimorbidity is associated with higher health services use across a range of providers, including higher likelihood of preventable hospital admission and readmission, and greater lengths of stay. Multimorbidity is also associated with higher premature mortality rates, polypharmacy, and higher rates of adverse drug events.[14] [15] [16]

A qualitative study of multimorbidity clinical decision-making in New Zealand primary care, involving interviews with GPs and practice nurses, found the complexity of patients' multiple conditions caused difficulty in managing care based on the number of items on the patients' agenda to be addressed in the time available. Indeed, chronic disease management is predominantly delivered using a traditional single disease model which means people with multimorbidity often receive fragmented, inefficient and duplicate health care delivery.[17] [18]

As well as the increasing prevalence of people with multiple morbidity, the complexity of health care is mounting as advances in research and technology are increasing the availability of different treatment, diagnostic and care management options.[19]

Increasingly the care of patients frequently involves a variety of health care professionals working within and between a number of health care organisations. Unsurprisingly this approach has led to a dramatic increase in the numbers of 'handovers' of patients and/or information and care about them both within and between health professionals and health provider organisations. A study comprising three structured literature reviews on the benefits, enablers, barriers and challenges concerning the processes of discharge, referral and admission found 'ample evidence' that these processes are "all potentially high risk scenarios for patient safety with dangers of discontinuity of care, medical and medication adverse events, including avoidable re-admissions and inefficient

health care practices in managing patient flow within the community, into hospital and during the return of patients to community settings".[20]

For primary care professionals, both the increasing complexity of modern medicine and the increasing prevalence of multimorbidity present challenges with respect to both clinical decision-making and health care delivery.[21] And the decision of where to refer a patient is becoming more complex with increasing sub-specialisation in hospital care and more differentiated hospital and community-service provision. Within this context, the question of destination is becoming ever more important as a dimension of quality.[22] [23] [24]

A study on the quality of general practitioner diagnosis and referral, including a literature review of more than 350 published articles on the topic, identifies a range of factors that create particular difficulties, including:

- assessing evolutionary and undifferentiated symptoms;
- the weak predictive value of diagnostic tests in primary care;
- the low prevalence of certain conditions, and the high degree of overlap between symptoms for common and serious conditions;
- a lack of reliable data on family and patient history; and
- the need to manage the competing demands of being a primary care provider and acting as gatekeeper to hospital care.[25]

There are wide variations in referral rates but interpretation of these is highly complex due to multiple factors that influence referral decisions. However, an international review of referral interventions from primary to specialist care, involving 140 studies, found the available evidence suggests that:

- not all referrals are necessary in clinical terms, and a substantial element of referral activity is discretionary and avoidable;
- there are patients who need a referral but fail to receive one;
- a large number of those currently referred to hospital care could be seen in alternative settings;
- many referral letters lack the necessary information;
- there is frequently a lack of shared understanding of the purpose of the referral between the GP, the patient and the consultant; and
- appropriate investigations have not always taken place prior to referral. [26]

Studies in the UK indicate many GPs and other health care professionals do not have advanced training in the diagnosis and treatment of conditions with which the majority of their patients present. For example, up to 50% of GPs had little or no paediatric training, despite paediatric cases making up 40% of their workloads. Similarly, skin conditions are one of the most common diseases encountered by health and dermatology consultations are expected to rise considerably with the ageing population, but GP training includes very little dermatology training. [27] [28]

Various approaches have been introduced to attempt to improve the quality of referrals, including clinical guidelines, structured decision support systems, clinical triage and educating GPs. But each, on its own, has shortcomings and overall they have not lived up to expectations. [29] [30]

A study reviewing the evidence for managing referrals from GPs to hospital specialists concluded there is no 'magic bullet' to managing demand for hospital care services: "the perfect solution does not exist and issues such as the context of a particular specialty or the location of a service impacts on the generalisability of interventions". What is clear, however is that in attempting to address increasing service demand the focus cannot be on primary care alone; "a whole-systems approach is needed because the introduction of interventions in primary care is often just the starting point of the referral process". [31]

A systems perspective adopting an integrated approach has been identified as becoming increasingly important in dealing with and understanding 'real world' complexities of modern health care.[32] [33] [34]

Conflicting accounts of the effectiveness of integrated care

In many health systems around the world, the potentially significant benefits of integrated care have been recognised for many years.[35] Yet the evidence supporting policies for integrating care is highly variable. On the one hand, for example, an international review of 53 individual controlled trials investigating the impact of integrated care on hospital admission rates found, in aggregate, a 19% reduction in hospital-admission rates compared with usual care. On the other hand, some studies indicate the evidence for integrating health care is, at best, weak, or too mixed to interpret in a meaningful way to support service design and planning. [36] [37]

There are various reasons for these discrepancies. Firstly, there is no universal definition or concept of integration, which can take many different forms, and there is a lack of standardised, validated tools that have been systematically used to evaluate integration outcomes. This makes measuring and comparing the impact of integration on systems, providers and at patient level challenging, producing uncertain results.[38] [39] [40]

Attempts to integrate care in some countries have also proved challenging because the political systems or health systems are not well designed to support integration. In Australia, for example, primary care is the responsibility of the Federal Government while hospitals are the responsibility of the states, leading to cost-shifting between them.[41] In the UK, while developing integrated services is key policy, the Government's reforms, which have led to top-down reorganisations of the National Health Service (NHS) and greater marketisation, have pulled the system in the opposite direction to integrated care. NHS Trusts are responsible for secondary and tertiary care while community care was the responsibility of the former Primary Care Trusts and now the newly forming Primary Care Networks. Changes made to the structure of the NHS have introduced greater fragmentation to the way that services are commissioned, making it harder to align incentives between different providers.[42]

In contrast, New Zealand's health system, with DHBs being responsible for the health of defined populations and for both community and hospital care, and the requirement for DHBs to undertake health needs analyses, lends itself more to supporting integrated care.[43]

Other well-known policy barriers to the development of integrated care include payment systems that reward organisational activity rather than collective outcomes; regulation that focuses too heavily on organisational performance rather than system performance; and the lack of a single outcomes framework to promote joint accountability for integrated care.[44]

Some attempts at integrating services have not produced the hoped-for results due to a lack of long-term investment, over-ambitious expectations in short-timeframes, and poorly prepared environments for establishing a platform for change.

The UK Government's 2014 plan for integrated health and social care services across England by 2020 is a case in point. The plan, which formed the basis of a 'Five Year Forward View' programme described by its architect as the greatest move to integrated care of any western country, was considered to be 'at significant risk' in a 2017 report by the National Audit Office (NAO) due in part to the pressures created by financial constraints while demand for services continued to increase.[45] The NAO commented that, "Integrating the health and social care sectors is a significant challenge in normal times, let alone times when both sectors are under such severe pressure." A parliamentary Health and Social Care Committee report in 2018 reinforced those comments, saying the scale and ambition of the plan "has not been matched by the time and resources required to deliver it", noting that "countries that have made the move to more collaborative, integrated care have done so over 10–15 years and with dedicated upfront investment".[46]

Furthermore, while intuitively integrating services ought to improve economies of scale and therefore cost-effectiveness, the literature indicates it may not necessarily be cost saving (a key aim of the UK's programme) if, for example, improving quality and safety and improving access to services in the face of increasing demand are taken into account.

Many attempts to integrate services have also faltered because they have focused primarily on organisational integration without recognising the critical importance of how people engage with services, or how professionals work together to deliver care.

The literature is clear that organisational integration does not necessarily lead to integrated care at the patient level.[47] Organisational integration may occur in the absence of clinical and service integration. One review found "the structures that were put in place to integrate different providers often failed to fundamentally alter the manner in which physicians practised medicine and collaborated with other health care professionals". The consequence was that "integrated structures rarely integrated the actual delivery of patient care". This observation is supported by a recent review of organisations claiming to deliver integrated care to older people in North America which found that only half actually provided more coordinated care for older people and their carers.[48]

A study examining attempts to integrate care in Quebec concluded: "Policy-makers and health care organisation executives often believe that organisational integration leads to, or even equates with, integrated care. This assumption doesn't hold true in practice." The study found that merging organisations could not facilitate integrated care unless all players wanted this to happen and were involved in an appropriate way to deal with service problems. Otherwise they triggered conflicts and mistrust.[49] Empirical studies in Sweden and Britain reached similar conclusions.[50] [51]

Another major study, which draws lessons from seven international case studies on integration, found that while there were potentially some advantages in having a unified organisation – for example, single budgets and clear lines of accountability – the evidence from the case studies indicated a great deal of time and effort is required to merge organisations, and they were more vulnerable to 'top down' interference, which was identified as a barrier to integration. The study, echoing other international studies, suggests integrated care is possible only if it comes from the 'bottom up' through the development of specific 'micro-level' interventions by a small number of providers. 'Organisational integration then comes as a consequence rather than a cause and may not occur at all.'[52]

A study providing a summary of published reviews on the economic impact of integrated care approaches (and found the evidence inconclusive), suggests that rather than viewing 'integration' as an intervention, it should instead be interpreted and evaluated as a complex strategy that involves multiple changes at multiple levels.[53]

A commonly identified requirement for integration of community-hospital care services is the quality of the relationships between hospital specialists and community-based health care teams, especially GPs, but this is often overlooked in attempts to integrate services. [54]

Building relationships to support integrated care

The importance of developing relationships at the hospital-community care interface based on trust is highlighted in a qualitative study of the relationships between GPs and hospital specialists in Scotland.[55] It reasons, from the literature, that developing trusting relationships is a part of an organisation's social capital; ie, GPs' and hospital specialists' willingness and ability to come together for the benefit of patient care. The study acknowledges evidence that suggests many doctors work hard, sometimes over many years, at developing good personal relationships with their colleagues. However, various factors impede the development of trusting relationships.

A combination of workload stresses, problems with accessing one another, and lack of shared opportunities to meet can lead to mutual perceptions of the other being uncooperative or disrespectful. Participants in the Scottish study referred to issues of perceived 'dumping' (defined as an inappropriate transfer of workload across the interface) and 'resisting' (a term used to depict the opposition of colleagues to take on work being handed over to them). Such perceptions can have a negative impact on the quality of conversations when they do occur, and in turn on the quality of patient care.

The study concludes that addressing barriers to forming relationships (including clinicians' heavy workloads and less shared meeting time) is necessary in order to improve effective care delivery. It makes a number of recommendations for improving information sharing, spending more time in each other's workplaces, and collaborating on devising shared clinical guidance, "with support from national and local health care managers."

The evidence shows that establishing trusting relations across the community-hospital interface leads to more effective and better-quality services.

> *Good clinical relationships facilitate information exchange, provide learning opportunities and underpin high-quality diagnosis and referral. Good relationships may also make it easier for GPs to seek informal advice, reducing the need for making formal referrals and avoiding duplication of tests.* [56]

Trusting relationships are also essential for integration, as "cooperation is a by-product of trust […] rather than a source of trust".[57]

The impact of strong relationships and collaboration is illustrated in the evidence concerning hospital specialist clinics being provided in the community. Although these types of services are increasingly common the evidence indicates there may not be sustainable differences in health outcomes, waiting times, or attendance rates compared to usual outpatient services. A Cochrane review concluded that specialist outreach alone may have few impacts. However, when implemented as part of more complex multifaceted interventions involving collaboration with primary care, and other community services, outreach is associated with improved health outcomes, more efficient referrals, less use of hospital services, better patient satisfaction, and better service accessibility. [58] [59] [60] [61] [62] [63]

Further, while much of the literature focuses on GP-hospital specialist interactions, the increasing multidisciplinary nature of health care requires good engagement between hospital specialists and the whole community-based health care team. There is growing recognition of the potential value of hospital specialists being involved in a wider range of activities that bring them into direct contact with community care staff, including providing training.[64]

This new way of working is a key element of the UK's Royal College of Physicians' vision for the 'future hospital', which calls for medical teams bridging hospital and community settings to provide a co-ordinated service closer to patients' homes.[65] [66]

Collective leadership

While improving communication systems, including aligning IT systems, and eliminating financial barriers are fundamental to integrating services across organisations, the evidence shows such changes will not produce successful integration without engaging and gaining the support of the staff on the ground from the beginning.

This is not merely because staff engagement and buy-in to any system change is widely acknowledged as good employment practice that can result in great efficiencies and effectiveness in any organisation. It is also because attempts to change models of service in a complex-adaptive system such as a health care system do not respond to the scientific management approach in which change is viewed as linear and predictable and can be achieved through orderly planning and control processes.

Transformational change instead is a highly organic and adaptive process specific to the local context, by which the organisation adapts to the innovation and the innovation is adapted to the organisation. It is a process which requires high levels of ongoing dialogue, debate and discussion at all levels to achieve shared understanding about quality problems and solutions. This requires collective leadership, where everyone takes responsibility for the success of the organisation as a whole – not just for their own jobs or work area. [67] [68]

> *At a time when there is growing interest in integrated care and partnership … collective leadership in local health systems has never been more important or necessary.*
>
> - The King's Fund 2014[69]

Because of the critical importance of collective leadership, including distributive clinical leadership, and the scarce attention paid to it by policy makers in New Zealand, the subject is to be examined in more detail in a separate paper.

In the meantime, Canterbury DHB's achievements in integrate hospital and community care services provide an instructive case study, incorporating much of what the literature indicates is required for successful integration. Those involved in the 'Canterbury Initiative' have emphasised there remains much work to be done; indeed the work is ongoing. Furthermore, the DHB's capacity to function effectively has been impeded on multiple fronts, including the substantial ongoing effects of the 2010 and 2011 Christchurch earthquakes, and nearly a decade of successive real-term funding cuts. The latter has contributed to what the DHB's clinical leaders assessed in 2017 as a 25% shortfall of senior medical staff needed to provide safe, quality and timely health care; and a study published in 2016 found a 47% burnout rate among the DHB's senior doctors. [70] [71]

Despite these challenges, Canterbury DHB's incremental moves to better integrate hospital and community services is recognised internationally as an initiative that has resulted in some measurable positive changes.[72]

The 'Canterbury Initiative'

Much has been written internationally about the 'Canterbury Initiative'. Since its beginnings in 2007 it has been credited with succeeding in creating stronger integration across organisational and service boundaries and in doing so has moderated demand for hospital care – one of the biggest challenges facing health care systems around the world. The model's achievements indicate that the ever-increasing demand on hospital services is not inevitable if investment is made in alternative models where collaboration between hospital care and community care services can strengthen both and can lead to more services being provided in the community.

To get there, Canterbury adopted three key approaches: the development of a clear, unifying vision behind a 'one system, one budget' message; sustained investment in giving staff skills to support them to innovate and giving them permission to do so; and developing new models of integrated working and new forms of contracting to enable this.

Developing the vision

Developing a vision of how the health care system should change involved significant staff engagement. This began with senior staff, involving training in change processes and management techniques, then broadening to include staff across the DHB and partner organisations, eventually involving more than 2000 employees who in a series of events were invited to offer their own solutions to the challenges facing their services.

The overarching vision emerging from this engagement process was a single, integrated health and social care system where services would work together to deliver patient-centred care and improve access to all services. The unifying concept was to act as much as possible as 'one system, one budget' even though the reality was far more complex than this.

Investing in staff

Staff engagement has been central to implementing the strategic vision as well as developing it. A significant investment has been made in equipping the workforce first with the insight that it is employees and contractors who can change the way care is delivered and then supporting them and giving them access to the tools to help achieve that. It is an illustration of how change can be brought about primarily "from within by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli". [73]

This supports the observations of some researchers who question whether 'integration' should be considered an intervention in itself or whether it should instead be interpreted and evaluated as a complex strategy that involves multiple changes on micro-level interventions emerging from the 'bottom-up'.

Developing new forms of contracting

Canterbury scrapped the method of determining hospital budgets by the level of activity they undertook, which ran counter to developing an integrated system. It was replaced with 'alliance contracting', a more relational approach involving organisations working together to manage care collectively and sharing risks and gains that may result. The DHB provides block grants to its providers and makes collective decisions with alliance partners on how to use any savings from efficiencies and how to address any overspends within individual services, recognising the viability of services is paramount.

It does not attempt to incentivise providers with additional payments or penalties for good or poor performance. Instead it emphasises the importance of strong relationships underpinned by trust, and strong staff engagement. As prominent American health administrator Don Berwick has commented, financial incentives "are destructive of what we need most in our health care industry — teamwork, continuous improvement, innovation, learning, pride, joy, mutual respect, and a focus of all our energies on meeting the needs of those who come to us for help".[74]

A clinically led alliance leadership team, supported by-service-level teams with responsibility for driving service improvements in their respective areas, means leadership responsibilities and capabilities are spread across the system, reducing reliance on a few senior leaders, creating stronger sustainability.[75]

Health Pathways

'HealthPathways' is a programme bringing together hospital specialists and GPs, and other health professionals to agree management and referral pathways for over 550 conditions. Rather than being traditional guidelines, each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context, reflecting local arrangements and opinion.

The programme was initiated by a group of Canterbury DHB hospital doctors and GPs and other health professionals with an aim of improving referral processes and communication between them. They then engaged with a larger group of doctors and other health care professionals to further develop and broaden the scope of the programme. Its use has since spread across other health care organisations in New Zealand (including most DHBs), Australia and the UK.

It was considered a 'step forward' from other online clinical guidance systems, such as 'Map of Medicine', a privately owned toolkit which had previously been used by a few DHBs until it was taken of the market, as it provided locally relevant information and was established by an iterative and collaborative process between healthcare professionals, management, and others. They are regularly reviewed, audited and updated using the same process.[76]

However, an evaluation of the implementation of HealthPathways at Southern DHB, and anecdotal reports on its introduction in other DHBs, suggest in many cases DHBs have failed to prepare the critical groundwork needed to successfully implement the changes. In Southern, there was "a lack of understanding about what was achieved in Canterbury during the planning phase and what was important to the successful uptake and use of HealthPathways". In particular, Southern and other DHBs do not appear to have invested in the time and resources to establish strong trusting

relationships and strong staff engagement to enable the changes to be led through distributed clinical leadership, with collective responsibility. The ongoing pressures from financial austerity and variable support from management have also been cited as major shortcomings in implementing the HealthPathways programme and associated changes. [77] It is significant that HealthPathways in Canterbury DHB commenced prior to successive years of real-term funding cuts to DHBs since 2009/10. Consequently CDHB was not confronted at least to the same extent with the same pressures as DHBs are now facing.[78]

Technology

Developing new IT systems has been an important part of Canterbury DHB's move towards integrating services.

One key development, an 'electronic shared care record view, combines GP records, hospital records, community pharmacy records and laboratory and imaging results. It did not replace existing systems but instead brings together information from different e-health systems through a central portal. The 'record view' has therefore been able to be implemented without the disruption of moving multiple organisations to a single IT system. Again, this initiative was developed collaboratively, overseen by a project team representing key clinical groups across the system.

Other IT developments in which hospital specialists and GPs were closely involved in designing, include an electronic request management system enabling GPs to request diagnostic tests, specialist assessments outpatient appointments and specialist advice more quickly and effectively.

Outcomes

Among other achievements, the development of the integrated care model in Canterbury has led to a significantly slower rate of growth of acute hospital admissions than in the rest of the country. One study estimated that if these changes had not been made and Canterbury had been admitting patients in line with national rates, it would have needed 100 more acute hospital beds in 2015 than it had. Compared with other DHBs, Canterbury has achieved low acute medical admission rates, short average length of stay for medical admissions, and low acute readmission rates.[79]

Despite the DHB's challenges discussed above, it remains one of the highest performers in achieving low acute admission rates and acute readmission rates, as well as avoidable hospital admission rates and amenable mortality rates (death that could have been avoided with timely health care). The proportion of GP referrals declined for a first specialist assessment at the DHB is also one of the lowest in the country. [80] [81] [82]

Lessons from Canterbury

The experience at Canterbury demonstrates that integrating hospital and community-based services requires significant long-term investment and time. As one commentator reported, "It takes years of trust and hard slog" – and recognition that such transformations continually evolve. They are the antithesis of short-term thinking and expectations that health policy-makers have tended to espouse.[83] [84]

Although the changes have moderated demand for acute care, they have not reversed it; they have not cut beds or taken resources from hospitals. Canterbury's experience casts doubt over expectations that new models of care will enable disinvestment in acute hospitals. A more realistic goal would be to bend the demand curve, slowing – but not reversing – growth. (The extent to which this is due to austere health funding policies and related staffing shortages over much of the transformation period is not possible to assess but they would have undoubtedly had an impact.)[85]

The model shows that it is not necessary to merge organisations, replace IT systems or introduce health targets to attempt to incentivise better performance to integrate services.

A key to its successes is down to developing 'strong relationships underpinned by trust, and strong staff engagement". Clinical leadership is 'not focused on just a few heroic individuals in formal leadership roles,' but is shared and distributed as a collective responsibility. [86] [87] [88]

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