EHMA 2024

Shaping and managing innovative health ecosystems

Hospitals vertically integrating with primary care practices

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#EHMA2024

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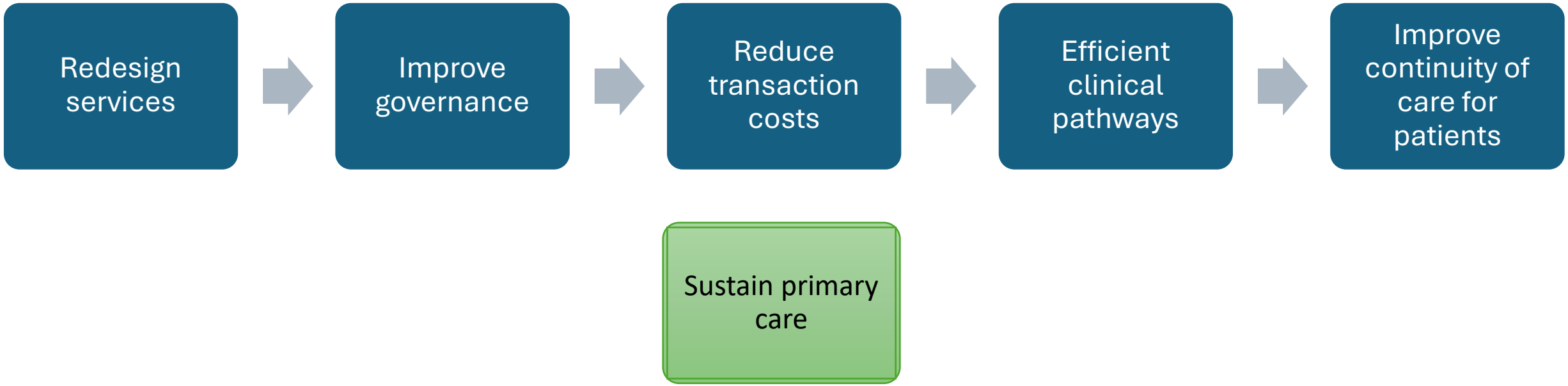
Vertical integration of hospitals and primary care

Why vertically integrate?



Vertical integration in England, 31 March 2021

26 NHS trusts running 85 primary care practices

Vertical integration is scattered across England:

- both urban and rural areas
- no great difference in socioeconomic deprivation

Primary care practices integrating with NHS Trusts, compared to other practices, had on average:

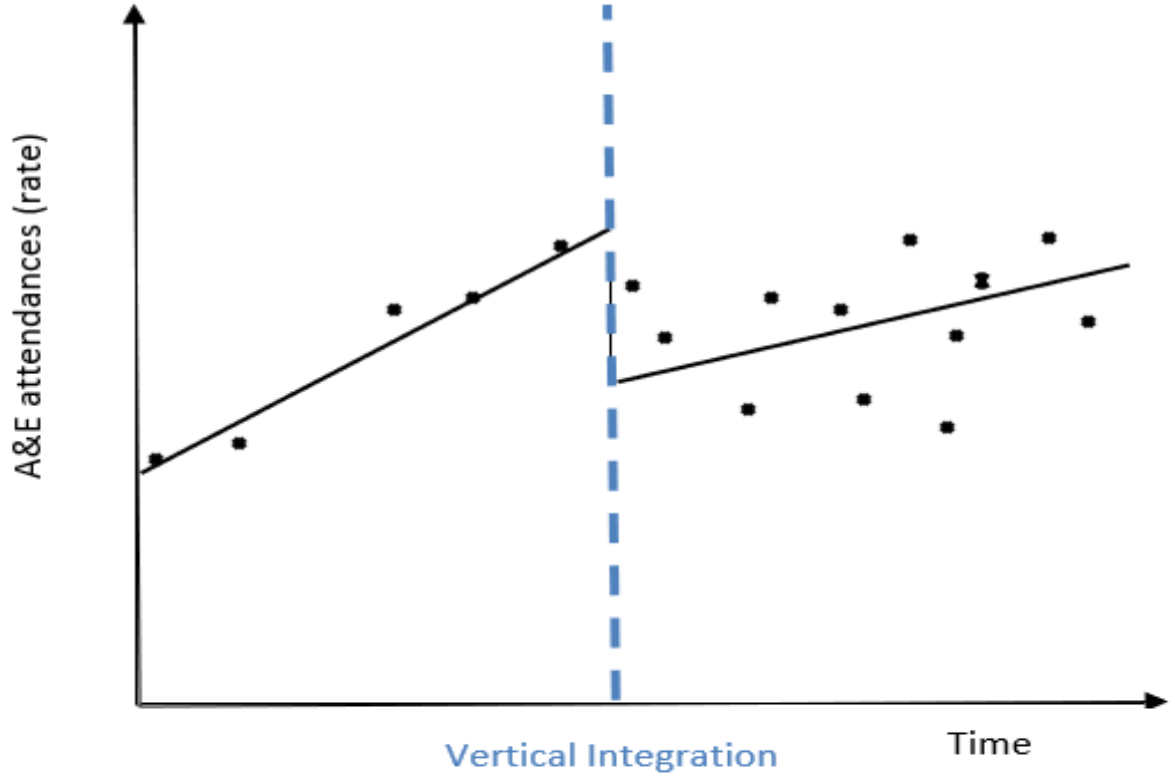
- Fewer patients
- Fewer primary care physicians (full time equivalents)
- Lower ‘Quality and Outcomes Framework’ scores
- Greater likelihood of being on shorter-term contracts with the National Health Service

Trends in hospital activity by patients of vertically integrated practices relative to a random sample of control practices: 2 years before and after vertical integration and step change at the date of vertical integration

A&E attendance rate: falls 2% at time of VI but reduction is only temporary

Additional yearly change in the pre-intervention period		Step change at time of intervention		Additional yearly change after the intervention	
Incident rate ratio (95%CI)	p-value	IRR (95%CI)	p-value	IRR (95%CI)	p-value
1.03 (1.01-1.05)	0.0008	**0.98** (0.96-0.99)	<0.0001	**1.02** (1.00-1.04)	0.012

Conceptual depiction of the pattern of A&E attendance rates for patients of vertically integrated practices relative to control practices



Outpatient attendance rate falls 1% at time of VI but only temporarily

Additional yearly change in the pre-intervention period		Step change at time of intervention		Additional yearly change after the intervention	
Incident rate ratio (95%CI)	p-value	IRR (95%CI)	p-value	IRR (95%CI)	p-value
1.03 (1.02-1.05)	<0.0001	**0.99** (0.99-1.00)	0.0061	**1.02** (1.00-1.03)	0.0064

Emergency inpatient admission rate falls 3% at time of VI

Additional yearly change in the pre-intervention period		Step change at time of intervention		Additional yearly change after the intervention	
Incident rate ratio (95%CI)	p-value	IRR (95%CI)	p-value	IRR (95%CI)	p-value
0.98 (0.96-1.00)	0.03	**0.97** (0.95-0.99)	0.0062	**1.00** (0.98-1.01)	0.61

Emergency inpatient readmission rate falls 5% at time of VI

Additional yearly change in the pre-intervention period		Step change at time of intervention compared with "stable" GMS practices		Additional yearly change after the intervention	
Incident rate ratio (95%CI)	p-value	IRR (95%CI)	p-value	IRR (95%CI)	p-value
0.97 (0.94-1.00)	0.093	**0.95** (0.91-1.00)	0.039	**1.01** (0.97-1.04)	0.74

Vertical integration has no significant effect on:

- Total inpatient admission rate
- Ambulatory care sensitive conditions (ACSC) admission rate
- Length of stay

Conclusions

- Main rationale for vertical integration has been to sustain primary care practice
- Which provides a platform for primary care service improvements
- Vertical integration can lead to modest falls in patients' use of hospital services
- But vertical integration locations are not typical
- So the findings do not imply support for a national roll-out of vertical integration

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