HSJ LOCAL briefing

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CUMBRIA HEALTHCARE CRISIS

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Longstanding problems for Cumbria's two acute trusts have escalated into separate but significant crises. Deep financial problems at North Cumbria University Hospitals have forced the trust to seek takeover. Since last summer University Hospitals of Morecambe Bay has been at the centre of a spiralling care quality scandal, which began unfolding just months after it became a foundation trust.

Context Both trusts face major challenges to remain sustainable in a huge, sparsely populated region, where hospital services cannot be centralised without significantly restricting access. Since 2007 commissioners have pursued a controversial strategy of increased community provision, to reduce demand for acute care. However, differences over the strategy exacerbated poor relations between NCUH and NHS Cumbria.

Outcome Cumbria Clinical Commissioning Group has pulled back from "heroic" assumptions about activity reduction and is building improved relations with providers. However, it remains committed to reducing hospital activity in coming years. It is likely to push for significant reorganisation of some services, particularly the development of clinical networks. The first proposals for service changes at UHMB will emerge later this summer. Short-term changes the trust has made to redress quality problems have pushed it into deficit, and it is likely to record deficits for the next two years.

Background

With its borders meeting Scotland to the north and the Irish Sea to the west, Cumbria is as remote from Westminster as you can be in England. But over the past five years the county has pioneered a model of NHS care that now lies at the heart of the government's health reforms.

In 2007 Cumbria Primary Care Trust embarked on Closer to Home, an ambitious strategy aimed at tackling rising demand for healthcare, geographical challenges, and ingrained financial problems by providing more and better healthcare outside of acute hospitals. It developed clinical commissioners among the county's GPs to champion and execute this programme, with budgets progressively devolved to six GP-led "locality" groups. Those groups are now widely recognised as forebears of the clinical commissioning groups that will replace PCTs from 2013.

In 2008 chief executive Sue Page wrote: "We have stopped the Cumbria NHS tanker from hitting the rocks. And, in place of the lumbering big ship, we have created a flotilla of small boats. That flotilla will be agile enough to plot its own course through the seas of changing healthcare." Within five years, she added, Cumbria would have seen a "significant shift in emphasis" from an "acute hospital centred model to a fully integrated community-based model". The PCT reported that, despite inheriting an underlying deficit of £18m when it formed in 2006, it had brought its spending within budget; reassured, the strategic health authority had provided NHS Cumbria with £28m to write off historic debts.

But over the past two years the Cumbrian health economy has been thrown back into very rocky waters. In 2010-11 NHS Cumbria again recorded a deficit – of £6m – one of just two PCTs to finish that year in the red. Meanwhile, both of the county's acute providers were sliding into serious, but distinct, crises.

At North Cumbria University Hospitals, financial problems snowballed. Even before the health service began its £20bn funding squeeze in 2011-12, the trust had been unable to live on the income it was earning at NHS payment by results prices. According to the PCT, North Cumbria needed extra funding of around £28m last year, up from £24m in 2010-11, £20m in 2009-10 and £26m in 2008-09. Becoming an independent foundation trust by 2014 – the government's target date for all NHS trusts to attain FT status – became impossible. Last summer the trust put itself up for takeover.

Then, in July last year, the Care Quality Commission carried out surprise inspections of the maternity services at University Hospitals of Morecambe Bay Foundation Trust, following an inquest into the death of a baby born at Furness General Hospital. The regulator reported "major concerns" over the premises, staffing, and quality monitoring of the service. Police launched an investigation into infant deaths at Furness, and foundation trust regulator Monitor issued the trust with a red rating for governance. As the two regulators focussed more closely on Morecambe Bay they found a catalogue of serious issues, ranging from "crisis level" staffing at the trust's Lancaster A&E department, to thousands of overdue follow-up appointments, to above-average death rates. Both UHMB and North Cumbria were among just 19 trusts identified in healthcare intelligence firm Dr Foster's latest hospital guide as registering high mortality against more than one key measure.

The respective crises at both trusts have been attended by the departure of senior leaders. Of the three NHS providers in Cumbria, the community services provider – Cumbria Partnership FT – is currently the only one with a permanent chief executive in post. UHMB's Tony Halsall stepped down earlier this year, shortly after Monitor installed a new chairman at the trust. Carole Heatly left her post as North Cumbria chief executive after the trust put itself up for acquisition.

Both trusts have now appointed interim chief executives, and Cumbria's clinical commissioners are showing increasing independence from the PCT, of which they are still formally a part. All three organisations say they have done much to move on from the damaged relationships that both exacerbated and were exacerbated by problems in the health economy. But fixing those underlying problems will be more difficult.

In the north, the strategy depends in the immediate future on securing the acquisition of North Cumbria by its preferred bidder, Northumbria Healthcare FT. At UHMB, it depends first on stabilising the services where regulators have identified failings, then on agreeing a plan with clinicians and the public to make those services sustainable. For some services it is plausible this will mean significant change, requiring formal public consultation.

For both trusts it depends on developing clinical leadership in organisations with histories of poor relations between clinicians and management. It also depends on persuading staff who have traditionally been disconnected even from other hospitals in their organisations to work in networks, across more than one site, more than one organisation, and in community as well as acute settings. It depends, in fact, on continuing the path laid by Closer to Home. "If you are going to provide care to a remote community," says Hugh Reeve,

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interim chairman of Cumbria CCG, you have to have a discussion with that community "about what services can be safely delivered in your local area, and which services do you agree with us will have to be delivered more remotely". That, he adds, "is going to be our job as clinical commissioners over the next four to five years".

However, according to North Cumbria interim chief executive Neil Goodwin, the situation Cumbria has found itself in remains "extremely unusual". "I doubt very much in my career that I've seen anything like it," he says. "Two hospitals providing services to the same health system, running into very significant, but different, operational difficulties."

He adds: "I would hope that at some point somebody senior says let's just stop and have a look at what we can learn here for the rest of the English NHS."

Geography

Asked why he believes Cumbria has ended up in this position, Dr Reeve responds: "I think some of it is around the challenge of trying to deliver healthcare to very remote, dispersed populations."

No conversation about Cumbria's problems lasts long without mention of geography. The county has a land mass of 2,635 square miles – more than four times that of Greater London – with a population of just 500,000. The main centres of population, in Carlisle, Barrow, and around the north-western coast, are separated by the mountains of the Lake District National Park. For these populations North Cumbria operates two acute hospitals, in Carlisle and Whitehaven, and UHMB a further three: FGH in Barrow, the Westmorland General Hospital in Kendal, and the Royal Lancaster Infirmary across the county's southern border in Lancashire.

This geography aggravates two problems. Financially, the "tariff" paid for most NHS services is set according to the average costs of providing them across all hospitals in England. Hospitals providing services to small populations face diseconomies of scale, and may not be able to cover costs at tariff prices. Clinically, the challenge of keeping those units adequately staffed has risen with the development of national standards for the "critical mass" of activity a hospital needs to ensure clinicians are practiced at handling complex cases.

The dilemma for the Cumbrian NHS is the limit to how far it can centralise services in response to these challenges without unacceptably rationing access to healthcare. When Dr Reeve became involved in Cumbrian commissioning four years ago the county offered acute medical services from five hospitals, he recalls. Clinical commissioners had needed to persuade the Kendal population their local hospital was no longer "the right place for them to be" if they suffered a heart attack – the hospital saw just two or three confirmed heart attacks a week. At that time, he continues, it meant those patients would instead need a 25-30 mile ambulance trip. Now, the CCG recommends anyone who has a heart attack in the south goes straight to Blackpool – 55 miles from Kendal, and more than 80 miles from Barrow.

Similarly, there has long been debate about whether North Cumbria can continue to provide the current range of services on its Whitehaven site. But the north west coast is home to much of Cumbria's population, and to the Sellafield nuclear reprocessing plant. "If there wasn't a medical obstetrics service on the west coast of Cumbria the nearest one is [Carlisle] and it's 45mins to an hour away," says Mr Goodwin. "If I was a resident on the west coast would I be happy about that? Or if there wasn't an emergency care service and I had a heart attack, would I be happy? Probably not."

He believes even if all inefficiency can be squeezed out of North Cumbria's acute hospitals, it will still need above-tariff funding: "You will then be left with a rump of inefficiency that is directly correlated to the need for duplication of hospital services."

The trust has not yet quantified what that underlying need for recurrent subsidy might be, but Mr Goodwin's "instinct" is the figure is around £20m.

Dr Reeve concedes the CCG cannot yet say "hand on heart" that Cumbria does not need ongoing "tariff-plus" funding for acute services. But Nigel Macguire, NHS Cumbria's chief operating officer and now interim managing director of the CCG, says there is a long way to go before concluding that it does. For a start, commissioners would want to know how Northumbria's NHS providers are able to operate within tariff. The neighbouring county is similarly sized, with a similarly dispersed population. Northumbria Healthcare operates three district general hospitals and seven community hospitals, for a population of around 500,000. "If it can be done in Northumbria," says Mr Macguire, "we'd want to check why it can't be done in Cumbria first."

The difference, believes Dr Reeve, is Cumbria has failed to develop genuine clinical networks within its trusts. Despite, he says, "a lot of attempts by various management teams" over the past decade it has yet to integrate either the two hospitals in the north or Lancaster and Barrow at UHMB to work as single clinical units. "It's about having clinicians in one specialty who will see their responsibility is to work across the whole system," he says.

At UHMB, the trust's newly-appointed interim chief executive Eric Morton says he believes it will "largely" be possible to operate within tariff, but services will need to be redesigned. If a service has enough patients coming through the door, he explains, tariff allows it to maintain appropriate staffing. "If you've got less than the number you need to sustain a safe service, there are two solutions. One is that you radically change the service model, the second is that you pay a local premium to sustain it." But, he adds, that will have to be considered service by service: "You can't have a local health community that funds all its services way above tariff, it ain't gonna work."

"When we've got assurance that everything is being done to operate effective clinical networks as whole systems across hospitals and there is still an argument it has to be tariff-plus we're clearly going to have that conversation," says Mr Macguire. "But, at the moment, it seems to be the wrong conversation to have."

Over the next two to three years, the CCG wants to concentrate on securing effective networks and configurations of services. It wants to begin, he says, with a conversation with clinicians about the "key specialties" that "have to work as networks" - such as urgent care, paediatrics, and obstetrics – about what that would mean in practice. He concedes that in some cases this may be about consolidating services into fewer units. But the CCG's strategy also depends on integrating primary, community and secondary care to better manage urgent treatment; and on bringing acute specialists out of hospitals to build GPs' knowledge, allowing more-challenging conditions to be managed in the

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community.

North Cumbria's medical director Mike Walker believes hospital doctors and specialist nurses now need to be given a responsibility to regularly share knowledge with community staff: "[As a vascular surgeon] part of my job plan should be to educate the community teams across Cumbria." That, he believes, may also help him maintain adequate staffing in the hospitals. "With the CCG," he says, "what we're trying to do now is balance the books, recognising every pound in health needs to be spent in the most cost effective way. That's about a trade-off. So what I'm saying now is, you're not cutting consultants, [those] consultants are coming into the community to educate."

In the future he sees all urgent care in West Cumberland Hospital's catchment area delivered by a single team, straddling primary and secondary care. GPs would take appointments only for patients who did not need to be seen within 24 hours. The existing out-of-hours GP service would be made 24-7 and fully integrated with the hospital's emergency department, with consultants rotating between elective secondary care and the urgent care team. The urgent care GPs, he says, would benefit from direct access to specialist knowledge, and the hospital would be able to discharge more patients into the community. "One of the issues we've got is I don't know what can be brought into the community – the GPs do. Together we can work out, 'actually, a nurse should go and visit that patient tomorrow'. It's about us keeping tabs on a group of patients who we feel it's safe to have at home, but only with input or monitoring from ourselves."

Closer to Home, or further from the hospital?

For the most part, however, these ideas are not new. They are, in fact, at the heart of the Closer to Home strategy. Perhaps more significantly for the wider health service, they are also based on the same principles which underpin a significant part of its plan to make £20bn efficiency savings by 2015. So what went wrong?

In October last year North Cumbria published a report by consultancy firms Deloitte and Finnamore, which had been jointly commissioned by the health economy to evaluate the progress of Closer to Home. The consultants explained the original strategy document envisaged investments in primary and community care reducing both the number and the length of hospital stays for people with long-term conditions. This would lead to a fall in acute hospital activity; service changes and a reduced bed base at North Cumbria would allow the trust to reduce its costs by £15m a year.

However, the report stated neither the planned falls in activity nor the planned cost savings materialised. Non-elective activity fell by around 8 per cent between 2007-08 and 2010-11, but in most other areas it remained constant. The cost base at North Cumbria grew by 3 per cent a year over the same period, and the gap had to be plugged with bailouts. The consultants calculated that North Cumbria's income grew by 13.5 per cent over that period, if you included "transitional support"; its cost base was around £25m a year above income, and projected to increase. They concluded that the continued implementation of Closer to Home would have "significant implications" for the trust, and Cumbria faced a "major challenge" to transform the health system. The PCT's financial projections forecast income reductions of £30m for North Cumbria and £17m for UHMB by 2014. Making the plan work would require North Cumbria and the PCT "to work effectively and openly together in a way that has not to date been achieved". However, "absent a shared vision and buy-in from both organisations, NCUHT will continue to remain unviable".

Dr Walker believes the concept of Closer to Home was sound, but the implementation was "a shambles". That, he says, was down to failings of both the trust and the commissioners. He says the strategy was implemented at a time when clinical leadership at the trust was weak, and relationships with its commissioners poor. There was "huge suspicion" between the consultant groups at its two hospitals; the trust had struggled in the years after their merger to persuade the two groups to collaborate. When Closer to Home came along, consultant teams were not "engaged as much as they should have been", and many did not believe GPs had the skills to handle higher-acuity patients. When those teams resisted the changes, he says, commissioners became frustrated and introduced changes in the community without collaboration or input of hospital staff.

This conflict spilled over into the trust's annual contracting rounds with the PCT, according to Mr Goodwin. The PCT used the projected activity reductions in Closer to Home to underpin its negotiating position, and grew increasingly frustrated with North Cumbria's failure to make efficiency savings. In 2009-10 and 2010-11 they had to go, respectively, to mediation, then arbitration to determine the contract value; the 2010-11 arbitration decision pushed the PCT into a £6m deficit for the year. "The management challenge of the trust just got bigger and bigger," he adds. "It had to deliver more and more financial efficiency, it had to help deliver Closer to Home, and it was clearly struggling to create a sustainable hospital based service across two sites 40 miles apart. Eventually the trust board realised that wasn't achievable, hence the acquisition."

Dr Walker says the community interventions in Closer to Home did have an impact, bringing down North Cumbria admissions at a time when they were steadily rising across the NHS. An internal analysis produced by the trust last October reports that North Cumbria's unscheduled admissions fell by 11.6 per cent between 2007-08 and 2010-11, against planned Closer to Home reductions of 14.2 per cent. However, it argues that since June 2010 they have again been on an upward trend.

"The efforts to keep some people at home have had an impact," he says, "but what I think's happened now is we're suffering the consequences of that. They're coming back into our hospital sicker." The report states that, along with admissions, lengths of stay for non-elective patients are also rising, indicating an increasing proportion with complex conditions. Some in the hospital, Dr Walker adds, now "want to have a discussion about whether that's as a consequence of keeping them at home too long". He argues that while an increasingly complex hospital case mix is "what you would expect" from the Closer to Home strategy, "what you shouldn't do when you implement Closer to Home is cut the [hospital] services, because down the track you're going to need them".

Nigel Macguire says the North Cumbria report was "flawed in its analysis". Independent NHS benchmarking data, he says, shows "significant reductions" in Cumbria, which have now plateaued. "I'm not going to deny that we have seen

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flatlining," he adds, but "I would challenge the idea that we've seen a steady and significant increase." Dr Reeve argues that the work so far on C2H could only take them so far. "In the last three years, hand on heart, we weren't preventing crises," he says. "Most of what we were doing was diverting people who didn't need to be in a hospital bed and keeping them at home, and putting alternatives in the community so they could be supported at home." To get further, he says, they need senior clinicians working in the community, and investment to help people manage long-term conditions.

Relationships

A common thread running through all of Cumbria's recent crises has been poor relationships at various levels: between clinical teams, clinicians and management, and commissioners and providers. Both acute trusts were formed by flawed mergers, which those involved describe in strikingly similar terms: failure to integrate the clinical teams of their various hospitals, the absence of strong clinical leadership, and disengagement of clinicians from management. And while the CCG says historic relations with UHMB were not as fractious as they were with North Cumbria, Mr Morton says that when he arrived in post a month ago "it was extremely obvious that there was disengagement with the CCGs" in Morecambe Bay.

He believes the trust has been able to repair that "very rapidly", because the CCG is keen to work with them to improve services. Both trusts have also committed themselves to building clinical leadership. Dr Walker says CCG leads have developed "robust" relationships with clinical teams at North Cumbria; clinical advisory groups have been formed at each of its sites, involving clinicians from the trust, Cumbria Partnership, and primary care. "That's a million miles from where we were before," he adds. "We've got more ownership, and it's clinical ownership."

Nigel Macguire notes that, leading contracting negotiations for 2012-13, the CCG managed to agree both its main acute contracts before the start of the financial year – an achievement in light of recent history. To do this, the clinical commissioners jettisoned "heroic assumptions about reductions in activity", but wrote in penalties and incentives to drive integration of urgent care. "We think the next stage will be about reductions in acute activity," he says. But to do this they needed a contract that would "put in the building blocks" to allow that.

If North Cumbria's contract for this year had been based on the projections of Closer To Home, says Mr Goodwin, it would have been allocated £145m for activity. The settlement it agreed was £170m, "based principally on [the trust's] actual hospital activity".

Northumbria Merger

However, the centrepiece of the current strategy to make North Cumbria sustainable is the Northumbria Healthcare merger. Given the poor history of mergers in Cumbria, how can Mr Goodwin be convinced that this will be different?

He argues that Northumbria already has a proven record of successfully integrating healthcare systems in dispersed communities, and that the wider catchment population will give each trust the opportunity to win new business for services not currently provided by the other. Moreover, the merger would create one of the biggest foundation trusts in England, stretching from coast to coast, with a turnover of around £750m. This, he says, offers significant economies of scale, increased purchasing power, and greater scope to absorb the ongoing additional costs that he believes are inherent in operating two hospitals in north Cumbria.

The latter point, however, poses a question: if those costs are inherent, does absorbing the costs suggest a cross-subsidy from efficient services in Northumbria? If so, the FT is likely to need to persuade Northumbrian residents that the benefits they will enjoy from the merger outweigh the loss of funds that would otherwise be spent on healthcare within the county.

Nigel Macguire points out that, "at the moment", Northumbria say it will take them just two years to make North Cumbria operate within tariff. The FT's bid proposal calls for a huge injection of DH money in the first year of the takeover - £30m of revenue support and £37.7m of public dividend capital – and a further £10m in the second year. But after that, the FT says, it will not require external support (see merger plans doc).

Mr Macguire says once Monitor have approved the takeover and it's clear that Northumbria "are going to come in" the CCG wants to go through its plans specialty-by-specialty, to understand how it intends to do this. But, he adds: "That conversation has yet to take place in the level of detail that would give us assurance that it's sustainable within tariff." Detail about Northumbria's strategy remains hard to come by, although further detail is likely to emerge later in the summer, when the transaction is due to be scrutinised by the Cooperation and Competition Panel and Monitor. North Cumbria consultants backed their bid, saying the FT had committed to "keep services local and not centralise them". However, it is clear the hospitals would need, at the least, radical changes to established ways of working to live within tariff.

North Cumbria – which aims to complete the merger by December – still has a number of hurdles to clear before it can be certain the two trusts can join up. Northumbria was due to contribute to this piece, but pulled out because they felt it was inappropriate to comment while Heads of Terms – a non-binding document outlining the broad terms of the planned merger – were yet to be signed. HSJ understands that the delay is not connected to the finances of the deal.

Gaining approval from Monitor is also unlikely to be a rubber-stamp process. Northumbria has a strong record of working in environments like Cumbria's, and of innovative cost savings (the FT is working on a deal to refinance its private finance initiative hospitals with a £100m loan from the local authority). But taking on North Cumbria would put a strain on any organisation's finances. Mr Goodwin says the trust is now implementing cost savings that will reduce that burden – North Cumbria anticipates reducing its borrowing requirements from NHS North of England by £9m this year. He also anticipates DH funding to reduce the "onerous" costs of its PFI hospital in Carlisle, which ate up around 10 per cent of the trust's income in 2010-11. However, it has still not received confirmation of that funding, which was due in March, and it is not expected to permanently reduce costs for the trust. Mr Goodwin's "hope" is that it will last for a few years.

Morecambe Bay

In October 2010 UHMB was authorised as a foundation trust, a designation intended to grant greater freedoms as a reward for sustainability, financial viability, and good governance. A year later its

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maternity services were subject to CQC enforcement action and a police investigation into infant deaths. Six months after that its emergency care was also subject to CQC enforcement action, reports had emerged of a catalogue of care and governance failures, and the chief executive had stepped down. Healthcare intelligence firm Dr Foster had also reported that UHMB's 2010-11 mortality rates were higher than average according to both the NHS's main indices; its hospital standardised mortality ratio (HSMR) was the highest in the country.

Sources familiar with UHMB's board in the years prior to its authorisation believe the drive for FT status was likely a factor in its fall from grace. CQC director of operations Amanda Sherlock has acknowledged that – as with the scandal at Mid Staffordshire FT - the drive for foundation status could have been "a distraction" for the Morecambe Bay board "when they should have been focusing on core elements of the quality of their services".

But documents published by Monitor when it took regulatory action at the trust earlier this year suggest many of the problems at the FT had a much longer history. A review of governance commissioned by the regulator described an organisation where clinicians were disengaged from management, there was "insufficient accountability" for medical staff, and the board did not receive reliable information on quality or risk. Monitor concluded that the board had been unable to drive effective management across three geographically disparate hospitals. It noted that many staff had cited their "unsuccessful merger" – under then-chief executive Ian Cumming, the DH's managing director for quality in the transition – as the origin of behavioural problems at the trust.

Since arriving at UHMB Eric Morton has agreed to reviews of all its service pathways, carried out jointly by trust clinicians and the CCG. "I don't think in the future we can deliver services as we have delivered them in the past," he says. "It can't work as it sits at the moment. That's more than just tariff, that's more about service configuration. It's about sustainability of numbers, being able to deliver safe services, being able to put the right levels of staffing in."

The process, which began two weeks ago, will focus initially on those services which have "had adverse reports" – maternity, paediatrics, emergency care, and stroke care. "This is unambiguously clinically led, he adds. "Managers aren't going to sit here and determine where the services are going to go, we're sitting the clinicians down to do that. I absolutely believe the local GPs and the clinicians working here actually know what the right answer is."

He anticipates the trust will be ready to consult the public on proposed changes to some services by late summer.

In the short term, the trust and the CCG have poured in cash to correct quality problems identified by the regulator, and particularly to increase staffing. The salient finding of a review of UHMB's high death rates, by the North West's Advancing Quality Alliance, was that ratios of doctors and nurses to beds were below average. Mr Morton acknowledges: "We've been told our mortality isn't where it should be. There's an indicator that staffing levels could be a significant contributor to that, so I'm going to move on from that and increase staffing".

Mr Morton says standards have improved and he is "reasonably confident that when the regulators come back we'll be OK". But "that isn't sustainable for the long-term".

The immediate actions it has taken to address quality problems have given UHMB a financial problem. It recorded a deficit in 2011-12, and is likely to do so for at least this year and the next. UHMB is currently working on financial projections to be submitted to Monitor by the end of the month. In the autumn it will submit its plans for turning around the deficit over the next two to three years. Mr Morton says there is not going to be a "one-year fix", but he would be "disappointed if we're running a deficit in year three".

It is plausible that some of the proposed changes will be so significant as to require formal public consultation. The most likely scenario would be the reorganisation of some services to concentrate complex aspects of their work on certain sites, and lower risk procedures on others. One possibility floated by Mr Morton would be increasing the amount of elective surgery carried out at Westmorland General, which no longer does emergency work, to take pressure off of non-elective surgery the Royal Lancaster Infirmary. He is "actively looking at" one possible means of doing this: taking the independent sector treatment centre that private firm Ramsay Healthcare operates from the Kendal hospital back under UHMB management.

Beyond that, the trust is also now working to establish clinical networks beyond its organisational boundaries. It has already agreed to work with Blackpool Teaching Hospitals on pathology, and wants to discuss cardiology services with the Lancashire FT as well. There have also been early discussions with North Cumbria about working collaboratively on "one surgical specialty". The model would be to maintain two operating centres, but bring the staff together for joint audit and education, and to provide additional staff should there be a spike of activity at one of the sites.

He also acknowledges that commissioners' work to improve community and primary care will continue to take activity out of acute hospitals. The trust, he suggests, will need to put empty wards to productive use, possibly by providing step-down or rehabilitation beds. "We've spent 10 years improving acute estate," he says. "We need to use it for something sensible. Increasingly, I think, hospitals will partner their acute facilities with non-acute."