

Research that makes a real difference

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Working Together for Health: Achievements and Challenges in the Kaiser NHS Beacon Sites Programme

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Executive summary

- a comparison of the NHS and Kaiser Permanente published in the British Medical Journal in 2002 has stimulated a pilot programme to adapt the experience of Kaiser in three areas of England
- these three areas – Birmingham and Solihull, Northumbria and Torbay – have drawn on the work of Kaiser Permanente in various ways, including improving care for people with long term conditions, achieving closer integration of primary and secondary care and health and social care, and strengthening the role of clinical leaders
- there has been continuing progress since the last report on the work of these three areas in 2006 and many examples of innovation
- these examples of innovation include a telephone based service that provides proactive care to patients with long term conditions in Birmingham, closer integration of health and social care via Care Trusts in Solihull and Torbay, and a focus on long term conditions and leadership development in Northumbria
- Torbay stands out as the area that is able to demonstrate most measurable progress, as evidenced by its reduced use of hospital beds, the lower than expected use of beds for emergency admissions in people aged 65 and over, the virtual elimination of delayed transfers of care, and improved access to intermediate care
- Northumbria and Torbay are both taking part in the national integrated care organisation (ICO) pilot programme set up by the Department of Health in the wake of the final report of The NHS Next Stage Review
- the work of the three areas has received external recognition e.g. in high ratings by the Healthcare Commission, by awards from the Health Service Journal, and by selection in the case of Birmingham for inclusion in a Canadian study of high performing health care systems
- a range of challenges has been encountered in adapting lessons from Kaiser and progress has rarely been linear. Torbay has benefited from being a receptive context for change, and experiencing greater organisational stability and leadership continuity than the other two areas
- the experience of these three areas underlines the challenges of partnership working highlighted by the Audit Commission and others, but shows that progress is possible with effective local leadership
- the time is now right to go beyond the relatively limited scope of the national ICO pilots and support integration of services on a more ambitious scale

Comparing the NHS and Kaiser

Since 2002 when Richard Feachem and colleagues published a comparison of the NHS and Kaiser Permanente in the British Medical Journal (Feachem et al, 2002), there has been intense interest in the lessons the NHS might learn from one of the longest established and best known health maintenance organisations in the United States. The work of Feachem and colleagues questioned the conventional wisdom of UK/US comparisons by appearing to show that Kaiser Permanente achieved better performance than the NHS at roughly the same cost. In the ensuing debate, there was criticism of the basis on which the costs of the NHS and Kaiser had been compared, and extensive argument about differences in the populations served and other variables that might account for the conclusions reached (see for example, Talbot-Smith et al, 2004). Feachem and Sekhri (2004) remained unrepentant in the face of this criticism, arguing that other work had tended to confirm rather than undermine their findings.

This other work included a study of the use of hospital beds in the NHS and Kaiser that I undertook with colleagues. The origins of this study were a concern to understand what lay behind the finding in Feachem and colleagues' comparison that bed day use in Kaiser was one third of that of the NHS. To this end, an analysis was undertaken of hospital utilisation for 11 leading causes of bed day use in the NHS, comparing available

data for the population aged 65 and over in the NHS, Kaiser in northern California and the Medicare population in California and the US. The reason for focusing on this age group was that all people aged 65 and over are covered by Medicare in the US, and therefore differences in bed day use cannot be explained by the exclusion of part of this population from health insurance. Our analysis confirmed that the NHS used three times the bed days for these causes as Kaiser (Ham et al, 2003).

Describing differences in health care utilisation is not the same as explaining these differences. In parallel with the analysis of routinely available data, I undertook a number of visits to Kaiser Permanente and with the support of the then NHS Modernisation Agency arranged for senior NHS managers and clinical leaders to do the same in order to understand how Kaiser delivered care 'on the ground'. These visits were in part a response to a commentary by Jennifer Dixon in the British Medical Journal suggesting that politicians 'should encourage a few seasoned chief executives in the NHS with a good track record to go to study Kaiser, take time to learn the lessons, and genuinely follow the maxim 'what counts is what works' (Dixon, 2002, 142). Box 1 summarises some of the lessons that emerged and that helped inform a pilot programme to adapt the experience of Kaiser in the NHS.

In this pilot programme, a number of areas of the NHS initiated work with a common theme being how to learn from Kaiser's integrated approach in a quite different political and social context. As time went on, three of these areas – Birmingham and Solihull, Northumbria and Torbay – were identified as Beacon sites that had made a concerted effort to adapt learning from Kaiser in relation to the populations they served. In a previous paper I described the progress made in the Beacon sites in the period up to 2006 (Ham, 2006). This paper updates that work and sets out how the work of the Beacon sites has evolved in the last three years. It has been written as a contribution to debate about the development of integrated care in the NHS at a time when the experience of these sites seems more relevant than ever.

Kaiser's model emphasises the **integration of care**, with Kaiser combining the roles of insurer and provider, and directly providing care both inside and outside hospitals. Care integration enables patients to move easily between hospitals and the community, facilitated by a model of multispecialty medical practice in which specialists work alongside generalists and have no incentive to build up facilities and resources in hospitals at the expense of other services.

Kaiser also focuses on **chronic care** rather than primary care and secondary care. Chronic diseases are a priority as they represent the major source of demand among the membership served by Kaiser. These diseases are tackled by stratifying the population according to risk and adopting a population management approach that combines an emphasis on prevention, self management support, disease management, and case management for highly complex members.

Population management is one of the factors that enables Kaiser to avoid inappropriate use of hospitals. This is summarised in the philosophy that '**unplanned hospital admissions are a sign of system failure**'. Put another way, Kaiser takes the view that patients who require hospital treatment that has not been planned have not received optimum care at an earlier stage in their illness. It seeks to provide optimum care through the use of evidence based guidelines and by managing care to reduce unacceptable variations in practice.

Kaiser's much lower use of beds in comparison with the NHS is driven by the **active management of patients in hospital**. This is achieved through the use of care pathways for common conditions like hip replacements, the employment of discharge planners to move patients through pathways, and the availability of skilled nursing facilities to provide rehabilitation for patients no longer needing to be in an acute hospital but not ready to go home. Like a number of US health care organisations, Kaiser also makes use of general physicians known as hospitalists to work only in the inpatient environment and to ensure that patients receive the appropriate level of care.

Chronic care and short hospital stays are underpinned by the provision of **self management support** to members. Self management support takes the form of the provision of information and patient education programmes, increasingly supported by information technology. Kaiser's **HealthConnect** programme involves a significant investment in information technology, including KP online that enables members to communicate by email, access their medical records, make appointments and order prescription refills.

Underpinning Kaiser's model of care is a relationship of **mutual exclusivity** between the health plan and the Permanente Medical Groups. A high proportion of doctors take on leadership roles in the medical groups, and it is within these groups that decisions are made on clinically appropriate care. Physicians in Kaiser take responsibility for the performance of the organisation, and are actively committed to its success. A significant investment is made in **leadership development** to support doctors and other staff to contribute effectively.

Birmingham and Solihull

Integration in Birmingham and Solihull started in February 2003 when six senior clinical staff from the Heart of England NHS Trust, the Eastern Birmingham PCT, and Solihull PCT participated in a study visit to Kaiser Permanente in northern California. The NHS Trust had a new chief executive who had been a medical director, and there was also a new chief executive at one of the PCTs. The chief executives decided not to go themselves to Kaiser but instead sent a team from the three organisations involved.

The visit to Kaiser showed the possibilities of running services in an integrated way, for example in the quality of care provided to people with chronic diseases. Kaiser also demonstrated the importance of having inspirational clinicians leading the development of services. To take this work forward, the Working Together for Health programme was established with a programme board comprising senior leaders and a dedicated programme manager. Working Together for Health was underpinned by a visit to Kaiser in 2004 by the NHS Trust chief executive, one of the PCT chief executives and one of the PEC chairs.

The experience and principles of Working Together for Health (see box) were presented by the six staff who had visited Kaiser to meetings of clinicians from Eastern Birmingham and Solihull and to the boards of each of the partner organisations, both individually and at joint 'three boards' meetings. Commitment was gained to these shared principles as the basis of the service strategies of each organisation. Notably, there was strong support from the Chairs and Non-Executive Directors, who in many ways represented the voice of the public.

In applying these principles, Working Together for Health focused initially on two key areas of work:

- improving the quality of care for people with long term conditions
- developing clinical leadership in partnership with management

Work on long term conditions included the opening of the **Partners in Health Centre** in 2005 in a converted building on a site adjacent to Heartlands Hospital. The Centre functions as a neutral space, neither secondary nor primary care, where professionals can collaborate to deliver

innovative services for people with long term conditions. Patients using the centre have access to self care support and educational programmes.

The work undertaken in the Centre encompasses care for people with diabetes, heart failure, elevated cardiovascular risk, and musculoskeletal disease. In the case of diabetes, a consultant led community based services has been developed, focused particularly on the south Asian population. GPs with a special interest and nurses have undergone training so that patients needing insulin injections can be treated in the community. Community based services have also been

developed for other long term conditions such as heart failure and chronic kidney disease.

Solihull PCT also developed innovative services for people with long term conditions. These include a COPD service making use of community clinics and group consultations, a community heart failure service, and the development of a new pathway for people with dementia. A number of services have also moved closer to home, including two ENT outpatient pilots run by GPs with a special interest, and audiology services in the north of the borough.

In Birmingham and Solihull clinical and service integration have been taken forward as part of a programme known as Working Together for Health based on the following principles:

- An emphasis on integration of care
- Priority given to keeping people out of hospital
- Active management of people to prevent illness and improve quality of life
- Promotion of self-care and partnership in care between clinicians and patients
- Clinical leadership to drive change
- Use of information technology to support integrated patient care and change management

A logo was designed to give the Working Together for Health programme an identity.



Working Together For Health

At a later workshop facilitated by leaders from KP, the principles were condensed even further into three slogans:

- *Patients as Partners*
- *Promoting Self-Care*
- *Care in the Right Place*

The logo and slogans were used on slides and paperwork connected with the programme to relentlessly reinforce the message.

Working Together for Health also drew on the experience of Kaiser in developing its clinical leadership, placing the emphasis on clinical leaders working in partnership with experienced managers.

Current priorities

Over the last three years the link with Kaiser has been sustained. There have been further visits to northern California from Birmingham and Solihull. In the opposite direction, Kaiser's clinical leaders have visited the UK to provide ongoing support to Birmingham and Solihull and the other two Kaiser Beacon sites.

This support has been important in sustaining the commitment to Working Together for Health at a time of significant organisational and leadership changes, including:

- the Heart of England NHS Trust became a Foundation Trust in 2004 and in 2006 it took over the running of Good Hope Hospital, a failing NHS Trust
- Solihull PCT became a Care Trust in 2006 and in so doing assumed responsibility for adult social care budgets and services alongside its NHS responsibilities. Since becoming a Care Trust, Solihull has engaged in the development of partnership working with Solihull Council as well as continuing to contribute to Working Together for Health
- Eastern Birmingham PCT was merged with North Birmingham PCT in 2006 to form the Birmingham East and North (BEN) PCT
- Solihull PCT/Care Trust has had five chief executives during the last six years

Progress has been marked by events where large numbers of clinicians have come together to develop their understanding of, and ideas for, an integrated health and social care community. Colleagues from Kaiser Permanente have acted in a mentorship role to the NHS clinicians through the Kaiser Beacon Sites programme. Relationships between individuals across organisations have developed and deepened during time spent travelling, learning and socialising together.

A project management approach has been used to design new kinds of integrated services, notably as a pilot site in the NHS Institute's 'Care Closer to Home' programme. In the programme, Birmingham

East and North PCT worked with its partners on three projects: continence management by specialist physiotherapists, managing chronic pain in the community, and supporting Asian patients to manage heart disease.

There have been many examples of service innovation. Alongside the continuing focus on long term conditions and the work of the Partners in Health Centre, the award winning **orthopaedic triage service** has been rolled out to other areas within the PCT. This service offers assessment in primary care by an extended scope physiotherapist for all musculoskeletal conditions where a GP feels that an orthopaedic consultation is required. Waiting times for treatment have been cut significantly and over 70% of referrals are now managed within this service.

Another innovation is **Birmingham Own Health**. This is a telephone based service that provides proactive care to patients with long term conditions. The service is staffed by trained care managers who offer support to patients referred by GPs. Each care manager can support up to 200 patients and currently over 5000 patients have made use of the service. An evaluation has shown that patients report high levels of satisfaction with the service, use urgent care services less frequently, and show improved outcomes (e.g. on hypertension and glucose control) when compared with patients receiving usual care.

Relationships

Experience has shown that integration is not primarily about organisational mergers and budgets. Rather, it is about relationships between people. These relationships are not informal friendships. They have to be worked on and built professionally if clinical integration is to be meaningful and sustained through good and bad times.

This challenge is being tackled by applying a fundamental principle: change will only happen and be sustained through the commitment of the clinicians and managers involved in delivering the care. If their ability to make change happen can be developed, then they will make the vision of an integrated system a reality. It is the responsibility of leadership first to provide the necessary training and development and then the project management support and framework for collaborative working.

Training and development are particularly needed in methodologies for clinical system

redesign using lean thinking. A collaborative approach to removing unnecessary processes (waste) and measuring system performance in terms of quality, timeliness and cost over time is proving an effective way of getting clinicians and managers to see issues from the patient rather than the organisational perspective.

The relationship between the PCTs and the NHS Foundation Trust is not always cosy. For example, one of the PCTs put out a tender for dermatology services, and the Foundation Trust lost part of the service. This challenge strengthened the resolve within the dermatology team in the FT to work with the PCT to create an integrated service which is now being developed. Recently the PCT has also commissioned home care services from an independent sector provider that may affect demand for hospital services and reduce the income of the FT.

Achievements and challenges

The progress made in achieving closer integration of services has been recognised in a number of ways. The Heart of England NHS Foundation Trust was named best acute trust of the year in the Health Service Journal's awards in 2006 and the Eastern Birmingham PCT was named runner up in the Health Service Journal's PCT awards in 2005 and 2006 as well as performing well in the world class commissioning assurance framework. Equally important was the selection of Birmingham East and North PCT and the Heart of England NHS Foundation Trust for inclusion in a Canadian study of high performing health care organisations in 2008 (Baker et al, 2008). There has also been recognition for innovative services, such as the orthopaedic triage service, Birmingham Own Health and work on pain management.

Notwithstanding these achievements, Birmingham and Solihull would still not claim to have created an integrated system. Whilst there are an increasing number of successful examples, the integrated way of working is not universal. One of the reasons for this is the existence of competing agendas and priorities for the Foundation Trust, the PCT and the Care Trust.

As already indicated, the Foundation Trust has taken over a failing NHS Trust and this has been a major preoccupation for its leadership. Similarly, the transition from PCT to Care Trust in Solihull meant that effort was focused on establishing the new organisation and building links with local

authority services, as well as maintaining involvement in Working Together for Health. For its part, Birmingham East and North PCT went through an organisational merger in 2006, and this inevitably consumed time and energies that might otherwise have been directed at other issues.

With organisational changes out of the way, at least for the time being, the challenge is to move from 'cottage industries' to industrial scale integration. This means moving from the enthusiastic innovators to the early and late adopters, and from the special award winners to 'the way we do business'. It also means reaffirming the commitment to the principles of Working Together for Health and seeing this as a priority for all the organisations involved. With this in mind, the Working Together for Health board was reconstituted late in 2008 and a new programme manager appointed to lead the next phase of work.

The current focus is on improving services for older people in Birmingham and Solihull. In common with other areas, acute hospitals have experienced increasing A&E attendances and emergency admissions. Much of the increase in demand is perceived to result from older people with complex needs making use of these services. This in turn has created challenges in meeting the government's target that patients should wait a maximum of four hours in A&E, and it has also resulted in an increase in delayed transfers of care (notwithstanding a commitment to pool budgets to deal with this challenge) in Birmingham.

Addressing these challenges is currently the main priority for Working Together for Health. A major piece of work has been initiated to understand the reasons for increasing demands and to engage with a range of stakeholders (including local authorities and the Birmingham and Solihull Mental Health NHS Foundation Trust) in exploring solutions. One of the early products of this work has been the designation of two wards within the Heart of England NHS Foundation Trust as step down facilities to be run by the Birmingham East and North PCT. The use of the wards in this way supplements investments already made by the PCT and the Care Trust in intermediate care and the development of urgent care services outside the hospital.

Solihull Care Trust is in many ways better placed in managing these pressures and is beginning to realise some of the benefits of joining adult social care, primary care and

community services in the same organisation. A single point of access to health and social care has been established and is being developed further to focus on admission avoidance. The aim is to create a service for urgent care that links together care managers, work on risk stratification and predictive modelling, the development of virtual wards, re-ablement and rehabilitation and care home support. Health and social care integration means that delayed transfers of care are much less of an issue in Solihull than in Birmingham, reinforcing the experience of Torbay reported below.

Another way in which partnership working is being taken forward is through the appointment of a former medical director and consultant at the Heart of England NHS Foundation Trust to the post of clinical director with the Birmingham East and North PCT. This is a mirror image of the arrangement in Northumbria where a GP has been appointed as a medical director in the Foundation Trust. The more general point here is the role played by key individuals in building stronger relationships between organisations and accepting leadership responsibility across the health and social care system.

Northumbria

Northumbria has been involved in adapting lessons from Kaiser Permanente following a visit to Atlanta in 2000. The visit was significant in highlighting the importance of providing patient centred care through clinical leadership and the use of information about performance. Under the leadership of the then chief executive of Northumbria Healthcare Trust, Sue Page, the initial focus was on improving the performance of acute services and strengthening integration with primary care and community health services. This included establishing a contact centre for patients providing a single point of access and offering information and opportunities to book appointments ahead of the national 'Choose and Book' programme.

As far as acute services were concerned, an early priority was to strengthen emergency care through the establishment of a 'front of house' team and to differentiate wards within the main general hospital according to the acuity of patients treated. These initiatives were supported by the use of Interqual, a clinically based software tool supplied by McKesson and widely used in Kaiser Permanente hospitals, to assess

appropriateness of hospital admissions, level of care and length of stay. Teams of experienced nurses known as care facilitators were employed to use the results derived from Interqual to actively manage length of stay and to facilitate discharge.

Work to integrate acute services with primary care and community health services included the appointment of a Northumberland GP as one of the medical directors of the Healthcare Trust. As well, priority was attached to improving the quality of care for people with long term conditions through partnership working with the Northumberland Care Trust and the North Tyneside PCT. This included work on both diabetes and COPD with the aim of strengthening the contribution of primary care teams in the provision of chronic disease management and investing in self management support through both the Expert Patient Programme and disease specific support, such as DESMOND and DAFNE for people with diabetes.

The experience of Kaiser has continued to influence developments in Northumbria in the last three years at a time of considerable organisational change. Under the leadership of a new chief executive, Jim Mackey, the Healthcare Trust achieved NHS Foundation Trust status in 2006. At the same time the primary care trusts were reorganised with Northumberland Care Trust, North Tyneside PCT and Newcastle PCT being placed under the leadership of a single chief executive and management team. A new chief executive was appointed to head up the new organisation, and one of his first tasks was to tackle significant financial challenges in the Care Trust.

The combined effect of organisational change, new leadership and financial difficulties might have derailed the work on adapting lessons from Kaiser if this work had not been firmly embedded within the health community. In practice, the belief that integrated services are effective and efficient and involvement in the Kaiser programme of senior managers and clinical leaders in both the Foundation Trust and the primary care organisations helped to ensure that this did not happen, even though some momentum was lost during this period as other priorities took precedence. The support provided through involvement with Kaiser Beacon sites in Torbay and Birmingham and Solihull, together with continuing contact with colleagues from Kaiser through their involvement with the Beacon sites, was also important in enabling the commitment to integration to be maintained.

Current priorities

There have been four main strands in the work undertaken in Northumbria. The first has been a **continuing focus on improving the quality of care for people with long term conditions** under the leadership of a partnership board comprising key stakeholders. Diabetes has remained a high priority through involvement in the national Year of Care initiative. This has included work to implement care planning for people with diabetes and to strengthen self management support.

In the case of rheumatology, group clinics have been used with evidence indicating that patients who participated in these visits valued them and indicated that they would attend again. The interest in group clinics was stimulated in part by a visit by David Sobel, a Kaiser Permanente physician who is an expert in self care. The experience of Northumbria is that not all patients want to try them, suggesting the need to offer a range of options.

In the case of COPD, Northumbria was selected as one of the national integrated care organisation (ICO) pilots by the Department of Health. The COPD pilot aims to implement an integrated care pathway through a key worker that supports self management and enables all patients to have a care plan by 2010. As well, the pilot seeks to improve links between primary care teams, hospital based specialists and community nursing services. It is anticipated that this will result in fewer unplanned hospital admissions and reduced lengths of stay for those patients who are admitted. The pilot aims to improve symptom control and quality of life through greater adherence to the locally agreed evidence based pathway.

Northumbria is also seeking to achieve closer integration of care for older people with complex needs. A local pilot has been initiated with the aim of developing an integrated approach for older people needing both short term support and ongoing care. As in the work on COPD, this includes training for patients and carers on self management and the development of care plans. Discussions about quality of life, place of care and end of life decisions are documented in the care plans.

The other aspect of the work on long term conditions has involved comparative analysis of data on the prevention of cardiovascular disease in association with colleagues in Kaiser Permanente in

California. This analysis has been led by Derek Thomson, a Northumberland GP who works half time as medical director in the Foundation Trust. Using routinely available data, the comparison has focused on the prescribing of appropriate drugs and the control of cholesterol and hypertension in the two populations.

The results show wide variations in prevalence rates of diabetes, heart disease and stroke. The mean score for the three PCTs were similar, although there were big differences (c.40%) between practices on some of the measures. Over time, there has been some improvement in hypertension control. When the results were compared with those of Kaiser, the latter performed marginally better than Northumbria with the exception of the use of statins to control cholesterol.

The second strand has concerned **patient satisfaction and increasingly patient safety**. Beginning with a pilot study in 2007, work has been undertaken to collect information on patient experience more frequently and more meaningfully than is possible through the national surveys commissioned by the Department of Health. Following the success of the pilot, the questionnaire has been rolled out across the Foundation Trust, covering all wards and out patient departments and seeking feedback on all consultants working in the trust.

The results are made available on the trust's intranet in real time. By gathering feedback from 100 patients for each consultant, it is possible to obtain a reliable assessment of patient experience and to use this as part of appraisal and revalidation and as a contribution to recommendations on clinical excellence awards. While the inpatient and outpatient surveys both indicated high levels of satisfaction, a number of areas for improvement were identified. These included the length of time outpatients waited for their appointments on arrival in the clinic, and the amount of written information provided to inpatients.

Alongside the surveys, the Foundation Trust is also making use of an approach known as 'Two minutes of your time'. This involves patients filling in a card and answering some simple questions in an approach similar to that used to assess customer satisfaction with hotel stays. The other element of the work on patient satisfaction involves an analysis of complaints and claims at the ward and specialty level as a tool for quality improvement. Work on patient satisfaction

mirrors Kaiser's commitment to use these kinds of data to improve performance.

Patient safety is a newer priority and has centred on involvement in The Health Foundation's safer patients' initiative and learning from international best practice, for example through the work of IHI. Work has been undertaken to benchmark outcomes against those achieved elsewhere using a risk adjusted mortality tool developed by CHKS. The results showed that the Foundation Trust performed well but a number of issues were identified using the IHI trigger tool. As well, an audit was undertaken of 50 critical care deaths leading to areas for improvement being agreed e.g. better documentation in patients' notes.

The third strand has focused on **the development of leaders in the health community**. This draws directly on learning from Kaiser and particularly the investment made in leadership development as one route to higher levels of performance. The Northumbria leadership development programme is a multidisciplinary programme that has involved 372 participants, including over 100 doctors (consultants and GPs), since its inception in 2000.

Run over twelve months, the programme is based on cohorts of 20-25 participants drawn from a range of backgrounds and organisations. It commences with a two day residential module and this is followed by eight one day learning events held at monthly intervals and a concluding two day module. The content of the programme combines contributions from international and national experts together with 360 degree leadership effectiveness analysis, individual coaching and peer networking.

Of critical importance is the way in which the programme is embedded in a comprehensive organisational development plan. Other elements of the plan include board and executive development, business unit development, programmes for ward managers and work to improve consultant recruitment. This work entails the development of a competency framework for consultants and the use of psychometric and capability tests in the appointment of consultants.

The investment made in leadership development has supported the establishment of the Trust's business unit structure and the Clinical Policy Group. This group brings together clinical leaders from secondary care with practice based

commissioning leads and it supports the development of care pathways and closer integration of care. The group also helps to resolve problems in care transitions.

The fourth strand is the **redesign of acute services**, taking forward earlier work to strengthen front of house and back of house care. To this end, the Foundation Trust has developed plans to build a new specialist emergency hospital close to the North Tyneside and Northumberland border. The new hospital would offer state of the art emergency care with 24/7 consultant delivered service for those in greatest need with existing general hospitals and community hospitals continuing to provide emergency care for people with routine and less serious illnesses alongside other planned services and diagnostics. Public consultation is now complete and agreement has been reached on investing around £75 mill in the new emergency hospital as part of a £200mill investment in the development of existing services over the next decade.

Northumbria continues to use learning from Kaiser and other organisations to reduce the time patients spend in hospital. Recent work has focused on specialties where there is the potential for the greatest gains. For example, following the introduction of fast track surgery, average length of stay for hip replacement has fallen from 7 days in 2007/08 to 3-4 days in 2009 and for knee replacements from 6 days to 4 days over the same period. The Foundation Trust board monitors lengths of stay in the corporate performance report presented to board meetings.

Achievements and challenges

The experience of Northumbria since 2006 illustrates that the journey of quality improvement is not always linear and there have been occasions when relationships have stalled at best, and have appeared threatened at worst. In these circumstances, it has been the belief in integration and working together and the commitment to learning from Kaiser and the other Beacon sites that has sustained the programme of work. From the perspective of the main commissioners of its services, the Northumbria Healthcare NHS Foundation Trust has demonstrated a continuing commitment to integrated care and to improving the quality of services at a time of ongoing change and financial challenges.

Looking ahead, local leaders recognise that further work needs to be done to build on the progress made and to ensure that the

different imperatives facing the Foundation Trust and commissioners do not drive these organisations apart. More specifically, the investment in acute services, when it goes ahead, has to recognise the financial pressures under which commissioners are operating, and the priority they are attaching to prevention and improving care outside hospitals. Equally, the policy of separating commissioning from provision within PCTs has to be taken forward without creating additional organisational obstacles to integration.

If there is confidence that these challenges can be tackled successfully, it stems from a maturity of leadership in the local health community and a sense that the policy tide is turning in the direction that Northumbria has been taking for almost a decade. Having kept the faith at a time when the health reform programme appeared to favour fragmentation over integration, and when organisational self interest took precedence over the performance of the health system, there is a sense in Northumbria as well as in Torbay and Birmingham and Solihull that the value of the work that has been initiated is at last being recognised.

Torbay

Torbay has enjoyed a history of good relations between the PCT and the Council and a commitment to integrated working extending over 20 years. This included creation of a whole district NHS trust in the 1990s, and more recently the appointment of a joint director of public health and joint management team meetings. In 2003 the Council established a commission to examine the future of children's services and one of the outcomes was recognition that any changes to children's social services would have implication for adult social services (Lavender, 2006).

It was at this time that the PCT chief executive, clinical leaders and senior managers visited Kaiser Permanente in northern California. The visit reinforced the importance of integrated care and the value of partnership working with both other NHS organisations and the Council. This was an important trigger behind the decision to combine the PCT and adult social services in what became the Torbay Care Trust. The decision enjoyed cross party support and was facilitated by the existence of co-terminous boundaries between the Council and the PCT. A further consideration was the concern to improve the poor performance of adult social services

through integration with a PCT that had achieved a high rating from the Healthcare Commission in its annual assessment. The Care Trust serves a population of around 140,000 and this includes a much higher proportion of older people than in other areas.

Governance of the Care Trust is centred on the Care Trust Board which includes two councillors nominated by the local authority. Alongside these voting members, the Cabinet Member for adult social care also attends board meetings. As well, a number of the Council's executive directors attend the board and take part in discussions. These include the People's Commissioner and the Executive Head Communities. The organisation of the Care Trust is illustrated in Figure 1.

Current priorities

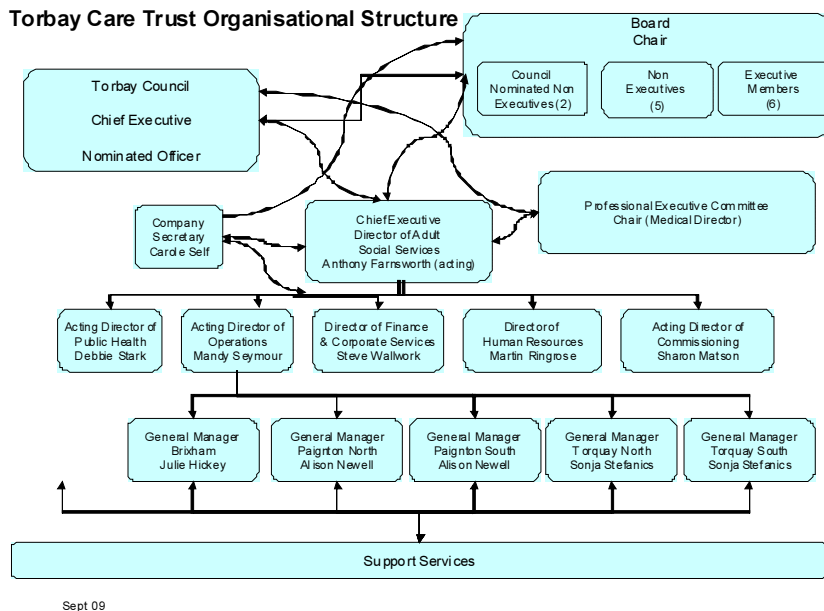
The vision behind the Care Trust was epitomised by Mrs Smith, a fictional 85 year old, living alone and requiring support from different health and social care professionals. Lavender has described the importance of Mrs Smith in the following way:

'A story was constructed around Mrs Smith, about the services she required, and the difficulties and frustrations she faced in trying to navigate the local health and social care system. Simple problems were highlighted, such as many separate assessments, having to repeat her story to many people, inherent delays in the systems due to the transmission of information, and the complexity of the system. This story was then contrasted with the vision of how health and social care services would operate within a care trust.

Central to the vision was the concept of improving access to services for Mrs Smith, and making the delivery of those services as simple and as quick as possible. It was recognised that this required a rethinking of how services were currently offered and development of new ways of working. The intention was to be as innovative as possible in the way in which the organisation operated, and to try and make the best use of all the skills staff had, rather than be constrained by the way the existing system worked...

The power of Mrs Smith's story was obvious, in the connection that everyone had with her. Many service users, carers and staff knew a Mrs Smith, and they all recognised the problems she faced.

Figure 1



Soon there was no presentation on the care trust which did not contain Mrs Smith, and she has become the symbol of the new organisation' (Lavender, 2006, 17).

To better meet the needs of Mrs Smith and users like her, Torbay has established **five integrated health and social care teams** organised in zones or localities that are aligned with general practices. The work of these teams was developed through a pilot in Brixham which found in early analysis that there were around 83 users who were at the tip of the Kaiser triangle in a population of 23,000. Similar proportions have been found in the other localities that have been established. These are users who need to receive intensive support from community matrons and the integrated teams.

Each team has been co-located and has a single manager, a single point of contact and uses a single assessment process. Teams meet regularly (often daily) to review the most complex cases they are dealing with and to decide on actions needed. In this way, all team members are aware of what their colleagues are doing and are able to coordinate their contributions with a view to providing the best possible care. For each team, the focus is on knowing their population, focusing on the most vulnerable, and managing their care. This is done in partnership with GPs and the teams deal with all cases, including long term conditions, palliative care and people with disabilities. They seek to proactively manage

vulnerable service users making use of patient-held yellow folders accessible to any professional involved in their care. Referral processes have been streamlined and are now much simpler.

Health and social care coordinators work within each team and their role is to accept referrals and act as the single point of contact. Coordinators liaise with users and families and with other members of the team in arranging the care and support that is needed. The appointment of these coordinators, who are not professionally qualified, is in many ways the most fundamental innovation in Torbay. Budgets are pooled and can be used by team members to commission whatever care is needed by service users like Mrs Smith. From April 2009, a fully integrated electronic health and social care record has been created to support these developments

A major priority in Torbay has been **investment in intermediate care services** that enable users to be supported at home and help to avoid inappropriate hospital admissions. This is linked to a review of **the role of community hospitals** and the redesignation of one of these (Paignton) from a traditional convalescent facility to an active intermediate care service. As part of this change, the role of nurses and therapists was developed, including establishing closer links with the acute hospital and its team of care of the elderly specialists.

A recent innovation is the establishment by the Care Trust of a **team that reviews patients in hospital and works with hospital staff to discharge patients** when there is pressure on beds. Torbay performs well in relation to delayed transfers of care (these are close to zero) and the work on improving discharge is designed mainly to cut lengths of stay from levels that are already among the best in the region. This is linked to a new project, one of the national integrated care organisation (ICO) pilots, focusing on improving discharge arrangements in the hospital. The focus of the Torbay pilot is **integrated care for older people** with the following elements:

- prevention, including the use of telecare services and remote monitoring to support people to remain independent for as long as possible at home
- intermediate intervention, building on investments in intermediate care, identifying older people at greatest risk of admission, and developing in-reach to the hospital to support discharge and smooth transitions
- acute care, ensuring that older people are cared for in a timely, dignified and clinically evidenced manner when they require an acute hospital stay
- rehabilitation, ensuring that people are helped to regain independence following a hospital stay or crisis
- palliative care, ensuring that older people at the end of life experience care of the highest quality and that an increasing number of people are able to die in the place of their choice

Achievements and challenges

A number of improvements have occurred. Intermediate care services are now available in each of the zones via the single point of contact, and these enable access to occupational therapists, physiotherapists, and district nurses within three and a half hours if urgent (this comprises 25% of the case load), and five working days for non-urgent cases. A weekend working pilot scheme has recently started, and a support worker in intermediate care role (SWIC) has been developed, with posts in each zone team.

Area	Apr 06	Oct 08
Community equipment within 7 days of request	90%	99%
Patients assessed within 28 days of referral	72%	83%
Care packages in place within 28 days of assessment	67%	97%

The impact of integrated working in Torbay can be seen in data on the use of hospitals which show that it had the lowest use of hospital bed days in the region and the best performance in lengths of stay. More specifically, analysis shows that:

- after adjusting for deprivation, the standardised admission ratio for emergency admissions for the 65 and over population is 87.7, the third lowest in the south west
- use of emergency beds for the 65 and over population is 2025/1000 population in Torbay compared with an average of 2778/1000 population in the south west as a whole
- for the population aged 85 and over, Torbay uses only 47% of emergency bed days for people experiencing two or more admissions for its benchmark group (Richard Hamblin, Care Quality Commission, personal communication)
- Torbay has the lowest rate of emergency bed day use for older people with two or more admissions and the second lowest rate of emergency admissions for older people with two or more admissions in the south west (John Bolton, Department of Health, personal communication)
- according to the Better Care, Better Value indicators produced by the NHS Institute, the Foundation Trust ranked fourth in England for use of beds and fifth for day surgery rates at quarter 3 in 2008/09
- from a commissioner perspective, Torbay had the lowest use of beds per 1000 population in 9 out of 19 HRG chapters
- the health community has reduced the average number of daily occupied beds it uses in both the district general hospital and the community hospitals from 750 in 1998/99 to 528 in 2008/09
- residential care makes up the majority of adult social care spending, but Torbay has the second lowest proportion of people aged 65 and over discharged to residential homes in the south west
- Torbay is second only to south Gloucestershire in the proportion of expenditure on direct payments in the region (John Bolton, Department of Health, personal communication).

These changes have led to improvements in the CSCI rating, good ratings from the Healthcare Commission, and a strong performance in the world class commissioning assurance process. The Care Trust has also performed well financially and user and staff satisfaction have improved. As an example, in a recent Ipsos MORI survey Torbay ranked highest in the south west in the proportion of people reporting that 'my local NHS is improving services for people like me'. The Care Trust's work has received external validation in the form of the HSJ award for managing long term care in 2008. On a recent visit, the NHS Chief Executive, David Nicholson, expressed his support for the work going on in Torbay, commenting 'I have seen the future and it is Torbay'.

One of the current challenges relates to the tougher financial prospects that lie ahead. The commitment to integration has contributed to good financial performance by both commissioners and providers. The Care Trust has been able to use some of the additional funds allocated to the NHS in recent years to support intermediate care services and social care provision that supports improvements in care for Mrs Smith. This will become more difficult in future in view of the much tighter prospects for NHS funding, not least because the Council itself will also be operating under greater financial constraints. There are also pressures on the Care Trust as the Foundation Trust attracts additional income in relation to increases in activity. The way in which these pressures are dealt with will provide a test of the commitment to integration and partnership working.

As the health reform programme goes forward, the future of directly provided services will have to be addressed. The Transforming Community Services programme in the NHS has required PCTs and Care Trusts to make a clear separation between their provider and commissioner functions. This will need to be handled carefully to avoid unintentionally setting back the progress that has been made. The policy of extending patient choice and provider

competition to community services carries clear risks in areas like Torbay unless this policy is applied with discrimination and sensitivity. Many of the social care services that were previously provided in house have now been outsourced e.g. domiciliary care teams and former local authority residential homes. Experience from Torbay suggests that integrated teams should not be outsourced. They are a complex mix of commissioners and providers and much of their work is micro commissioning for service users.

Looking ahead, a priority is to build on good relationships with South Devon Healthcare NHS Foundation Trust and establish closer integration with secondary care and specialist services. Participation in the national ICO pilot programme should help to facilitate closer partnership working between the Care Trust and the Foundation Trust. As this happens, a great deal of work needs to be done to build better understanding between staff working in the hospital and those working in the community of each other's roles and responsibilities.

A related priority is to build stronger links with mental health services through the Devon Partnership NHS Trust in view of the increasing importance of dementia and other conditions in older people. There are also opportunities to extend partnership working to other council services such as housing and leisure. In comparison with the progress made in improving services for adults, children's services have not moved forward to the same degree, and it is recognised that the Council and the Care Trust need to address this issue.

Next steps

Torbay has continued to make progress on integration despite changes among the leaders who initiated this approach. These changes include the appointment of a new chief executive in South Devon Healthcare NHS Foundation Trust, a new acting chief executive in the Care Trust and the appointment of a new People's Commissioner in the Council.

As in the other Beacon sites, continuing progress has been possible because of the depth of commitment to integrated working in Torbay and the tangible benefits that have been demonstrated. The recent appointment of a senior manager from the Care Trust as chief operating officer in the NHS Foundation Trust will underpin further progress in integrating health and social care on the one hand and secondary care on the other.

Discussion

This report has shown that the Kaiser NHS Beacon sites have continued to make progress in improving services to the populations they serve. As the evidence summarised here illustrates, progress has rarely been linear and a range of challenges have been encountered along the way. Nevertheless, it is clear that the promising early reports brought together on the work of the sites (Ham, 2006) have been justified by the work done in the last three years. There are examples of innovation in all sites and increasing evidence of improvements for patients.

Torbay stands out as the site that is able to demonstrate most progress in the period covered in this review, most notably in the continuing reduction in the use of acute hospital beds and the lower than expected use of beds for emergency admissions in people aged 65 and over. Coupled with the virtual elimination of delayed transfers of care, and improved access to intermediate care, Torbay can claim with some justification to be showing a measurable return on its long term investment in integrated care.

By comparing Torbay with Birmingham and Solihull and Northumbria, it can be suggested that the following factors help explain its progress:

- **a receptive context for change:** there has been a commitment to integrated working for around 20 years in Torbay and it can therefore be considered a practical example of the importance of having a receptive context for change – a factor that is widely discussed in the health services research literature (Pettigrew, Ferlie and McKee, 1992)
- **organisational stability:** there has been much greater organisational stability in Torbay compared with the other two Beacon sites and this has enabled local leaders to focus on a programme of service improvements without many of the distractions experienced elsewhere
- **leadership continuity:** until recently, Torbay has enjoyed continuity of chief executive and other senior leadership in both the Care Trust and the Foundation Trust. This has enabled sustained progress to be made in the implementation of integrated services and care closer to home; by comparison, there has been greater turnover in the other two sites

- **partnership working as the local strategy:** all three sites are committed to partnership working, but in Torbay it is the local strategy whereas in the other two sites it is a strategy that has had to compete with other priorities
- **keeping the Kaiser vision centre stage:** all three sites have been involved in various partnerships throughout the period under review but Torbay is different because its Kaiser vision has remained centre stage. Elsewhere work in adapting Kaiser principles has had to compete for scarce time and attention with other partnership e.g. between the Care Trust in Solihull and other local authority services; between the Heart of England NHS Foundation Trust and Good Hope Hospitals NHS Trust; and between three primary care organisations in Northumbria

Having highlighted these differences, it is also important to acknowledge some similarities. These include the way in which the commitment to the Kaiser vision was embedded among clinical leaders and senior managers in all three sites and the importance of their role in sustaining the vision as top leaders changed and organisations were restructured.

Another common factor was the long term commitment in all sites to partnership working, even as newer priorities and challenges emerged. This factor is particularly important in view of evidence about the length of time it takes to realise the benefits of new ways of working. The opportunity to visit Kaiser and learn from its experience has been important in creating an appetite for learning and improvement in all sites and has spawned visits to other leading edge health care organisations as newer priorities such as patient safety have emerged.

The final reflection on the work reported here is the inherent challenge of partnership working in public services. This challenge has been demonstrated in a review conducted by the Audit Commission:

'Working across organisational boundaries brings complexity and ambiguity that can generate confusion and weaken accountability. The principle of accountability for public money applies as much to partnerships as to corporate bodies. The public needs assurance that public money is spent wisely in partnerships and it should be confident that its quality of life will improve as a result of this form of working.'

Local public bodies should be much more constructively critical about this form of working: it may not be the best solution in every case. They need to be clear about what they are trying to achieve and how they will achieve it by working in partnership'
(Audit Commission, 2005, 2)

The work of the Kaiser Beacon sites shows that with effective leadership it is possible to sustain partnerships and to deliver improvements in care. This is all the more remarkable given that the sites have pursued integration at a time when national health reform policies have promoted competition and increasing fragmentation of care, and have encouraged organisations to look after their own self interest rather than to collaborate. Yet with the NHS Next Stage Review explicitly recognising the need for integration and leading to the establishment of 16 national ICO pilots, including two in the Beacon sites, it seems that there is now a conducive and supportive policy context for the work going on in the sites.

A key message from this paper is that the time is now right to go beyond the relatively limited scope of the ICO pilots and support integration of services on a more ambitious scale. The results that have been demonstrated in Torbay show that a sustained commitment to integration can deliver many of the core objectives of the QIPP programme set up by the Department of Health to identify opportunities for the NHS to release resources while also continuing to improve performance. In a recent letter to NHS chairs and chief executives, David Nicholson stated that 'it is already clear that many of the most significant quality and productivity opportunities lie in the interfaces between organisations'. Realising these opportunities demands that integration be placed at the heart of the agenda in the next stage of NHS reform.

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