Developing integrated care in the NHS: adapting lessons from Kaiser

Kaiser Permanente (KP) is a long established, non-profit health maintenance organisation, originally established to offer pre-paid medical care to workers in the construction and shipyard industries, and opened to the public in 1945. It currently has over 8 million members, mainly in California, and it combines health insurance, the ownership and management of hospitals and an exclusive relationship with large, independent, multispecialty physician group practices known as Permanente Medical Groups. As an integrated financing and delivery system, Kaiser Permanente is in some ways more similar to the NHS than to other types of health care organisations in the US.

Comparing the NHS and Kaiser: the original BMJ analysis

An analysis of the NHS and Kaiser conducted by Richard Feachem and colleagues (Feachem et al, 2002) claimed that Kaiser achieved better performance than the NHS at roughly the same cost. The work of Feachem and colleagues attracted huge interest, at least in part because it questioned the conventional wisdom of UK/US comparisons. In the ensuing debate, much of it conducted via electronic correspondence on the British Medical Journal’s (BMJ) website, there was criticism of the basis on which the costs of the NHS and Kaiser had been compared, and extensive argument about differences between the two systems that could account for the conclusions that had been reached.

For example, many contributors to the debate focused on differences in the populations served, suggesting that the requirement that the NHS serve all comers, whereas Kaiser’s members came only from the insured population, might explain variations in performance. These and other points were brought together by Talbot-Smith and colleagues in a summary critique of the methods and conclusions of the original analysis (Talbot-Smith et al, 2004). Feachem and Sekhri (2004) remained unrepentant in the face of this critique, arguing that other work had tended to confirm rather than undermine their broad conclusions.

Comparing the use of hospital beds in Kaiser and the NHS

The other work referred to by Feachem and Sekhri included a study of the use of hospital beds in the NHS and Kaiser (Ham et al, 2003). The origins of this study were a concern to understand what lay behind the finding in Feachem and colleagues’ analysis that age adjusted bed day use in Kaiser was one third of that in the NHS. In view of the high cost of keeping patients in hospital, and the pressure on beds in the NHS, it seemed important to understand whether this finding was an accurate reflection of differences between the two systems, and if so what might explain the much lower use of beds in Kaiser.

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, and the Medicare population in California and the US. The study focused on the population aged 65 and over as all people in this age group are covered by Medicare in the US, and therefore differences in utilisation cannot be explained by the exclusion of part of this population from health insurance. The analysis of bed day use confirmed the results reported by Feachem and colleagues.

For the 11 medical conditions studied, the NHS used three and a half times the number of bed days as Kaiser on an age standardised basis for the population aged 65 and over, almost twice that of the Medicare California standardised rate, and over 50 per cent more than the standardised rate in Medicare in the US. Kaiser achieved these results through a combination of relatively low admission rates, and much shorter hospital stays for the conditions studied. Of particular interest in the study was the way in which length of stay varied directly with age in the NHS but not in Kaiser (Ham, 2005).

Explaining the differences between Kaiser and the NHS

Describing differences in health care utilisation is not the same as explaining these differences. In comparing the NHS and Kaiser, the question at stake was: how was
Kaiser able to provide health care to its older members using far fewer bed days than the NHS? This question could not be answered just through further analysis of differences in resources and practices between the two systems. Rather, it called for study of how Kaiser delivered care ‘on the ground’, including doctors, nurses and health service managers from the NHS spending time in the US and seeing at first hand the way in which care is organised and delivered.

During these visits, a number of factors were identified as contributing to Kaiser’s model of care. Particularly important was the emphasis placed on integration of care, with Kaiser combining the roles of insurer and provider, and directly providing care both inside and outside hospitals. Care integration enabled patients to move easily between hospitals and the community, facilitated by a model of multispecialty medical practice in which specialists worked alongside generalists and had no incentive to build up facilities and resources in hospitals at the expense of other services.

Another important factor was the focus in Kaiser on chronic care rather than primary care and secondary care. Chronic diseases were identified as a priority as they represented the major source of demand among the membership served by Kaiser. These diseases were tackled by stratifying the population according to risk and adopting a population management approach that combined an emphasis on prevention, self management support, disease management, and case management for highly complex members.

Population management was one of the factors that enabled Kaiser to avoid inappropriate use of hospitals. This was summarised in the philosophy that ‘unplanned hospital admissions are a sign of system failure’. Put another way, Kaiser took the view that patients who required hospital treatment that had not been planned had not received optimum care at an earlier stage in their illness. It sought 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 was driven by the active management of patients in hospital. This was 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 made use of general physicians known as hospitalists to work only in the inpatient environment and to ensure that patients received the appropriate level of care.

Chronic care and short hospital stays were underpinned by the provision of self management support to members. Self management support took 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.

Following the visits made by NHS staff to Kaiser, a number of pilot projects were initiated in different parts of the NHS, with a common theme being how to learn from Kaiser’s integrated approach in a quite different political and social context. These projects are concerned less with the importation of an overseas model than with selecting aspects of Kaiser’s approach that seem to have particular relevance to the challenges currently facing the NHS. This briefing paper describes the work being undertaken in these pilots, and draws out the lessons for the NHS.

Adapting the learning from Kaiser

A number of NHS organisations in England have participated in the visits to Kaiser under the aegis of a programme initiated by the NHS Modernisation Agency. In parallel, NHS organisations in Scotland and Wales have participated in visits to Kaiser and have used these visits to identify ways in which they can learn from Kaiser’s integrated approach (see box). This paper focuses particularly on the three areas in England that were identified as Kaiser Beacon sites by the NHS Modernisation Agency and were given support to enable them to move further and faster in taking forward the learning from Kaiser.
Torbay Origins

Plans for the integration of services in Torbay were developed following visits to Kaiser by the PCT chief executive and senior PCT staff in 2003. The acute trust was involved at an early stage and clinical leaders and managers from the trust participated in subsequent study visits to Kaiser. The PCT has been working closely with the local authority to integrate health and social care provision and a Care Trust was formed in December 2005.

The Care Trust serves a population of 140,000 in Torquay and neighbouring towns and villages. Twenty six per cent of the population is aged over 65. There are 92 GPs in the area covered by the Care Trust working in 22 practices. Almost all specialist care is commissioned from Torbay Hospital. In 2005/06 the budget of the Care Trust was around £225 million.

The vision

Work in the Torbay pilot has involved a number of projects. The common concern in these projects has been to achieve much closer integration of the three organisations involved (the PCT, the acute trust and the local authority) and the services they provide. The vision is to create world class services to patients and service users in Torbay, with the needs of patients and service users central to services. The Care Trust aims to create the ‘right care, in the right place at the right time.’

Specifically, as partners in care the Care Trust and the acute trust have committed themselves to:
- integration of care
- promotion of supported self care, particularly in the management of long-term conditions
- avoidance of unplanned hospital care
- personal care management for vulnerable people with the most complex needs

The projects

One of the early projects discussed was the North Torquay integrated health and social care centre. The aim of the project will be to bring together three practices in new premises, with much closer involvement of social care staff. The plans for the centre also involve the provision of services that are normally available only at Torbay Hospital, for example outpatient services and some diagnostic facilities. At the time of writing, a site for the centre has been identified, and when complete it will serve a population of 28,000.

North Torquay is an example of the work going on across Torbay to integrate health and social care services in localities known as zones. Five zones have been established, serving populations of between 25,000 and 40,000. In each zone there is an integrated health and social care team under the leadership of a single manager. The zones provide a geographical focus for service integration and much of their work is concerned with meeting the needs of older people.

The work of the integrated teams is directed at reducing reliance on unscheduled care. To this end, practices have been encouraged to understand the populations they serve and to identify patients who are most at risk of unplanned admissions, making use of the local enhanced service provisions of the new GMS contract. In the event, the incentive scheme did not work as intended and zones used the available resources to invest in district nursing support to identify older people at risk.

In support of this work, patients most at risk are allocated a case manager and are given care plans. Care plans include treatment objectives, planned interventions, and recommended actions in the event of a crisis. These care plans and related information are kept in yellow folders in patients' homes and in this way are readily available to the health and social care staff involved in the provision of care. The name of the case manager is included in the yellow folders.

One of the most significant projects undertaken in Torbay was a review of the role of community hospitals. Attention focused particularly on Paignton hospital, a 50 bed facility that is in the process of changing from a traditional NHS community hospital into an active intermediate care service. This involved developing the role of nurses and therapists and establishing closer links with Torbay Hospital and its team of care of the elderly specialists.

As a consequence, lengths of stay have fallen and more patients have been treated. In its new role, Paignton Hospital plays an increasing part in reducing pressure on beds at Torbay Hospital by providing a step down facility for post acute care. GPs are still involved in the provision of care but the emphasis now is on GPs with a special interest in care of the elderly who work as one full time equivalent from 9am to 5pm Monday to Friday.

The acute trust has become increasingly involved in the Torbay integration with the enthusiastic involvement of its chief executive and a number of senior clinicians. The experience of adapting Kaiser’s principles has influenced thinking on plans for a new hospital in Torbay. These plans envisage a hospital with 20 per cent fewer beds than at
The views of local leaders

Reflecting on experience to date, Peter Colclough, chief executive of the Torbay Care Trust, says:

‘Links with Kaiser Permanente have helped us develop our thinking about how we deliver health and social care. We are committed to making the best use of the skills of both generalist and specialist staff to deliver innovative and integrated services, and reduce dependence on inpatient services.’

Steve Smith, medical director of Torbay Hospital, adds:

‘Clinical integration, with robust pathways of care across primary and secondary care, are key to delivering whole health community objectives. The KP experience has demonstrated how important it is to have a clear whole community sense of “purpose” and that strong clinical leadership underpins the whole process.’

The future

Priorities for the future in Torbay include the development of self care, exploiting further the opportunities in the new GMS contract and practice based commissioning, and using the white paper, Our Health, Our Care, Our Say, to continue the shift of care out of hospitals into more appropriate settings.

As a relatively self contained health community with strong working relationships between health and social care organisations and visible leadership by chief executives and senior clinicians, Torbay is well positioned to build on progress made so far and demonstrate the potential of integrated health and social care provision.

Northumbria

Origins

The Northumbria pilot was developed following a visit to Kaiser in Atlanta in 2002. The pilot is led by the Northumbria Healthcare Trust which has an annual budget of £200 million and is responsible for three general hospitals and seven community hospitals. Its two main commissioners, North Tyneside PCT and Northumberland Care Trust, are also involved as key partners.

Northumbria Healthcare Trust provides services to a population of over 500,000 living across a large area. Northumberland Care Trust serves a population of 312,000 covering a mixture of deprived rural population and concentrations of deprived ex-mining populations. It delivers primary care through 52 practices, most of which operate under personal medical services contracts. North Tyneside PCT serves an urban population of approximately 220,000 and it delivers primary care through 32 practices to a population containing areas of significant deprivation.

The vision

Following the initial visit to Atlanta, clinical leaders and managers have participated in subsequent study visits to Kaiser in California. A high priority has been to improve the performance of services in the acute hospitals and to strengthen integration with primary care and community health services. A tangible expression of the commitment to integration has been the appointment of a Northumberland GP as one of the medical directors in the Healthcare Trust.

The projects

An early priority in Northumbria was to reform emergency care. This involved the establishment of a ‘front of house’ team comprising three consultant physicians (acute care physicians) and two A&E consultants. The front of house team operates as the Hospital at Night team after 9pm, and is supported by a single emergency care team of junior doctors. The effect of these changes was to bring consultant input onto the shop floor and to create a more integrated emergency care service.

A related priority was to improve ‘back of house’ care. This involved the differentiation of wards according to the acuity of patients treated. The aim was to concentrate acutely ill patients on wards with senior staff, and to use other wards for the treatment and care of patients with less acute needs, but who had a predominantly skilled nursing and therapy need. The Trust is working with its partners in the health economy to expand the ‘back of house’ levels of care to out of hospital services such as community hospitals and intermediate care.

Improvements to back of house care are 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. The results of applying Interqual showed that initially 23% of patients were at the wrong level of care. Most of these should have been receiving a lower intensity of care although some should have been at a more intensive level.

Teams of experienced nurses known as care facilitators have been employed in the Trust to use these results to actively manage length of stay and facilitate patient discharge and the differentiation of back of house care.

Although initially the Interqual project encountered resistance from clinicians, this has changed over the last year with the benefits of the programme starting to be realised. Recently Northumbria found that for most of the common reasons for admission, the average length of stay was around half the national average (see table).

Underpinning this work has been the development of the three acute hospitals in Northumbria as a hospital network. In this network, medical staff work across different sites, and are therefore able to sustain services in the new 96 bed hospital at Hexham which provides care to a population of only 70,000. The trust has also invested in a contact centre, which was seen in action in Kaiser, Atlanta.

This provides a single phone number for patients and offers information and a ‘choose and book’ service until the full direct booking service is available.

Alongside these projects focused on improving the performance of hospital services, Northumbria has given priority to strengthening integration with primary care and commu-
Condition: HRG (Ver 3.5) and description

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The views of local leaders

Reflecting on experience to date, Jim Mackey, chief executive of the Trust, says:

‘Both ourselves and Kaiser aspire to provide personalised care in delivering the highest quality of service for our patients, hence our natural affinity for what we saw in Kaiser. We learned from them how they achieved this and used their best ideas and introduced some of them into our work programmes. Looking to the future, the Trust is aiming to achieve NHS Foundation Trust status and personalised care is the bedrock of the Foundation Trust application.’

Derek Thomson, GP and medical director, adds:

‘We were able to see first hand and understand how Kaiser embed their vision and purpose throughout their organisation, providing high quality care and maintaining this at the lowest cost base. We observed how they achieved this investing heavily in their clinical leadership and development programme.’

The future

In future, Northumbria will be seeking to exploit the opportunities created by the new GMS contract and practice based commissioning. This includes making use of the new QoF data and the existing Medics Data, which has been used for nearly 5 years as a tool for the development of high quality chronic disease management in Northumberland.

This data base will help the trust to focus its efforts in commissioning locally based community services, targeted at the areas of greatest priority and potential benefit. As this happens, effort is being concentrated on four clinical care streams (urgent care, elective care, family care and long term conditions) with a view to developing more integrated services through agreed care pathways.

Eastern Birmingham and Solihull Origins

This pilot involves the Eastern Birmingham PCT (EBPCT), the Solihull PCT and the Heart of England NHS Foundation Trust. It was developed following a visit to Kaiser by a group of senior clinicians from the three organisations in 2003. Other managers and clinicians from Birmingham and Solihull have participated in further study visits and the Working Together for Health programme, as it is known, has emerged out of their collaboration.

A programme board and manager provide leadership for Working Together for Health. The programme board is led by a sponsor group which comprises the Chief Executives of the partner Trusts and which is accountable in turn to
the combined boards of the Trusts. Regular three board meetings are held to monitor progress and the Chairmen and Non-Executive Directors of the Trusts take a close interest in the programme.

The PCTs serve a combined population of around 460,000. They provide primary care and community health services in a predominantly urban community that includes pockets of deprivation as well as areas of affluence. A particular challenge in Eastern Birmingham is the provision of care to a diverse ethnic population. There are 90 practices and in Eastern Birmingham over half are single-handed. Both PCTs have effective partnerships with social care and Solihull PCT has developed close relationships with its local authority and is in the process of becoming a Care Trust.

The vision

Over 90% of Heart of England NHS Foundation Trust activity is generated by the two PCTs. The Trust’s application to Monitor was not based on the assumption that it would increase admissions and hospital activity along the lines proposed by other applicants. Rather, its involvement in Working Together for Health led to the assumption that hospital use would stabilise and in time become lower volume and more specialised as a result of more integrated working with the PCTs.

The three organisations involved in Working Together for Health have committed themselves to the following principles:

- a strong emphasis on integration
- priority given to keeping patients out of hospital
- active management of patients to prevent illness
- strong emphasis on self care and shared care
- clinical leadership
- the use of information technology to underpin change management and patient care

The projects

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

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

In the area of long term conditions, particular attention has been given to heart failure, COPD, diabetes, and (more recently) chronic kidney disease. Clinical teams from across the health community have undertaken process mapping to understand existing care pathways and to agree how these can be improved.

In response to particular challenges in capacity and demand, EBPCT invested in an intermediate care diabetes team to support primary care in developing the skills and processes to manage the burden of disease in its most disadvantaged wards. This resulted in it becoming the highest performer in the SHA under QoF in the registration of diabetic patients, a key requisite of structured care. Dedicated community based clinics have been developed to support and advise GPs in the management of both heart failure and COPD with heart failure piloting an approach based on group interventions with patients.

Alongside the work on process mapping, teams of assertive case managers have been appointed to care for the most vulnerable patients with long term conditions. These case managers work across the hospital/community interface in support of district nursing, providing advanced nurse practitioner advice in the systematic review and intervention with patients at high risk of multiple admissions, resulting in a significant reduction in hospital admissions for the patient cohort.

To support the work on long term conditions, the Partners in Health Centre was opened in July 2005. The centre is a converted building on a site adjacent to Heartlands Hospital and it is a location for the provision of innovative services for patients with long term conditions. It operates as a neutral space, neither secondary or primary care, where professionals can collaborate to deliver integrated care. Patients using the centre have access to self care support and educational programmes.

In this spirit, the orthopaedic triage service has a major presence in the centre. This began as a pilot programme with two practices and has subsequently been expanded to cover the whole health community. It offers orthopaedic assessment in primary care by an extended scope physiotherapist for all musculoskeletal conditions where a GP feels an orthopaedic consultation is required. The service includes a mobile clinic and a choice of locations for patients. Waiting times for treatment have been cut significantly and the achievements of the service were recognised by a Health Service Journal award in November 2005. Over 70% of all referrals for orthopaedic outpatients are now managed within this service.

Like Northumbria, Working Together for Health is in the early stages of applying Interqual to establish the appropriateness of use of hospital and intermediate care beds and the medical fitness for discharge of patients. The Heart of England NHS Foundation Trust has trained staff in the use of Interqual and is carrying out initial ward audits with a view to introducing it on a routine basis to the wards during 2006/7.

The second key element of work has been a core focus on developing the relationships between individual clinicians in primary and secondary care and a model of leadership which emphasises managers and clinicians working together to develop excellence in local health services. This programme has seen the strategic identification of key individuals to bring into the programme, and to develop as local leaders on both a locality and clinical specialty basis. The management and clinical partnership has been modelled at its most senior level by the partnerships between PCT CEO (a general manager), Trust Medical Directors (surgical and medical), Trust CEO (originally a surgeon) and PEC Chairs (GPs).

The views of local leaders

Reflecting on experience to date, Sophia Christie, chief executive of Eastern Birmingham PCT, says:
‘One of my first meetings as PCT Chief executive was with Mark Goldman, CEO at Heartlands, and we noted then we shared an aspiration to deliver world class health services to a historically disadvantaged and deprived population. We thought that that would only be achieved by us working together in a different way than the traditional model of confrontation. This has been a learning curve for us as individuals and for our organisations but we have seen tangible outcomes and external validation in the PCT receiving 3 stars (from a 0 base) and the Trust becoming a first wave FT. We still have lots to do.’

Hugh Rayner, medical director of Heart of England NHS Foundation Trust, adds:

‘The experience of visiting Kaiser Permanente opened our eyes to the opportunities for major improvements in patient care that would come from creating an integrated local health service. Over the last three years, a large number of clinicians and managers have shared this experience and we have learned together how to make the transition from division to integration. With such commitment, I am confident we will make our vision a reality.’

The future

Looking to the future, Working Together for Health has prepared a clinical service strategy setting out plans to build on progress made so far. A key development has been the development of ‘the Torbay agreement’ as a guide to core behaviour across the local economy.

The Torbay Agreement

“Eastern Birmingham PCT, Solihull PCT and Heart of England Foundation Trust commit to sharing control of information, financial resources and clinical responsibility whenever and wherever it is agreed this will improve the health and well being of the people of Birmingham and Solihull”

The work programme for 2006/7 expands the current clinical focus into a greater range of areas and has begun to take shape as the acute services strategy for the economy. The strategy recognises that a number of political imperatives and policy drivers present challenges for the future, including payment by results and practice based commissioning. The boards of the three trusts involved in Working Together for Health have committed themselves to meet these challenges and to not allow them to derail the commitment to integrated working.

Emerging lessons

The work that has been undertaken in the three Kaiser Beacon sites and in other NHS organisations that are involved in adapting Kaiser’s integrated care approach reflects the commitment and enthusiasm of NHS managers and clinicians who have seen at first hand the way in which Kaiser delivers care to its members. As this briefing paper has shown, Kaiser’s approach is multifaceted and goes well beyond the provision of specific interventions such as case management and risk stratification.

The complexity of this approach helps explain why the Beacon sites would not claim to have brought about a transformation in the provision of service provision, even though real progress has been made in improving care in defined areas of need. The reality is that all three sites have started a journey of integrating care and have done so by focusing on diseases, populations and localities that are priorities in their local contexts.

On this journey, the sites have encountered barriers and facilitators of change. The barriers include government policies that risk further fragmenting care rather than supporting closer integration. Particularly important in this respect are NHS Foundation Trusts based on acute hospitals only, the system of payment by results that rewards additional hospital activity, and practice based commissioning that, in the wrong hands, could accentuate instead of reduce divisions between primary and secondary care.

The facilitators of change include the leadership provided by chief executives, medical directors, PEC chairs and others who have visited Kaiser and become convinced in the process that there are valuable lessons to be learnt in the NHS. Equally important has been the continuing support provided by Kaiser’s own staff to the NHS Kaiser programme, involving work with the programme in the US and

Kaiser in Wales and Scotland

The Welsh NHS Confederation and Pfizer visited KP Colorado in February 2005 with a multi professional study group from across Wales. The purpose of the visit was to see, at first hand, the management of people with long term conditions. The issues that most impressed the study group were the KP approach to partnership and teamwork, integrated care, care management, self care and shared care, clinical leadership and the role of pharmacists. The subsequent publication From the Rockies to the Rhondda – Better care for patients and better use of hospitals - Can Wales learn from Colorado? helped to stimulate a wide scale debate which underpinned the importance of disease management and managed care for people with long term conditions. This was seen as fundamental to the means of redesigning healthcare in Wales and in reconfiguring acute hospital services.

The NHS in Scotland has hosted visits by KP staff and a number of individuals have explored the adaptation of KP’s model of care. With its emphasis on collaborative working and a culture of professionalism that, like Kaiser, emphasises the role of the physician, Scotland would seem to be more fertile ground for the transplantation of elements of the Kaiser model. The opportunities lie in embedding some of the Kaiser principles around leadership, the systematic development of chronic disease management systems and the expansion of self care. Some barriers to this are the lack of any element of competition to create quality and reward excellence and a Scottish culture which tends to be suspicious of externally generated ideas, particularly those embraced by the English and born in the USA. Scotland’s engagement with Kaiser depends more on the influence of individuals within the Scottish Executive creating the right climate and culture than on the development of demonstrator projects.
the UK, and an apparently inexhaustible willingness to share experience and contribute ideas and assistance when requested. The recent emphasis in government policy on long term conditions has also facilitated change. At the time of writing, the facilitators have proved more influential than the barriers, and this has enabled local leaders to keep faith with their visions and to make steady progress even in conditions of adversity. In this context, the white paper on the future of community services, Our Health, Our Care, Our Say, sets out a direction entirely consistent with the work of the Beacon sites. At the heart of this vision is the provision of care closer to home through a stronger focus on meeting the needs of people with long term conditions, thereby avoiding inappropriate use of hospitals. As the white paper argues, implementing this vision requires an integrated approach to the provision of services that is prefigured by the changes described in this paper and that have been the focus of the work of the Beacon sites.

From this perspective, the work reported here holds important lessons for the NHS as a whole in the next stages of reform. In the words of one of Kaiser’s leaders who has been involved in the programme, the key to achieving successful change is to build momentum rather than speed. The Beacon sites have started to build the momentum required to enable change and improvement to become sustainable, and the following lessons can be identified at this stage:

The Kaiser Beacon sites have been adapting aspects of Kaiser’s integrated care approach in the NHS for over three years

A common theme in the work of the sites has been learning from Kaiser’s model of integration, involving joint working between PCTs, acute trusts and in some areas, local authorities

All sites have focused particularly on care for people with long term conditions with the aim of improving quality of care and reducing inappropriate hospital use

In Eastern Birmingham and Solihull the establishment of the Partners in Health Centre is a tangible expression of the commitment to service integration

In Torbay the role of the one of the community hospitals has changed to support the development of integrated care

Two of the three sites (Northumbria and Eastern Birmingham and Solihull) have applied Intequal to assess the appropriateness of hospital care and the third (Torbay) has reduced the number of acute beds used

In Northumbria there has been a particular focus on improving the performance of services in the acute hospital, and lengths of stay for common causes of admissions are much lower than the average for England

A common priority has been to strengthen leadership, drawing on Kaiser’s approach. Clinical and managerial leaders and champions of change have been identified at each site and programmes of leadership development have been established

Beyond these specific lessons, there is the intangible impact of the work with Kaiser, expressed simply but powerfully in the following way by one of the clinical leaders in the Beacon sites:

‘It is so hard to describe simply the benefit from our experience with Kaiser but it is safe to say that I use it almost every day’

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