lessons in integration

UK health systems have much to learn from a New Zealand health board's experience of delivering integrated care. Steve Brown traces its journey and talks to senior manager Carolyn Gullery about how the board has responded to key challenges

Like health systems across the world including the NHS, Canterbury District Health Board on New Zealand's South Island is looking to integrate care across the boundaries between primary, community, hospital and social care. What marks it out from the crowd is that Canterbury has already been on its integration journey for 10 years. This offers more would-be 'integrators' significant opportunities to learn from its experience.

Structures differ from those in England – although they share similarities with other parts of the UK NHS. New Zealand had experimented with a purchaser-provider split, but brought these two sides together in 2001 within 20 health boards. There are also differences in funding mechanisms. Social care funding in New Zealand is part of health board allocations and there are some elements of co-payments, particularly for its well-organised primary care sector.

Payment for services delivered internally by the board have moved from a tariff-style system, introduced with the purchaser-provider split, to setting budgets built from the bottom up. And, similar to English health systems, services for the 500,000 local population are provided by an alliance of 12 pharmacy and community healthcare provider organisations and primary care networks. Known as the Canterbury Clinical Network, the partnership is built on alliance contracts that try to share risk fairly – with the gains and losses dependent on overall, not individual organisation, performance.

This provides major parallels with moves to primary and acute care systems (PACS) and accountable care systems in England, underpinned in many cases by capitation-based gain-sharing contracts.

Canterbury's journey towards integration began in 2007, driven by pressures and a context that NHS staff will recognise all too well. The health board was already running a deficit (about 1.5% or NZ$17m on a turnover of about $1.2bn) and faced rising admissions, growing

Canterbury Q&A

Carolyn Gullery, general manager planning, funding and decision support at Canterbury District Health Board

Q How have services changed for patients as a result of integration?

There are so many examples, but one is how the system responds to women with heavy menstrual bleeding. Before integration, primary care clinicians would refer a patient to hospital and they'd go on the waiting list for a specialist. The specialist might order a pelvic ultrasound and the patient would go back on the waiting list for the specialist. The specialist would then decide if surgery was needed or some other medical intervention. Under the integrated model, 78% of patients who go to their GP get their entire treatment in the community within 28 days. And the other 22% who need surgical intervention get their procedure much faster. We only see the people in hospital who need to be seen in hospital. It is good for patients and much more cost-effective.

Q How does the financial challenge affect the transformation agenda?

Transformation is more difficult in times of tight finances. But we were in deficit at the start of our transformation work and we saw that the only way out was to change the system. We were about to break even when we were hit by a major natural disaster. We were grateful we'd done all that work or we wouldn't have got through so well.

Where we are now – especially with two very tight years ahead – the risk is that people get distracted by the financial issues and start making the wrong decisions. So we need to manage the financial side of the business in a way that doesn't stop service improvement. Clinicians are now used to change as the natural way of operating, and the leadership team is getting pulled rather than having to push the change agenda. New work has demonstrated that our integrated system has created system efficiencies of around $40m, compared with New Zealand's standardised expenditure – a result of doing so much less in a hospital-based environment and so much more in the primary and community system.

We wouldn't and can't unwind this way of working now. But it does require courage and leadership from the board down.

Q Will integration reduce your requirement for acute beds?

We have a rebuilding programme as a result of the Canterbury earthquakes and

Christchurch Hospital – Canterbury District Health Board's largest hospital

waiting times and a rapidly ageing population – even by comparison to other parts of New Zealand. An analysis – its own mini 'forward view' – calculated that, if nothing changed, by 2020 it would need another hospital nearly as big as its main 500-bed Christchurch facility and an almost doubling of staff working across health and social care.

2020 vision

This was not only unaffordable but, in terms of recruitment, unachievable. Instead a vision was developed for how the service should look in 2020. This involved massive staff engagement and use of quality management techniques such as Lean. At the heart of this vision was a system integrated around patients and a recognition that, despite different funding streams and a range of healthcare partners, there was fundamentally only 'one system, one budget'. This was rapidly adopted as the mantra for the transformation programme, with the key performance metric 'not wasting the patient's time'.

The move to integration has gone hand in hand with engagement of, and investment in, staff and has been underpinned by the new contracting arrangements. In 2013, Carolyn Gullery, general manager planning, funding and decision support at Canterbury Health Board, told the King's Fund – in a detailed briefing on the Canterbury approach – that alliance contracting had moved the board from 'being solely accountable to having a collection of people trying to make the whole system work'. Underperformance by one partner is now met with offers of help from other participants and often further investment. Describing the approach as 'high trust, low bureaucracy', Ms Gullery said: 'We either all fail or all succeed.'

A number of initiatives helped to translate the vision into practice. These include the development of more than 900 HealthPathways, which set out how patients with particular conditions should be managed,

our population is growing extremely fast – up about 53,000 [since before the earthquakes]. When our new acute services block comes on stream in 2019, we will only have 30 more acute beds than we had before the earthquakes. But we've never argued we would see a reduction in beds. We have completely moderated medical growth and our actual bed days are now running 7.7% below the forecast built into the business case for the new hospital.

But we can't slow down surgical beds. It is hard to mitigate growth in surgical beds and counterintuitive when the government wants you to do more and more elective surgery. We also fund long-term care beds. Ten years ago we were remarkably successful at putting people into long-term care beds; now we are remarkably successful at keeping them out.

Q How have clinicians responded to the HealthPathways initiative?

Initially, a few talked about 'cookbook' medicine. But the way we implemented it avoided this. We got primary and secondary care in a room – gynaecologists and GPs, for example – and redesigned the pathway and then talked about how we were going to inform everybody. That's how HealthPathways was born – it was a tool for dissemination.

There were 180 GPs involved in different workgroups for designing pathways – so the whole project was done with them and for them, not to them. As a result, we had no pushback. We also introduced a hospital-facing HealthPathway a year and a half ago. This reinforces the right pathways for patients and gives the opportunity to audit practice against the preferred pathway. For example, in the case of pipelle biopsies (used as a diagnostic in the heavy menstrual bleeding pathway), we can check all biopsies have been followed up.

Q How important is data in general to your work?

We are completely focused on data. One of the great outcomes we've had as a result of our integration work and use of a number of data tools, is that we can do the analysis alongside clinicians and no-one questions the data. We do look at cost data, but our focus is on flow, and patient time is the key metric we use as a proxy for cost. If we can reduce the time a patient is in the system, we'll reduce cost. This makes it easy to grasp if something is the right thing to do.

Focusing on flow helps us to look at the patient journey and identify improvements. For instance, despite our acute admission avoidance system, we noticed we had wards full of chronic obstructive pulmonary disease patients. Analysis of the data showed us that many of these patients were coming in via the ambulance service and bypassing the demand management pathway. As a result, ambulance paramedics have been given criteria for how these patients should be handled and which services are most appropriate. We saw an immediate result, with 30% of these people who called for an ambulance now staying at home.

»

Devastation in the city of Christchurch after the 2011 earthquakes put increased pressure on local health services

supporting assessments and referrals by general practitioners. Involving GPs and hospital specialists in the development of the pathways has led to a much higher degree of acceptance and use by GPs, compared with other sets of treatment guidelines and localised versions deployed in more than 30 health systems across Australia and New Zealand (and now in the UK, by South Tyneside Clinical Commissioning Group).

An acute demand management system has also been introduced to directly prevent hospital admissions. This involves general practice teams managing patients in the community with support from community providers, advice from hospital-based specialists and co-ordination from the primary health organisation.

It has evolved over time – for example, enabling ambulance paramedics to access the service – and has more than doubled the number of cases it manages annually from 14,000 to 34,000 per annum.

In a further initiative, a community rehabilitation enablement and support team targets reductions in length of stay once in hospital and aims to avoid readmissions and admission to long-term care with intensive home-based rehabilitation.

Earthquake aftershocks

Part way through implementation of its integration plans, Canterbury was struck by a series of earthquakes and aftershocks in 2010 and 2011. This added significantly to the health board's challenges. It increased the immediate and ongoing demand for services – demand for mental health services, for example, has grown significantly. The board's estate also took a hammering, with some buildings no longer usable and

Canterbury Q&A continued

Q How has your alliance approach helped your integration model?

The alliance is central to delivery and the alliance contracts provide a flexibility that enables providers to meet patient needs. For example, we used to fund district nursing and home support services effectively on a fee per service basis and costs were growing at about 13% per annum, which was unaffordable. It was delivering an old-fashioned model about tasks – cleaning the house – rather than what the patient really needed at that time.

Under the alliance, we selected providers based on quality and use a casemix model where resources are allocated to providers based on complexity. The model allows the provider to flex what is done for a patient each week to meet needs, and it gives the provider the opportunity to become more efficient in how they use their workforce.

Risk is shared across the alliance – and after seven years it's working well. If there are problems – for example, with higher levels of activity than forecast – then we work together to find better ways of doing things. We are constantly innovating. It is about everyone helping and being fairly rewarded. For example, occasionally a provider might struggle to recruit staff or lose a key manager – our response might be to help them with health board staff.

Q What are your key challenges over the next five to 10 years?

We have financial challenges. We have a building programme and will be working on a construction site for at least another five years. Running and rebuilding a hospital at the same time is quite complicated. It's been a long haul since the earthquake and there is a challenge in getting people refreshed and refocused and then seeing where the next opportunity lies. Our government is pushing for its agencies to take more of a preventative and long-term approach, which absolutely suits Canterbury.

The big issue we face is the long-term impact of a very traumatic natural disaster particularly on our children and youth. That is our focus going forward. We're seeing it in our schools. We have a stable system around older people now, but there is now a demand coming at us for services for our children and youth.

In addition, we need to see some change is general practice, where we have an ageing and declining workforce and too much demand. General practice does a fantastic job – for example in helping reduce acute admissions. But the core model hasn't changed, based on 15-minute appointments. How do we move to a more technology-based and flexible model and use other channels and tools to support our patient population?

HFMA introductory guide
Fourth edition

hfma

New for 2017

Building a solid foundation

A guide to developing good governance

Whether it be financial, clinical or organisational, good governance is the key foundation on which NHS organisations can build so they are ready to face the challenging times ahead.

New for 2017, the latest edition of the *Introductory Guide - NHS Governance* provides easy to read but comprehensive guidance, helping everyone (whatever their role) to understand their part in ensuring effective governance is in place and working.

By explaining what governance is and how it works in practice within an NHS organisation, this guide will help your organisation to develop a sound and effective framework of governance that is not regarded as an unnecessary bureaucratic 'add-on' but rather an intrinsic part of the organisation's DNA.

Volume discounts available
for orders of 5 or more copies

This essential guide is available now priced at

£29.50

For more information, or to order any of our guides:

hfma.org.uk/publications
0117 938 8340
publications@hfma.org.uk

A 24-hour urgent care centre run by Pegasus Health (Charitable) – partners in Canterbury's Clinical Network

Find out more

Carolyn Gullery is speaking at this year's HFMA Convergence conference in July. The London event brings together the annual HFMA commissioner and provider conferences (see page 29)

others needing substantial repairs. This has led to staff having to move regularly as the renovation programme moves across the board's facilities. There was an immediate financial impact. The health board had been on track for an $8m surplus in 2010/11, but that inevitably turned into a deficit as a result of the earthquakes. Since then, the board has relied on revenue deficit funding to support its financial position. For example, in 2015/16 it received $16m in support to help it deliver an overall deficit of just under $0.5m – although this support has now come to an end.

Subsequent earthquakes, including last November's 7.8 magnitude North Canterbury earthquake, have continued to challenge the region and its health services.

The most recent government allocations have just made Canterbury's financial position significantly more challenging. Allocations are based on an age and deprivation weighted capitation formula. And recent census data has led to Canterbury receiving the lowest increase of New Zealand's five biggest health boards – giving it a significant shortfall when inflation and population growth are taken into account.

This is a result of a necessary migration of some 10,000 families out of East Canterbury's most deprived communities following the earthquakes. Levels of deprivation haven't reduced, the health board argues, it has just been dissipated across the wider region. And following an immediate dip in population growth following the earthquakes, it has subsequently been rising rapidly.

Sticking to strategy

The board's large capital programme will certainly continue to drive costs. But the added financial challenges have not changed the board's minds that its integrated health system is the right approach to delivering sustainable services. If anything, it has underlined the urgency of making further progress.

A number of English sustainability and transformation plans are targeting a reduction in inpatient beds on the back of more community services. The King's Fund's 2013 report said that Canterbury had not shrunk its hospital base – nor was that its goal. But it had avoided the growth in bed numbers originally predicted in the 'do nothing' option.

Measuring performance using a core set of agreed measures, including outcome measures, shows positive progress, such as sustained reductions in the number of smokers and acute medical admissions growing at a much lower rate than the New Zealand average. Medical admissions per 100,000 population are 30% lower than the national average.

Acute readmissions have levelled off after several years on the rise and are now in line with the New Zealand average, although with lower than average admissions, admitted patients are likely to be more frail and more at risk of readmission. The number of older people (75+) living in their own homes (88%) is also increasing and fewer are going into aged residential care, with a reduction of 34% in the past five years in the less complex area of rest-home care.

The health board also boasts a lower avoidable admission rate and emergency department (ED) attendance rate that is 25% below the national average, with the credit going to its acute demand management service and other targeted initiatives. More remarkable is the reduction in the rate of ED attendances by over-65s to 260 per 1,000 – well below the national average.

There are still major challenges. In-hospital falls continue to exceed the national averages – though they have decreased slightly recently and the board believes its figures also reflect improved falls coding. A new system-wide falls prevention strategy is now in place.

Canterbury District Health Board is convinced its integration programme has been a success and is the only way to meet ongoing service and financial challenges. It is increasingly recognised as a model showing how integration can deliver better care and help ensure services are sustainable.

The difficult financial challenge facing the board can only make it an even better example for UK health bodies as they attempt to deliver similar goals through more integrated services.