This is a tale from New Zealand, the land of the long white cloud. More particularly it’s the story of the quest for better integrated care in Christchurch and Canterbury, Canterbury being the largest district, region in New Zealand and Christchurch, so to speak, its capital. Christchurch is famous for a whole bunch of things from the Canterbury Crusaders who at times appear to provide about half of the All Blacks Rugby Team but also for this...

On February 22nd 2011 Christchurch suffered a devastating earthquake that killed 185 people and wrecked not just the city centre but large surrounding areas, an event from which the city is still working hard to recover.

The Canterbury Health System survived that. It partly did so because it had for some years been working hard to change the way it functioned. This story could start at a number of different times but for this purpose we are going to begin in 2007 when the Health Board was in deficit, waits for care were long and there were plenty of problems. The Board sat down and worked out that if nothing changed then by 2020, Canterbury would need a hospital twice the current size, 20% more GPs and 2,000 more residential care beds, a 40% increase.

It decided that was neither affordable, nor achievable. That even in the unlikely event of the money being there, it would simply not be possible to recruit those numbers of staff. So the Board deliberately set out to create a burning platform for change. It created an interactive workshop in a disused factory called Vision 2020 which took staff through the challenges and asked them how they would like to see how the health and social care system operate and how they personally would change it given the opportunity.

It also began an experimental learning programme called Accelerate which introduced staff to lean thinking, to Six Sigma and chaos theory. It took them out to other industries that had made major changes: New Zealand Post, Air New Zealand, big retailers and sports franchises and, given that the Board had the luxury of funding both health and social care, it stressed that in Canterbury they had in future to be one system and one budget. That each New Zealand dollar could only be spent once and problems would not be solved by cost shifting from one sector of health to another or between health and social care and from all of their contracted providers to another.

Now in practice in Canterbury and New Zealand there is not just one system. Despite the Board funding both health and social care there are, in fact, two major sources of public funding, a pretty lively private sector, appreciable co-payments to visiting the GP, means-tested social care plus a wide mix of public and private providers but it is true that each dollar can only be spent once and instilling the idea that the whole had to operate the one system with one budget was crucial.

A health services plan in 2008 set out a number of principles to change rather than a detailed plan, the means by which they would be achieved. A pictogram was produced which put the home at the centre of the health care system and the hospital on the outside. Not the instinctive way that people normally think about health care, but it is one you can see in various versions on the walls of health and social care organisations in Canterbury to this day and the Board came up with the concept if they stopped wasting the patient’s time, the health and social care system might operate a lot more efficiently as a result. The slide that follows is a long quote but it is worth digesting.
On top of Accelerate, shorter, similar versions of leadership programmes known as collaborate and participate were developed and there is a long standing continued investment in such staff development, it is anything but a one-off. It embraces everyone: porters and secretaries as well as clinical and managerial staff and staff who work in social care and in the various health and social organisations with whom the Board contracts.

The Board itself employs some 9,000 people but 18,000 people in total work in health and social care in Canterbury and today well over 1,000 of them have been through these programmes during which they are asked to come up with proposals for improvement, changes that will save patients’ time, staff time, GPs’ time etc. So how did this all happen? Well first of all Canterbury created a vision; second, it provided people with the tools with which to innovate and third, it changed the way the money works. The way it did that was, first, ideas that saved patient time got funded. Second, the price volume schedule, which is New Zealand’s equivalent of the tariff, was scrapped. That removed the hospital sense of entitlement that if it did more work it should get paid more but it also removed the fear that it would lose money if it changed the way care was provided to the patient’s advantage but in a way that saw the hospital do less.

And third, the Board stole the idea of alliance contracting from the construction industry. This replaced traditional individual contracts with suppliers usually with penalties for late delivery and possibly rewards for early completion with an understanding that in complex projects one is dependent on everyone else. That certainly applies in health care. So you form an alliance where when things go wrong. The aim is to help your partner solve the problem rather than result to penalties and the law to put things right.

So what happened as a result of all this? Well a whole host of initiatives, many initiated by the staff themselves rather than led or imposed by management. There are a whole load of acronyms here and for more detail you can read the report but Health Pathways is a highly impressive set of locally agreed and enforced guidelines on what GPs need to do before referring patients to hospital: for what tests to do, precisely where to get them, who to consult, what to try. Crucially they were drawn up by hospital specialists and GPs working together agreeing what is the best practice locally for each pathway. There are now more than 400 of them. ADMS is a system for preventing unnecessary hospital admissions by providing care and/or observation at home. Nurses in the accident and emergency departments spot and pull patients who do not need to be admitted and GPs can also refer to it.

Crest works at the other end of the hospital stay, aiming for early and swift discharge to rehabilitative support at home. There is an electronic referral management system, electronic shared records and falls and medication management programmes and within the hospital the way the radiology departments works has been fundamentally re-organised and there are medical and surgical assessment units that reduce overnight admissions and there is a lot more. Much of this has been possible because Canterbury already has strong, well-organised primary care operating most noticeably through Pegasus, an independent practitioner organisation which undertakes extensive GP education and also runs a 24 hour surgery in effect a sort of poly clinic.

It handles as many patients a year as the emergency department and for a small but growing range of conditions including COPD ambulances are now being diverted away from the A&E to the 24 hour surgery. Some of the changes follow swiftly on from the
2011 earthquake. They have been planned before and the earthquake’s effect was to accelerate the introduction or to expand these programmes but without the earlier groundwork that would not have happened. So what has been the outcome of all this? Well there are a lot of charts that follow but the story they essentially tell is that Canterbury improved its already low standardised acute medical admission rate. It has low lengths of stay and low re-admission rates for both medicine and for acute and elective surgery. It is doing more elective surgery and the hospital which regularly used to go into gridlock with patients backing up in the Emergency Department now rarely does so.

Emergency department attendances among the elderly those at whom the acute demand and community available programmes are aimed are down. There is much more done in primary care. For example propelled biopsies, spirometry, the management of COPD and the removal of skin lesions in a country where skin cancer is common but at the same time the use of the most costly social care is down and so is spending on care home places marginally when previous projections had it rising steadily.

So what hasn’t changed in Canterbury? What this has not done is shrink the hospital base beyond the thirty or so beds permanently lost in the earthquake but to be fair that was not the aim. What it has done is flatten the demand curve so the hospital re-build that was planned before the earthquake now requires 200 fewer beds than would have been the case in 2007. Difficulties remain that are far from unique to either Canterbury or New Zealand in measuring the impact at this more integrated care and while the language in Canterbury is about transforming the system it has yet to be fully transformed. There is no doubt however that it is transforming the way care is provided. There is a clear and sustained vision of where health and social care system is going. There is continued investment in leadership and innovation skills for all levels of staff including in partner organisations and that has empowered arguable re-empowered the staff to innovate in the way services are provided. Intriguingly when compared to the UK it has moved away from competition and financial incentives as the key drivers are changed instead seeking to harness the professional pride in the ability of staff at all levels to make a difference whilst given the tools to do that. You might say a little more like Scotland than England.

It has taken advantage of its existing strengths - strong primary care for example - and built on them. Relatively little of what is done - though Health Pathways is something of a notable exception - is unique to Canterbury. Instead it has adopted and adapted ideas from elsewhere and it has, unlike England, had the advantage of a broadly stable operating environment. There has been no major structural organisation of the way health care operates in New Zealand for more than a decade now while the issue of measuring the impact of integrated care remains. There is no doubt that from first deliberately creating a burning platform and then taking the opportunities and challenges brought by the earthquake, the shaking ground so to speak, Canterbury has made significant progress towards transforming its health and social care system into a more integrated one. You can find out more with the Commission Report on The King’s Fund Website.