Purpose of report
This report is intended to share learning from a study trip with people across the health and social care system with the intention to galvanise work towards integration in Cornwall and the Isles of Scilly.

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Executive Summary

NHS Kernow is working on an integrated care model for Cornwall and the Isles of Scilly through collaborative partnerships with system leaders across health and social care. The study group was selected by the Leadership Summit which has been meeting regularly since July 2012 to make progress on integration through joint programmes such as unscheduled care and patient flow. We embarked on the study trip to create a shared experience which would inspire innovation and enhance the relationships between different organisations.

We chose Denmark and Sweden specifically because there is a history of integration over a 10 year period and we know that the Swedish model of public service is one that the current UK Government follows closely and derives inspiration from.

From the first visit to the last we were impressed by the generosity, the personal attention and respect we received by all the people we met. We were treated with great hospitality and our hosts emphasised the importance of the social side of organisations and relationship building through social contact as well as professional contact. Our hosts invited us to join the ritual of the mid-morning snack, healthy open sandwiches with cheese and fresh bread and coffee; clearly they thought that these social spaces of sharing creates a culture of mutual trust that helps to build confidence and cooperation. We literally got a taste of the culture of each organisation through the way we were welcomed and hosted.

Our focus:
1. Patient centred healthcare, including:
   a. urgent care;
   b. patient flow;
   c. safety; and
   d. continuity of care.
2. Integrated healthcare systems – particularly Chains of Care.
3. Economic models including different ways of using resources and funding.
4. Healthcare systems for the frail elderly population.

Our visits:
1. Patient records and integration project for frail elderly in Denmark.
2. Integrated healthcare theory and research at the Nordic School of Public Health.
3. Esther Project for frail elderly – an example of integrated design and delivery.
4. Improvement projects including MRI scanning for children and self-dialysis.
5. District General Hospital, demonstrating different projects using integrated approach.
6. Qulturum, an academic institution set up to support improvement through knowledge sharing and research.

Key messages:
- We have the same problems but they have been working on integration for 10 years and have come to accept integration as the only way to deliver high quality, patient centred healthcare within the limits of our resources
- Integration is a continuum, most organisations are somewhere in the middle
- Mergers are not seen as the answer to overcoming the gaps in service delivery
- Chains of Care has been most successful in delivering integration
- Culture and intention to collaborate are seen as essential to making progress
Three major determinants of integrated health care development were identified:
1. professional dedication – focus on patient
2. legitimacy – clinical acceptance
3. confidence – trust in each other

Figure 1: Determinants of integration
Denmark

We visited four sites covering the following areas:

Patient Records

Joy Youart and Dympna Cunnane met Dr. Erling Havn, an academic at Copenhagen Technical University who has been involved in setting up a patient records system and Dr. Elisabeth Plum, academic, consultant and author (Cultural Intelligence pub. Libri 2007), an expert on cultural integration who has been working with health services to manage integration. Both highlighted the benefits and challenges of successful integration, from the human perspective as well as the technical challenges.

We were impressed by the success of a project to provide every Danish citizen with access to their own personal health records via a secure site protected by individual ID number and data encryption software. According to Dr Havn this system took a long time to build because the team had to overcome many barriers including the integration challenge of collecting and integrating different databases across health and social care organisations. We were able to see for ourselves the personal records of both Dr Havn and Dr Plum, access was as simple as accessing your bank account on line.

Elisabeth Plum organised and accompanied us on a visit to Roskilde Region in Denmark, a large area close to Copenhagen, to meet with system leaders there who have developed an integrated service for the frail elderly with some success. This group of patients are also a strategic priority for NHS Kernow.

Roskilde Municipality – Frail Elderly Project

We met with the two leaders of pioneering projects for the care of the frail elderly, one from the municipality, Thilde Lydiksen and the Director of the Roskilde Hospital and a geriatrician called Dr. Solveig Henneberg Pederson. They have been working on a collaborative programme across health and social care for over ten years with the support of research. (papers available on request). Their BMJ article states that they have had significant success in reducing the re-admissions rate for the frail elderly through a number of actions, processes and culture.

Background to Danish healthcare environment:
- Shared responsibility between hospital and local authority.
- Three sectors, primary care, hospitals and welfare and prevention.
- Remote locations including islands with small populations.
- Services divided into treatment and care.
- GPs are gatekeepers to hospital treatment, patients are offered the treatment they need, not more complicated than they need.
- GPs refer patients to other professionals, arrange home nursing and home care, all coming from the same budget.
• Care closer to home is the aim for as long as possible.
• Avoidance of acute admissions, making care more planned.

Initiatives to reduce re-admissions
• **National Action Plan for the Elderly 2012-2015** to prevent unnecessary admission to hospital through encouraging organisations to work together.
• **Follow Home Project** to look at discharges at risk and adverse outcomes, what are the risk factors, they are not always what we think they are, we need to identify key factors (25% are social or soft issues around care).
• **Co-ordinators** to navigate the system on behalf of the patients to ensure quick transfer from hospital to home (hired by the county council), their contract allows them to work across all sectors.
• **The Observation Wheel “Keep the wheel turning”** - Observation is important all professions are trained in a method with a simple instrument (observation wheel covering six areas which was generated by cross-section of disciplines and organisations)

Follow Home Project
• Hospital contacts co-ordinators when there is a complicated discharge.
• Team is located in the hospital, enabling close collaboration and informal sharing of information and data. (Overcoming separate computer systems by having two computers in one room.)
• Municipality nurse is in the home when patient arrives home, has a teleconference with hospital describing conditions at home, solving real problems to avoid deterioration and re-admission.
• Shared data on medication whereby medication history but not patient history is available to all organisations.

Research
• Intervention group showed different results than the wider group, this may be because the investment in the transition from hospital to home was different, more research is underway to identify the significant factors leading to better outcomes
• Research evidence indicates that the last four years of life are most expensive in terms of medical support as it is often complicated and intensive, need to target medical resources in this area
• Think tank called Future of Geriatric Care which researches level of resources needed, which kind of resource (shortage of geriatricians) by what specialists, how can patients enter the system in the best way for them (the right door), looks at trends, patterns, identifies problems and proposes solutions.
Roskilde Hospital, Geriatric Unit


- Environment is clean and friendly, patients know the Director and the staff are open and welcoming to us, invite us into the wards and discuss what makes it a good place for them to work and care for patients.
- Staff are proud to show us around and appear to be highly engaged – they were eager to talk to us and share their ideas.
- Emphasis on nutrition, food planned and prepared from fresh ingredients according to the health needs of the patient e.g. high calorie meals for patients who are reluctant to eat, low sugar meals for diabetics etc.
- Patients are in two person wards mostly - “many patients fare better when they have someone to talk to and they help each other out.”
- Equipment is designed for minimum stress on patients when assessments are taking place.

Sustainable Care Home and Rehabilitation Unit

The following visits focussed on innovation and improvement projects for rehabilitation patients and residential care for the elderly, both are funded by the regional government.

Care Home

- New building which is designed around patients’ needs within a context of spending cuts and the need to get maximum value for investments.
- Sustainable approach to design - uses no heating due to technological advances in use of light, water and insulation providing reduced costs on maintenance and energy consumption.
- Nursing home also uses light to improve wellbeing, all rooms have large windows and open spaces have views and balconies. Colours have been carefully chosen and local artists have contributed paintings and art works.
- Food is cooked in kitchens from fresh ingredients and each floor has an open kitchen area where staff prepare food for serving. The ritual of preparing and serving food is considered an important part of the quality of life and the care of the elderly.
- Staff share space with residents.
- Large space for special occasions with café tables, piano etc, shared by staff and residents who can use it to host guests and parties.
Rehabilitation Unit

- Rehabilitation area is designed to facilitate recovery as quickly as possible, from attitudes and training of staff to equipment and facilities.
- No set time for recovery, “these are very sick people”.
- Patients are asked to take responsibility for getting better, dependency on staff is discouraged and staff see their role as supporting recovery and professional advice on specific conditions.
- Encourages different ways of working and different approaches to disability, building a dynamic staff group who think about what they are doing and what rehabilitation means and how to navigate it.
- Staff are asked not to over-help patients (“this is not a hotel!”)
- Culture change in staff group is led by the new Director, a highly motivated and committed professional who is proud of what they have created.
- One of the challenges is to get good staff who keep learning and improving care services and rehab services.

Key lessons from the Danish visits

What makes co-operation across boundaries possible:

![Virtuous circle of co-operation](image)

Figure 2: Virtuous circle of co-operation
Sweden

A larger group of 15 people from across the health and social care system in Cornwall visited Sweden. We visited three locations including the Nordic School of Public Health to hear about health economics and research related to Integration, specifically Chains of Care, a District General Hospital to look at the implementation of Chains of Care concept there. Finally we visited the Qulturum Institute at Jonkoping where we were told about a number of improvement projects based on integration principle and focussing on different populations and diseases and an academic institution where we heard more about the research and development of integration projects and organisation development to support such changes.

Why Sweden?
The Scandinavian model of the welfare state has become internationally known. It is similar to the UK in advocating universal social benefits and free or strongly subsidised services. Sweden has undergone a transformation in health and social care in the last 20 years. These changes were in response to external factors and internal pressures. There are strong similarities and their solutions will be of interest to us as we move into a different economic, social and political landscape.

Sweden has a large sparsely distributed population where maintaining geographical equity and economies of scale are a real challenge. Swedish healthcare is highly decentralised with three different sources of funds: national and regional government and municipal authorities collecting taxes which fund healthcare. National government only develops policy and does not get involved in the design of delivery or direct funding. The method of financing healthcare has changed from annual adjustments of historic costs to a more sophisticated system of contracts aiming to improve quality and performance. Hospitals are becoming highly specialised treatment centres, simpler cases are dealt with on an outpatient basis. Specialised services are delivered in fewer larger hospitals, thereby gaining economies of scale and higher quality treatment through a higher quantity of complicated patients seen by each physician. This move has been strongly opposed by local politicians and citizens but is now accepted by most regional governments and municipalities.

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“The Scandinavian model has been based on flexibility, local solutions and country variations. Previously choice was seen as an unnecessary trait (US system) but is now a part of every Scandinavian country’s healthcare system. Choice is now seen as a necessary adjustment to the information age and more demanding consumers, not just passive recipients of healthcare but active participants in its design and delivery. Choice implies increased use of market-type initiatives which can correct inefficiencies across the system which has been characterised by structural and managerial rigidity.”

(Professor Bengt Ahgren, Nordic School of Public Health)
Cultural Context
Scandinavia, in general, has a less hierarchical culture than the UK, with different levels of autonomy at local levels, regions, municipalities and institutions. A history of social democracy means that public services have been an important part of the culture for generations, however this is changing. Bottom up as well as top down change has been part of the political landscape and citizens were prepared to pay higher taxes to support social equality in health and education. The language of prevention is common currency and collaboration and consultation is firmly established as a means of running both business and public service. The focus of healthcare is moving from an emphasis on illness to a focus on how to enable and support self-care and independence which encompasses prevention, ongoing management of disease and medication, medical interventions and social care: ‘what does the citizen want/need to be able to do?’ is the key question in designing health and social care.

Economic Context
Obviously different economic models inform the different healthcare systems we choose to design and these models are fundamental to designing system change and delivery systems. The most commonly used economic model is free market economics, with its emphasis cost, efficiency, standardisation and the use of competition among suppliers. This means that each organisation is seen as operating alone and in competition for income generating activity to fund the services it provides.

Methods of organising include:

ANTAGONISM
- competing for resources and power

COMMENSURATION
- one benefits and the other is unaffected

MUTUALISM
- both benefit

We understand that the economic model underpinning Integration is Ecological Economics which is based on the idea of a complex eco-system where the different players deliver different parts of the value chain. They work in concert rather than alone and the culture and strategy is underpinned by the idea of co-operation rather than competition.

Ecological Economics
In brief, Ecological economics is based on the idea that the economy, like any other subsystem on the planet, cannot grow forever. “In nature, things don’t grow forever and if
you want to tie economics back to nature, you have to recognise that the economy is going to stop growing at some point. That's not necessarily a bad thing. That's the way natural systems work. So what we need to do now is make the transition from the growth phase to the steady state; all natural systems do that.” (Constanza, Daly and Bartholomew ‘Ecological Economics).

What does that mean in terms of the health economy is a shift away from sort of brute-force competition towards more cooperative, alliance-building, stable kinds of relationships, it means that the cut-throat competition is probably going to come to an end, and we'll have more collaboration among the different parts of the system. With reference to healthcare the intention is to connect different actors through networks within a framework of local care.

**Nordic School of Public Health in Gothenburg**

Professor Bengt Ahgren, a recognised expert on integration, hosted a discussion of integrated healthcare and research projects, which measure impact and outcomes. He described the *Chains of Care* concept and its importance in developing integrated care. All the county councils have adopted this concept but progress is slow and variable. Projects initiated locally by dedicated professionals have been shown to have a high chance of success.

Prof Ahgren talked about a continuum of integration from fragmentation to full integration and pointed out that most healthcare systems are somewhere in the middle and as you move further towards integration you find fragmentation occurs through increased specialised service providers.

![Chains of Care](image)

**Figure 3: Chains of Care**
He pointed out that there are three drivers of integration, arising out of:

1. **Decentralisation**
   Tighter economic conditions mean tighter control of spending and local solutions to local problems with performance related reimbursement for health care providers. Frontline managers have increased delegated authority.

2. **Specialisation**
   Accelerated specialisation due to clinical developments whereby healthcare professionals need to acquire more in-depth knowledge in an ever-narrower field of expertise, speaking different languages and having different cultures.

3. **Professionalisation**
   Healthcare professions have vast responsibilities and increasing independence, which results in the professions having more loyalty and sense of belonging to their professions rather than their organisation. There is also competition for influence and power between professional groups.

**Figure 4: Patient Bermuda Triangle: Fragmentation of Healthcare**

Integration is designed to bring together three perspectives, the patient, the professional and the management and to avoid the ‘Patient Bermuda Triangle’ (Berwick 1991) where patients are lost due to the fragmentation of health care delivery systems. Clinical integration is seen as the foundation of integrated healthcare and projects are evaluated by research which provides managers with crucial data to support new evidence based solutions and configurations which are high value and cost effective. The most widely accepted method of collaboration is a system called ‘Chains of Care’.

Resistance from the body of physicians was a serious obstacle to such a development. Local health care depends on developed chains of care, but it seems that health care managers do not have the management systems necessary to run these clinical networks, mainly due to a lack of acceptance from the medical profession.
7 Habits of Integration

1. Thinking in system terms rather than mergers was seen as a more useful framework for designing integration processes, asking what links different providers.
2. Organising around a patient (citizen is the preferred word) where different organisations link to provide services to a group of people.
3. No financial transactions, they need to see the advantages of integration and be willing to enter into collaborative networks for the good of the citizen.
4. Move away from ‘Who owns the patient?’ New models and concepts are often seen as a threat to the identity and role of organisations or professional groups.
5. See the benefits of Collaboration - Chains of Care may overcome territorial battles provided you can see the benefits of collaboration, if you cannot then you should avoid it!
6. Willingness to change, what matters most to you? Your organisation, your own position or the welfare of the citizen?
7. Make it about people rather than processes or economics.

Space for prime movers and trust between participants were crucial success factors, while “top-down” approaches targeting, at the same time, a change of management systems were negative for the development of chains of care”. Prof Bengt Aghren
Research into Chains of Care Projects

The research showed a significant reduction in rates of re-admission and also on patient satisfaction but it did not prove that savings were achieved overall and more research is needed on a longer term to test this hypothesis.¹

Chains of Care project for frail elderly

- ED initiated the study.
- Agencies worked together supported by research.
- Research was seen as key in linking people together by enabling different professions and organisations to see the links more clearly.
- Research crossed organisation cultures, financial models and built networks across clinical and managerial boundaries.

Local care

- No distinct definition.
- No single model, designed according to need and demography.
- Combination of tele-medicine, local hospital and GP.
- Community and family oriented care, using these resources well.
- GP can admit patients to hospital.
- Combinations of actors who provide services to meet the needs of different populations, held together by a series of values or mottos:
  - Accessibility – closeness in distance and time.
  - Continuity – closeness in relationships.
  - Co-operation – closeness of professionals and organisations providing care.

Visit to Alingsas Hospital

This is a district general hospital, employing 720 staff and having 7,000 patients on wards.² We visited this hospital because it is engaged in integration projects with the municipality and social care organisations to develop care strategies and practices with the patient in mind. We met the Chief Executive of the hospital (previously a cardiologist) and the Director of Social Services at the local Council and a number of clinical leaders.

Background: General practice and medical centres

Medical Centres are independent financial entities, people can choose their medical centre and this has made co-operation more difficult. GPs compete for high value patients; they do not want 'vulnerable' patients who will consume more resources. This impacts on the ED in the hospital which fills up with primary care patients.

¹ Continuum of care for frail elderly people: experiences from a research project, by Eva Holmgren and Katarina Wilhelmsson
² Slides
The Chief Executive welcomed us personally, waiting at the lift and greeting each of us individually with genuine warmth and professional etiquette. They had collected together a group of people from different organisations who had prepared presentations and case studies. We were offered refreshments which had been chosen to represent their culture and we were encouraged to feast on these special treats. We were impressed by the culture of openness, honesty and generosity in which they shared both the bad and good stories with us, asked us for our perspectives and experience and gave us time and space to think, to share and to learn. It seemed that this culture of openness and generosity was part of the reason why collaboration was at the heart of their improvement projects.

The Project: How do patients get into hospital?

They commissioned a study of people of patients aged 65 + who had more than three visits to the ED in six months and asked “How did that patient get into hospital, through the ED or GP”? The objective was to track the journey and identify ways of intervening to prevent, minimise and follow up admissions and reduce re-admission. This project used mobile teams for out-of-hours services and they delivered an 80 percent reduction in admissions.

Following these patients journey through the system they developed a group of specially trained nurses who coached the patients with telephone support in order to keep them out of hospital, they found that when they did this the hospital stays were shorter and there were fewer re-admissions. This group of patients mostly called in the night because of fear and loneliness.

The President of the City Council presented a patient story to illustrate the issues they were addressing. Her name was Anne; what might she need? She is in the category of citizen between the ages of 65 and 79, the number of which is increasing by 25 per cent in this region. She will need healthcare and social care but organisational boundaries make it difficult for her to get the care she needs.

Previously, there was a lot of buck-passing in order to pass costs on from one organisation to the next. In 2007 the regional government decided to organise around the needs of citizens, it has taken four years and has been fraught with difficulty. There are three different taxes (sources of funding), the city council tax which is the biggest, the regional tax and a national tax (smallest).

Regional healthcare strategy
- Health promotion, risk identification and prevention.
- Keep patients out of hospital through mobile teams, screening from risk of falls, pressure ulcers, malnutrition, and medication checks.
- Care plans if admitted to hospital.
- Involve patients and relatives in understanding the disease and the treatment, what should they look out for, who should they talk to if in doubt, what is the medication, dosage etc.
- Contact the patient within 48 hours of discharge (achieved an 18 per cent reduction in readmission).
Leading the Change

A Community Care Steering Group, similar in makeup and vision to our Leadership Summit Group, was established with a mandate to sort out strategic collaboration between hospitals, primary care and regional government. At first the hospital was reluctant to co-operate or to invest in the collaboration because it took away resources from core tasks. However, they decided to take a risk and put time and people into the task of integration.

- Regional government commissioned the activity.
- Educated each other through seminars.
- Developed a consistent way of designing care packages.
- Started where it was obvious we needed each other (e.g. children’s services).
- Target groups, elderly, vulnerable children and mentally unwell.
- Research groups work alongside to test if solutions/strategies are delivering the expected results in terms of patient care and economics.

Principles

- Proximity to home.
- Continuity – seamless transitions.
- Security – citizen knows where to turn.
- Availability – 24/7 close to home.
- Community – use resources in the community. Increasingly people in mid 60s to mid 70s are often in good health and want to contribute to society; we need to use that resource.

Target Groups

1. Children and young adults
2. Frail elderly
3. Disabled
4. Dying

Key Questions

- What is measured, how do we know what improves quality outcomes?
- What do we believe is of value?
- What are the barriers we need to overcome?
- Are you dedicated to development work?
- Do you have the willingness and agreement to integrate?
- Do you have clarity about the problem?
- Will you invest in developing a solution?
- Is the accountability process designed to facilitate vertical working?

Strategic, political and operational collaboration was achieved through:

- lots of dialogue (cross-sector meetings);
- clear goals for collaboration (equal health);
- long term planning;
- patient choice;
- cutting waste and becoming more efficient;
- prevention; and
- Seamless transitions from one service to another.
Visit to the Qulturum Project in Jönköping

Qulturum is a centre for the development of improvement of knowledge in healthcare. It is part of the Jönköping City Council which has the responsibility to provide healthcare and medical treatment for the county. It has research projects which support healthcare delivery and addresses the following topics:

- learning and innovation;
- leadership and culture;
- care quality;
- prevention and self-care;
- patient flow and co-operation between organisations;
- clinical improvement;
- patient safety;
- medication;
- finance and governance; and
- Reliability.

We met with Goran Hendricks, the CEO and co-founder of Qulturum.

He talked about his vision of whole system, research and evaluation to drive improvement across the healthcare system. The vision in 2000 was “the recovery of a sense of care in the deliverers of healthcare”. He wished to bring together the policy makers, the leaders, the managers and the people who deliver the care at the frontline, to have a humble approach to the challenges we face, believing that individuals make change and leaders enable change. The idea that the leaders enable initiatives, free people up to improve, engage patients in their care, engage staff by listening to them and creatively developing themselves and the system is at the heart of the vision.

Guiding Principles

Qulturum has become a meeting place for many different people to create a rich soil for improvement. The following principles guide the work:

- ‘The Future is Now’.
- ‘Every system is perfectly designed for the results it gets’.
- Develop our own eyes, move away from the idea that things are better somewhere else, its here and now.
- Organisations are complex adaptive systems.
• Feedback – what did we learn from before, Feedforward, what are our expectations, ambitions, inspirations.
• Patients’ view of the process.
• What needs to be in place for the right things to happen, not what needs to be finished?
• Search for best examples and copy these.
• Mindset – move away from the ideas that strategic development comes from good stewardship of finances.

Vision

To have the world’s best knowledge and to engage with nurses, doctors, health economists and social workers to create tools, models and methods in six areas to achieve reliability and good finances.

Figure 5: six areas of learning
How the patient meets the healthcare system, led by the patient.

Examples of Improvement Projects

We were invited to listen to a number of presentations where improvements were pioneered and supported by research, demonstrating the mission and purpose of Qulturum, real projects which encompass all the aspects of integration and collaboration as well as evidence based innovation in the interests of patients.

The Esther Project

Esther was invented by a team of physicians, nurses, and other providers who joined together to improve patient flow and coordination of care for elderly patients within a six-municipality region in Sweden. The productive work that has been done on Esther’s behalf recently led the Jönköping County Council, responsible for the health care of 330,000 residents living around Höglandet, to become one of two international teams participating in the Pursuing Perfection initiative. This program, launched by the Robert Wood Johnson Foundation, is designed to help physician organizations and hospitals dramatically improve patient outcomes by pursuing perfection in all their major care
processes. The Institute for Healthcare Improvement (IHI) serves as the national programme office for this initiative.

"Esther is 88 and lives alone in a small apartment. During the past few nights her breathing has become worse and worse, and her legs have oedema severely enough that she cannot lie down, but sits up all night. She knows she needs health care. She phones her daughter in a nearby town, who tells her to call her home nurse. The home nurse visits and says she needs to see her GP. But Esther lives on the third floor and can’t manage the stairs."

“So the nurse calls an ambulance, and Esther goes to the doctor, who says she needs to go to the hospital. Now three hours have passed. An ambulance takes her to ER, where she meets an assistant nurse and waits for three hours. She meets with a doctor, who examines her and orders an x-ray, and says she will have to be admitted. She comes to the ward and meets more nurses."

“Most days Esther is a little lonely, but today she is happy because she has already met 30 people!”

The health system is designed in a traditional, functional way: Each link in the care-giving chain — the primary care physician (PCP), the hospital, the homecare providers, the pharmacy — acts independently according to its function. But Esther needs it to all fit together. It needs to flow like an organised process, so each provider of care can take advantage of what others have done or will do.

Objectives of the Esther Project:
2. Better working relations in the entire care chain.
3. Higher competence through the care chain.
4. Shared medical documentation.
5. Quality through the entire care chain.
6. Document and communicate the results.

The Esther Project grew from a need that many health systems share: to improve the way patients flow through the system of care by strengthening coordination and communication among providers.

We can each imagine our own Esther; and we can ask ourselves in our work: ‘What’s best for Esther?’
Esther proved inspirational for the team. During the three-year project, they were able to achieve the following improvements:

- Hospital admissions fell from approximately 9,300 in 1998 to prognostic 7,300 in 2003.
- Hospital days for heart failure patients decreased from approximately 3,500 in 1998 to 2,500 in 2000.
- Waiting times for referral appointments with neurologists decreased from 85 days in 2000 to 14 days in 2003.
- Waiting times for referral appointments with gastroenterologists fell from 48 days in 2000 to 14 days in 2003.

**Research phase**

**Partnership to deliver what Esther ‘wants’**

Who has to co-operate to meet her needs? What is important to her? What does she want now? Perhaps we don’t ask because we fear that we cannot fulfil her wishes?

We asked her and we got a list and asked again for the most important which delivered the answer ‘less healthcare and more social care’, more relationship and less treatment. We now have a volunteer ‘elder’ in our planning sessions and we have learnt a lot, we were disappointed to hear from him that we are still talking about the patient rather than on behalf of the patient, we still assume we know what she wants but we are making progress.

To establish a clear picture of where the problems existed, team members conducted more than 60 interviews with patients and providers from throughout the system. Together they analysed the results, which included such statements as “patients in a nursing home rarely see their doctor” and “a patient getting palliative care at home was in contact with 30 different people during one week.”

The interviews also helped providers to arrive at valuable realisations about how their individual work processes did or did not dovetail with the work of their colleagues in the care chain. Interviewers would exclaim: “Are you doing that?!? I'm doing that, too!”

The result of this lack of coordination is that while Esther’s social worker knows all about how Esther lives, her GP asks her how about how she manages, and she tells him, and the hospital asks her, and she tells them, and so on. Lack of co-ordination of information, particularly where medication is concerned, causes considerable redundancy and waste. In the worst case, it can lead to medical errors.

The team examined the demand and capacity within the system and saw that inadequate capacity for planned care was forcing patients to seek urgent care in inappropriate settings. For example, if Esther complains of headaches, and her GP says she should see a neurologist, in our system that referral would take three months. For Esther this is not acceptable. So she goes to the ER, and the doctor there knows that if he puts her in the hospital, the next day there will be a neurologist in to visit her.

Although it appeared that the demand was for inpatient admissions, it was really demand for better access to speciality care. So the team tested a process in which the ‘queue’ for care was redesigned from two — one for acute care and one for planned — into one. Instead of having acute care go into the wards, it goes to the team.
Important Initiatives

- **My Time** - Patients want ‘my time’, created a time budget for this of 30 minutes a week to be with the person alone, quality time, can be accumulated into bigger blocks at the patients request (up to half a day).

- **Welcome Home Package** - how the person comes home is important and done well it reduces re-admission significantly (see above and presentation slides). First four hours are significant, use volunteers in the community if possible.

- **Esther Coaches** – trained in system thinking (eight days over one year). Level 1 delivers problem solving techniques such as fishbone analysis, PDSA cycles etc. And Level 2 is project based, across organisations. Use healthcare assistants and volunteers.

- **Esther Cake** – local bakers were invited to create an Esther cake and sell it to raise funds on one day every year - this was given as an example of ideas that at first seem trivial or gimmicky but in fact this initiative raised awareness in the community, raised money and engaged volunteers in helping the elderly. It is an example of a good idea which was listened to, despite reservations at first, an example of the value of ‘SAYING YES’: being open-minded.

Key points from the project:

- Safety is important to her.
- Don’t work on the physical side only, real life needs.
- She can choose where help will come from.
- Use a network with less formal rules of communication and organisation.
- Focus is value not cost alone, what is best for Esther? Economics follows.
- Practice values of generosity, openness, ethics, heart and soul.
- Brave doctors let go their prestige to make it work.
- Person centred culture, your problems are my problems, mutual responsibility.
- Mutual meetings and education, multi-professional learning.
- Ask each other what information does the next provider need, meet and agree what is a good discharge plan, doctor, nurse, physio etc.
- Talk to one another across professional boundaries.
- Engage in system thinking, if one part fails it has a knock-on effect.
- Beware measurement - when things go well we measure different things and the system develops.
- Co-ordination at hospital level, discussions about the patient, planned route to right place either quick or slowly.
The Vision
“To create a durable and energetic network to enable Esther to feel confident and independent”.

The team devised an action plan that spelled out six main projects designed to correspond to the six goals.

The projects the team identified were:
1. Develop flexible organisation with patient value in focus.
2. Design more efficient and improved prescription and medication routines.
3. Create ways in which documentation and communication of information can be adapted to the next link on the care chain.
4. Develop an efficient IT-support through the whole care chain.
5. Develop and introduce a diagnosis system for community care.
6. Develop a virtual competence centre for better transfer and improvement of competence through the care chain.

Education Challenge
Additionally, patient education was recognised as a critical element in keeping patients out of the hospital. Nurses were trained to educate heart patients, for example, about how to take vital measurements at home and tweak their medication accordingly.

All 250 providers in the network received training in the project's goals and processes. And the investment paid off. About 20 per cent of the bed capacity was closed and moved to where the need is bigger.

The continuing focus of the team's work is how to create value for Esther. The project changed the attitudes among those who work for Esther, because ‘the focus is on her now.’

Leadership Challenge
The important thing for us to ask as leaders or workers in the health care system is to ask yourself the following questions and if the answer is yes then you need to unblock the system to allow integration to happen:

“Can we still continue to work in systems that are not integrated?
“Are we making the best use of our resources and our knowledge?”
“Is it what we want to do?”
“Is it best for Esther?”

Success factors for Esther Project
- Person-centred.
- One story, one vision, one set of values.
- Meeting places, site visits.
- Participation of all staff.
- Improvement initiatives with partners.
- Simple rules – no money and no bureaucracy.
- Open-minded, say YES.
- Trust is a must.
Two Improvement Projects in Hospital Setting

Hospital for Children undergoing MRI scanning under anaesthetic

The Vision: To allow the clinic to care for the child; to be dedicated to the child.

This project was an example of an improvement initiative involving cooperation in the best interests of the patient as well as using medical resources efficiently. It was initiated by four nurse specialists who work in the scanning unit of Jönköping Hospital. The team have been together for some time and noticed how scared most children are when undergoing the MRI procedure which is stressful even for adults. They also noticed that those children often had many different and stressful procedures to endure, the idea is to minimise the distress and anxiety of children and parents by using the time to do other procedures while the child was under anaesthetic.

This meant collaborating with other departments and specialists. Around 35-40 per cent of children have to undergo other procedures which causes them stress. Use of time and equipment for optimum return requires cross-professional cooperation and communication. These procedures are run on a tight time schedule, smooth running and patient flow are key to reducing stress and waste for both patients and clinicians.

Self-dialysis in hospital

Vision was to enable the patients to be free to come and go according to their life needs, to become a 24/7 resource which patients could access independently.

This project was initiated by a long-term dialysis patient who wanted to reduce the amount of disruption to his life. He approached the nursing staff who supported his idea and trained him in self-dialysis. This project developed over a number of years to the point where patients now administer their own medication, fluids, operate the machines, teach each other and support each other through the stressful waiting time before transplant surgery.

The unit was relaxed and open and the staff were generous with their time and showed us the technology, talked to us about the history, the ambitions and answered practical and medical questions with ease and generosity. The unit has high patient engagement, no problems with governance (risk management), clinical safety issues (incidents or accidents are zero over a four-year period) and high patient satisfaction as well as optimum use of resources. It is open all year with and without staff on a 24/7 basis.

Trust was the key learning from this visit, the patients trusted the staff, the staff trusted the patients, the clinical staff trusted each other and enabled the project to happen in the first place. No abuses of trust had occurred.
Key Messages from the Visits

Encouraging collaboration and integration
- Put heart into the work, go back to why we went into healthcare in the first place.
- Go to other professions, cross the boundaries that separate us, do not assume you know what other people do or the way they see things.
- Be careful about our language, using clear plain words to communicate.
- Make whatever we do our own, do not import things, import the ideas.
- Have many parallel tracks, addressing different dimensions.
- Understand the difference between ‘need’ and ‘want’. Do we know what the patient wants, or do we provide the treatment we /our organisation is set up to provide?

Lessons from improvement projects
- Where there is a will there is a way.
- Understand where we are today and where we want to go in the future.
- Deal with the macro system and micro system at the same time.
- Leaders must come together from primary, secondary and social care to make things happen.
- Teach back and teach forward – patients teach clinicians and patients teach each other and carers.
- It is about patients, real people, not about my status or my costs. Tell stories about real people and their lives.
- Ethics are important.
- Work together, first to do what patients want, and that will be supported and enabled by the system leaders.
- Establish priority groups (A Good Death, re-admissions in elderly etc).
- Consistency across the system enables co-operation. Remember “The system is perfectly designed to achieve the results we find”.
- Follow up is crucial (welcome home, reviews etc).

Leadership
- Ask every day, ‘why are we here?’ what can we improve? Create an environment of pride and energy.
- Leaders need to be passionate about what is possible.
- Generational change in the way we provide healthcare, things have changed, so should we
- Bridge organisational boundaries, primary, secondary and social care. Learn about the system you belong to – spend one day per year in another part of the system (in your contracts of employment and annual review).
- Create stories of success, get real people to tell their stories.
- Use simple language and the same message at all levels.
- Use national data on improvements, use webinars, call ins to make people aware of what is going on in other places, nationally and internationally.
- Ownership and leadership at the micro-system level.
- Link up and share knowledge, learn from one another.
- Have pride in our work, measure and feedback so that people know when they are doing well.
- Make it happen and measure it.
- Research and support new initiatives.
Observations/Take Home Messages

1 Integration – necessary because there is a finite and diminishing set of resources to solve a growing number of problems, offers a different way of using resources, cutting out duplication, costly delays and waste due to over emphasis on medical solutions and overly complex interventions. It involves working across boundaries of organisation and professional discipline, the development of strong links between managers and clinicians real time research which guides innovation and improvements for patients.

2 Project based change - each integration project had a clear vision, a focus on a particular disease (e.g. kidney failure and dialysis) or a patient group (e.g. frail elderly) and involved a cross section of clinicians, managers, researchers, support staff and patients who analysed the problem, set the objectives and measured the outcomes.

3 Shared Risk - for integration to work there is a need to share risk rather than off-load the financial and clinical risk to other organisations. There is a need to think systemically as well as the benefit to one organisation or another; actions in one part of the system have an impact elsewhere.

4 Cooperation/Collaboration – we heard many times, in many different settings that it is necessary to have the intention to collaborate and to see the benefits of this in the interests of patients, the economics follow rather than lead.

5 Culture of Trust – social rituals such as greetings, refreshments, (meals, morning snack, coffee time) had an impact on the attitudes and behaviour of everyone, we felt respect and warmth from all whom we met, they had thought about us and taken time to prepare for us in many ways. It seems that there is a conscious intention to make and maintain social bonds which build a culture of interdependence and mutual trust.

6 Communication – integrated working requires high levels of communication, data sharing and interpersonal skills. There is a need to invest time and energy in meetings to align intentions and actions, to learn from one another, to identify overlap, to clarify roles and responsibilities. The manner in which the communication is conducted is as important as the content of the communication. We were impressed with the simplicity of the language, no jargon or acronyms were used to tell the story of the project or the patient.

7 Engagement – staff morale is significantly higher in people who are engaged in improving things for patients, there is a sense of pride in the work and a sense of achievement and personal wellbeing in working for the good of others. Patients who are engaged in designing the service will use it better and be more satisfied with the outcomes.

8 Care – healthcare is about care, we make assumptions based on our background and training what this means, the patient can tell us what care means for them and they will be more engaged when they co-design the care. We heard many times that what we think the patient wants may not be what they need, we may want to provide more complicated solutions than are necessary.
**Concluding Remarks**

It is difficult to capture such a rich and varied visit in writing and it may be sufficient to say that we organised the visit to help inspire and energise the whole system in Cornwall and we were definitely successful in achieving this aim.

We were reassured that much of what we are already doing was reflected in what we saw, we are dealing with the same problems and we are looking at the same kind of solutions to these problems. We heard that it is not always easy, as one speaker put it, “It’s not always Happy Days here”. There are many barriers and problems to overcome and resilience is as important as inspiration. Frustrations are part of leading change, it rarely goes smoothly but working together towards the same goals will provide personal satisfaction and will improve things for those we serve.

We were inspired by the people we met, we experienced the culture we heard about in the presentations and this is unusual. We found their dedication and passion for their work impressive and this was balanced by a very rational kind of professionalism where evidence was used to shape new practice, where authority was devolved and the best solution was generated from different perspectives.

Perhaps Swedish culture had an impact on the way people communicate and build social cohesion or perhaps they have been working together longer and have made a lot of progress on collaboration and co-operation, whichever it is, we came back with the knowledge that integration is possible and desirable; the only game in town. Something important happened on this trip, it will not be forgotten or put on the shelf, it has already generated actions which will live on as well as the memory. This report is a pale reflection of what the trip was about, it is intended as a record and a resource.