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# Integrated systems

## take elderly out of hospital, improves care

By Norma Beavers

Hospitals may be smarting at the criticism their care of the frail elderly is receiving but in North Derbyshire the patient experience is improving with help from integrated working between health and social care.

Commissioners in North Derbyshire are synchronising the care frail elderly patients receive with an approach called QFI Jonah. Working as an integrated health and social care system, commissioners and health and social care providers are partners in fast tracking the care of frail elderly patients – both in and outside of hospitals – and in the process are delivering the type of care envisioned by Sir David Nicholson, Head of the NHS Commissioning Board. Nicholson says hospitals "are very bad places for old, frail people," and wants to see better alternatives.

North Derbyshire Clinical Commissioning Group is providing that alternative by working with its full range of providers and QFI Consulting to embed Jonah and its Theory of Constraints approach at every level – from acute to community and eventually within primary care. Bill West, Founding Partner, QFI Consulting, said, "Jonah does two things – it manages the patient journey and puts the patient at the center of care. It asks all the time of everybody engaged in the patient's journey, of all the patients which should I work on next?, so that everybody gets the same answer. Jonah improves synchronization of activity not around the busiest person, or the most qualified, but around the patient's journey so that everybody is working on the right patient in the right order." Jonah is constantly asking what causes delays in care so that improvements can be focused around those few areas damaging the performance of the whole system.

The approach is improving the flow of frail elderly patients through community hospitals and into rehabilitation, often within their own homes, said Tracy Allen, Chief Executive, Derbyshire Community Health Services NHS Trust. "We have achieved some fantastic outcomes with Jonah in our inpatient rehabilitation and over the past 12 to 18 months we have been looking at how we can actually provide much more care in people's homes rather than in hospital and support rehabilitation in patient's homes with an integrated team working around the patient."

For patients who need inpatient rehabilitation Jonah and its Theory of


Tracy Allen, Chief Executive of DCHS NHS Trust

Constraints approach have reduced the average length of stay from "above 50 days to below 20," Allen said. "We have managed to reduce the number of beds that we need in the community hospitals and that has had savings for us as a provider of more than £2 million. It has also saved more than £1 million in excess bed days for commissioners," said Allen.

Ben Milton, Chair, North Derbyshire Clinical Commissioning Group, said, "We are rolling out a community version of Jonah because one of the big drivers at the moment is to reduce the time people spend in acute hospitals. We are using several approaches one of which is admission avoidance – we've looked at how we keep people out of hospital that don't need to be there, and also once we've got them in hospital at how we make sure we don't keep them languishing in hospital for any longer than they need to be there. Community Jonah is about giving us more transparency to what the services we have got are doing and how they are doing it so we can drive further improvement."

North Derbyshire CCG is also working with Chesterfield Royal, one of its main acute providers, to install a Jonah-type project within the hospital. Following that the Theory of Constraints approach and Jonah will be taken into primary care, thought to be the most challenging setting for it, "to see where we can work more efficiently," Milton said. "Some of the way the reforms were originally sold to primary care was that it was very much primary care's opportunity to change the rest of the world to the way it wants it to be. But getting primary care to understand the need for it to change as part of this process is very important and is a work in progress."

Allen said, "We have been reorganizing from a system where we have lots of different services – from community nurses, community matrons, intermediate care services, rapid response teams, rehab teams – we have been putting those teams together and developing integrated community-based teams who work closely with their colleagues in primary care and social care to provide support for this frail elderly group." The result is "we are seeing fewer patients needing to go into hospital at all – either acute or community – and those who do are spending much less time in those hospital beds and are getting home quicker."

## Social enterprises, voluntary sector, forge links with CCGs

The NHS Commissioning Board has awarded twelve communities across England with up to £50,000 each to help them build partnerships between Clinical Commissioning Groups, charities, community groups and social enterprises. The project is part of the Building Health Partnerships Programme to share best practice nationally in relationships between healthcare commissioners and the voluntary, community and social enterprise sector. More than 100 clinical commissioning groups have expressed an interest in taking part in the programme.

The twelve communities receiving funding are Bradford & Airedale; Bristol; City & Hackney; Croydon; Dudley; Durham; Hampshire; Manchester; Shropshire; Staffordshire; Swindon; and Wakefield. Each area will also receive training support with customised partnership development days and master class sessions. The funding comes as more than 100 Clinical Commissioning Groups have been fully authorised by the NHS Commissioning Board and others are waiting to be authorised before April.

Ceri Jones, Head of Policy and Research at Social Enterprise UK, said: "This programme aims to bridge the gap of understanding between the voluntary, community and social enterprise sector and the new CCGs. Groups of local clinicians are going to be responsible for commissioning for the first time and it's important they understand what our sector can bring to communities. Social enterprises and the voluntary sector have been delivering quality health and social care services for years, including to the hard-to-reach, and we need to ensure they continue to be commissioned to meet the needs of people across England."

Tim Kelsey, National Director for Patients and Information, NHS Commissioning Board, said, "Local communities and voluntary sector partnerships need to be at the heart of how the new system operates. Increasing participation and supporting active citizens is essential, not just an added extra."

Health and Wellbeing Boards and the emerging local Healthwatch organisations are expected to benefit from the 12 new learning sites. Earlier pilots have already resulted in new, productive engagement and relationship-building programmes in Central Bedfordshire, Cheshire, Cornwall and St Helens.

## NICE backs apixaban over warfarin

Prescriptions for warfarin look set to be challenged by scripts for a novel oral anticoagulant recommended in guidance from the National Institute for Health and Clinical Excellence for patients who have Atrial Fibrillation. Instead of warfarin, which until now has been the standard of care, GPs can now prescribe Eliquis (apixaban, Bristol-Myers Squibb and Pfizer).

In final draft guidance NICE recommends that the decision about whether to start treatment with apixaban should be made after an informed discussion about the risks and benefits of apixaban compared with warfarin, dabigatran etexilate and rivaroxaban, and taking into consideration the patient's current level of international normalised ratio (INR) control if they are already taking warfarin.

Apixaban received a Fast-Tracked Positive Final Appraisal Determination (FAD) from NICE in January and is expected to be fully approved by the end of this month (February). George Kassianos, a GP in Bracknell and Fellow of the European Society of Cardiology, said, "If we are to move away from warfarin, the new options must be better and safer than warfarin. Apixaban ticks both boxes and for our patients and us, GPs, is a very welcome new drug."

Dr Matt Fay, General Medical Practitioner, Westcliffe Cardiology Service, Shipley, Bradford, said, "Atrial fibrillation, or AF, is a heart rhythm problem that increases the risk of stroke five-fold. People who are at risk of an AF-related stroke require anticoagulation but for decades the only oral anticoagulant in common usage was warfarin, which requires regular monitoring to ensure clinical effectiveness and patient safety. Warfarin interacts with many other medications commonly used by Atrial Fibrillation patients and requires regular attendance at clinic so many people have been treated with the much less effective option of aspirin. Having a wider choice of effective anticoagulants will assist in ensuring many more people have appropriate intervention to reduce their risk of stroke tailored to their personal needs."

Prof. Carole Longson, NICE Health Technology Evaluation Centre Director (below), said people with AF often struggle to comply with warfarin, "because, among other things, its use requires regular monitoring of the blood's clotting properties and dose adjustments which can cause disruption and inconvenience. It also has multiple interactions with food, alcohol and drugs that can cause further inconvenience." The Appraisal Committee heard from patient experts that warfarin can have a greater impact on a person's quality of life than atrial fibrillation itself, she said. "Apixaban, like rivaroxaban and dabigatran etexilate, which NICE recently approved as options for this indication, has potential benefits for people with AF in these circumstances because it doesn't require such regular monitoring and dose adjustments."