INTEGRATED CARE
Best Practice

INSIDE
• Key findings from our evidence-based programme
• Blueprints for uniting local services

FIGHT FOR EVERY HEARTBEAT
bhf.org.uk
Cardiovascular disease (CVD) is a long-term condition (LTC), often associated with comorbidities such as diabetes, hypertension (high blood pressure) and obesity. The number of people living with multiple LTCs is predicted to keep growing, adding billions to health and social services costs in the UK.

Currently, the healthcare system is struggling to cope with the increased demand of managing people with multiple LTCs. These patients often require regular hospital admissions due to current healthcare infrastructure.

People living with CVD often have complex requirements around medication optimisation, management of comorbidities and social care support. An integrated approach to improve the interface between primary, community and acute services can enable people to have a better quality of life through improved access to treatment and care, help avoid unnecessary hospital admissions and make better use of NHS resources and its workforce.

The British Heart Foundation has funded and tested nine models of Integrated Care to tackle CVD in the UK.

The NHS is currently committed to developing new models of care. These will allow the health and social care system to manage multiple comorbidities in an increasingly ageing population.

In line with this commitment, our Integrated Care programme has funded and evaluated several models of care for CVD in the UK. These evidence-based studies support current thinking that integrating services can maximise resources and improve population health by implementing ways of working such as:

- early supported discharge and active hospital in-reach
- nurse-led, open-access hospital and community clinics
- specialist service home visits
- healthcare professional (HCP) education and professional development
- patient-led focus groups, shared decision-making and self-management tools.

Implementing Integrated Care led to:

- improved patient access to care and quality of life
- provision of care outside of hospitals and closer to home
- HCPs working across organisational boundaries to better support the needs of patients and their families
- a more cohesive care journey, reducing hospital admissions and generating cost savings and productivity gains.

- Five out of nine NHS sites have had their services fully commissioned after successfully implementing customised models of integrated care.
- Two of these sites demonstrated combined savings of almost £1.5m over one year, with one site effectively saving the NHS £9 for every £1 spent on healthcare.

Turn the page to learn about three BHF-funded case studies. These examples of service integration can help you form the basis of new models of care in your area, to manage CVD and other LTCs more effectively.
Case study one East Cheshire
Multi-CVD service

Local challenges

- Population of around 375,000, with a growing number of elderly people with multiple LTCs.
- CVD accounts for approximately 25% of early deaths each year.8
- Pressures on consultant cardiologist access.

15% of East Cheshire hospital admissions due to CVD

Local solutions

- Hospital in-reach improved earlier diagnosis and management of CVD patients identified outside of cardiology wards.
- Early supported discharge plans developed by nurses for in-patients, with follow-up community care plans.
- Nurse-led services such as rapid-access clinics provided earlier care for patients with HF, AF and chest pain.
- HF community clinics, working with the local intravenous therapy service, moved care away from the hospital and into the home.
- A self-management tool helped patients access care in line with severity of symptoms. Patients also played an active role in shaping local services via focus groups.

Outcomes

- Waiting times down from one week to two days for cardiac review of patients in hospital.
- Fewer patients seen in secondary care.
- Patients allowed to remain at home, especially at end of life, despite being on intravenous diuretic therapy.
- 96% of patients surveyed reported improved health outcomes.13
- Patients reported being more comfortable, empowered and feeling safer.
- Over one year, £1.1m saved due to fewer hospital admissions and shorter stays.
- The East Cheshire services have been sustained beyond the BHF programme.

Case study two Swansea
Heart failure service

Local challenges

- Population of 242,000, where nearly one in 10 are aged over 75, covering a mixture of primarily urban, but also rural areas.
- Above-average diagnosed prevalence of HF (1% versus 0.7% UK average).4
- Lack of community-based HF services.

1% Diagnosed prevalence of HF in Swansea

Local solutions

- Nurse-led teams developed early supported discharge plans and helped patients transition from the hospital to community care.
- Community clinics run by HF clinical lead nurses supported patients after hospital discharge in terms of longer-term management, medication optimisation, and referral to services such as palliative care.
- Home visits to the frail and elderly prevented exacerbation of conditions and hospital admissions.
- A multidisciplinary clinic saw complex HF cases referred from primary care within a waiting time of two weeks.
- Education and training helped 15 HCPs complete a degree-level distance-learning module on HF.
- Development of HF Nurse Champions across several hospital wards.
- Cost savings of £300,000 achieved during implementation of new service due to hospital admission avoidance.
- Parts of the Swansea services are to be sustained beyond the BHF programme.

Outcomes

- 84% of patients reported an improvement in their quality of life.11
- 90% of patients improved self-care behaviour.11
- 590 local multidisciplinary HCPs improved their knowledge around care of HF patients, including holistic approaches and mental wellbeing.
- Development of HF Nurse Champions across several hospital wards.
- Cost savings of £300,000 achieved during implementation of new service due to hospital admission avoidance.
- Parts of the Swansea services are to be sustained beyond the BHF programme.
Case study three Tayside

Arrhythmia service

Local challenges

- Around 7,900 patients diagnosed with AF.
- 30% of patients not receiving recommended optimum treatment with anticoagulants.
- Awareness needs around AF and use of key audit tools (CHADS2-VASc and GRASP-AF).

Local solutions

- Education and support programme taught primary and secondary HCPs about AF diagnosis and management, focusing on medication optimisation and stroke prevention.
- Auditing programme reviewed GP disease registers using GRASP-AF and CHADS2-VASc for improvement in diagnosis and prevention of stroke.
- Nurse-led rapid-access clinics managed AF patients. Hospital in-reach identified patients outside of cardiology wards with possible AF and referred them to the clinic.
- Specialist support services offered wider psychological support for people fitted with cardiac implantable devices.
- Multidisciplinary clinics brought genetic, cardiology and nurses together to manage inherited cardiac conditions.

Outcomes

- 7,900 patients in Tayside with AF
- 94% of patients said a nurse helped them better understand their condition.

Tips for you

- Plan in advance
  An initial setup phase of six to eight months can help gently ease in changes or new services.
- Involve patients and carers from the start
  Patient opinion is crucial for matching up services to a population’s needs.
- Involve multidisciplinary teams
  Involving a variety of HCPs can lead to faster implementation and sustainability of new models of care.
- Monitor demand
  Your local area demographics can help you prepare for demand for services in the future.
- Secure clinic space
  You will need adequate venue space for new services and to deliver new models of care.
- Nurse-led clinics reduce waiting times, provide better access to services closer to home and link primary and secondary care.
- Auditing of disease registers gives primary care practices more accurate data on disease prevalence in their area.
- HCP education improves knowledge around CVD, which can lead to improved outcomes for patients.
- Patient-led focus groups and shared decision-making enables services to address gaps in care based on the local population, and empowers patients to self-manage where appropriate.

Common solutions across the nine BHF-funded sites

- Hospital in-reach can improve rates of diagnosis, and management of CVD.
- Community support means specialist nurses work with cardiologists to develop discharge plans and arrange follow-up care.
- Home visits with specialist services reduce hospital visits and ensure care reaches patients who are better managed at home.
- Multidisciplinary and specialist clinics/teams allow HCPs to learn from each other and provide a collaborative management plan for patients.

Further information

For more information on CVD Integrated Care, visit bhf.org.uk/integratedcare
To claim your CPD points visit bhf.org.uk/cpd

Other tools to support you

- Our BHF Best Practice Resources contain reports, evaluations and case studies to help you redesign services: bhf.org.uk/bestpractice.
- Prepare a business case for service redesign using our business case toolkit: bhf.org.uk/businesscasetoolkit.
- Join the BHF Alliance for access to funding for HCP training and development: bhf.org.uk/alliance.
- Explore CVD statistics across the four nations: England: ncsrin.org.uk
  Scotland: scotlandhealth.gov.uk/Topics/General-Practice/Quality-And-Outcomes-Framework
  Wales: www.wales.nhs.uk/sitesplus/922/page/66680

References

1. Department of Health (2013). Cardiovascular Disease Outcomes Strategy
2. BHF UK estimate from 2013 QOF data.
3. Department of Health (2015). Improving the health and wellbeing of people with long-term conditions
11. 10 patients were randomly selected using the Advanced Quality Alliance (AQuA) self-management assessment questionnaire and a modified version of the Patient Activation Measure (PAM).
12. Based on data taken from multiple surveys.
13. Based on data taken from multiple surveys.
For over 50 years we’ve pioneered research that has transformed the lives of millions of people living with heart disease. Our work has been central to the discoveries of vital treatments that are changing the fight against heart disease.

But heart and circulatory disease still kills around one in four people in the UK, stealing them away from their families and loved ones. From babies born with life-threatening heart problems, to the many mums, dads and grandparents who survive a heart attack and endure the daily battles of heart failure.

Join our fight for every heartbeat in the UK. Every pound raised, minute of your time and donation to our shops will help make a difference to people’s lives.

**Text FIGHT to 70080 to donate £3**

*This is a charity donation service for the BHF. Texts cost £3 + 1 standard rate msg. The BHF will receive 100% of your donation to fund our life-saving research. To opt out of calls and SMS text NOCOMMS BHF to 70060, or if you have any questions about your gift call 02032827863.

© British Heart Foundation 2016, a registered charity in England and Wales (225971) and Scotland (SC039426)