



INTEGRATED CARE

Best Practice

**FIGHT
FOR EVERY
HEARTBEAT**

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CHALLENGES

Cardiovascular disease (CVD) is a long-term condition (LTC), often associated with comorbidities such as diabetes, hypertension (high blood pressure) and obesity¹. 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^{1,2} 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.

Long-term conditions (LTC)

- More than 18 million people are living with LTCs in the UK.²
- 70% of inpatient bed days in England are used by people with LTCs.³
- £7 in every £10 of the health and social care expenditure in England is spent on people with LTCs.³
- The number of people living with multiple LTCs is predicted to keep growing, adding billions to health and social services costs in the UK.

Cardiovascular disease (CVD)

- More than 500,000 people have been diagnosed with heart failure (HF) in the UK.⁴
- More than one million people in the UK have been diagnosed with atrial fibrillation (AF).⁴
- Around 1.2 million people in the UK have had a stroke.⁴
- An estimated £11bn was spent on healthcare costs for CVD in the UK in 2014.⁵

SOLUTIONS

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 care⁶. 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 working⁷ 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.

£1.1m

saved over one year, due to fewer hospital admissions and shorter stays

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.⁹
- 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.
- Bottlenecks for consultant appointments.
- Hospital admissions and length of stay for HF higher than the Welsh average.
- Significant levels of health and socioeconomic deprivation, resulting in higher CVD risk factors.

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.

590

local multidisciplinary HCPs improved their knowledge around care of HF patients

Outcomes

- **84%** of patients reported an improvement in their quality of life.¹⁰
- **90%** of patients improved self-care behaviour.¹⁰
- **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.¹¹
- 30% of patients not receiving recommended optimum treatment with anticoagulants.
- Awareness needs around AF and use of key audit tools (CHA2DS2-VASc and GRASP-AF).
- Slow referral process to cardiology and under-resourced specialist services, resulting in high rates of hospital admissions.
- Need for better care coordination for people with inherited heart conditions and cardiac implantable devices.

7,900
patients in
Tayside with 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 CHA2DS2-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 geneticists, cardiologists and nurses together to manage inherited cardiac conditions.

94%

of patients said a nurse helped them better understand their condition¹²

Outcomes

- **Decrease** in hospital admissions.
- **Increase** in AF detection rates, due to better education of HCPs around diagnosis.
- **Reduction** in strokes associated with AF.
- **More efficient and timely care** for patients due to nurse-led services working across several clinical areas.
- **98%** of patients were satisfied with a nurse providing their care.
- **Up to 94%** of respondents said their nurse helped them better understand their condition.¹²
- Tayside services have been sustained beyond the BHF programme.

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.
- **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.

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.
- **Get support**
Successful service needs adequate IT and administrative support.
- **Engage with GPs**
Be aware of existing time pressures on primary care HCPs – this can affect education and training.
- **Define measures of success early on**
Decide your measures of success at the start of your project – this will ensure all the relevant data is collected for your model of care. Outcomes such as patient experience are essential when putting forward a business case to sustain services.

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.
- Explore BHF statistics: bhf.org.uk/statistics.
- 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: ncvin.org.uk
 - Scotland: isdscotland.org/Health-Topics/General-Practice/Quality-And-Outcomes-Framework
 - Wales: www.wales.nhs.uk/sitesplus/922/page/66680
 - Northern Ireland: health-ni.gov.uk/articles/quality-and-outcomesframework-qof-statistics-annual-report

References

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8. *Living Well for Longer in Cheshire East. The Annual Report of the Director of Public Health, 2012-2013*.
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10. From approximately 200 survey respondents.
11. Quality & Outcomes Framework prevalence data 2014/15; ISD Scotland.
12. Based on data taken from multiple surveys.



**British Heart
Foundation**

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*

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