



Integrated heart failure service working across the hospital and the community

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FOR EVERY
HEARTBEAT**
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Heart Failure is an epidemic....

THE CHALLENGE



435,000

people in England are living with heart failure¹⁵



1 million

- bed days attributable to heart failure in the UK each year¹⁹



57,000

- the number of emergency hospital admissions in England and Wales caused by heart failure in 2014/15, the most common cause of admission in people aged over 65²⁰



Heart failure admissions are predicted to continue to **rise as the population ages**



50%

- the share of hospital admissions for heart failure in England and Wales in 2014/15 associated with moderate or severe oedema²⁰



- NICE has issued very relevant and up to date guidelines and quality standards which highlight what good care looks like for both chronic and acute heart failure.
- Health care services, commissioners, patients and the public can understand the quality of care being provided by using carefully chosen metrics.

NICE National Institute for
Health and Care Excellence

Acute heart failure: diagnosis and management

Clinical guideline

Published: 8 October 2014

[nice.org.uk/guidance/cg187](https://www.nice.org.uk/guidance/cg187)

Chronic heart failure in adults

Quality standard

Published: 29 June 2011

[nice.org.uk/guidance/qs9](https://www.nice.org.uk/guidance/qs9)

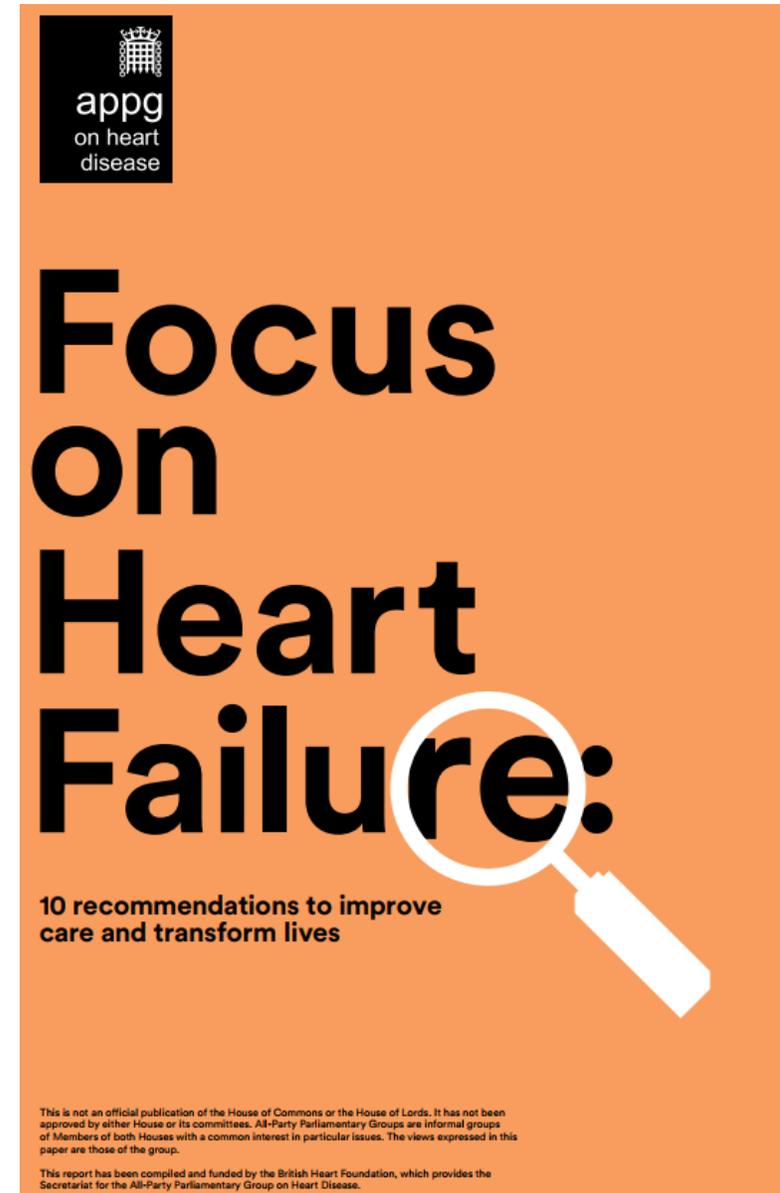
CHRONIC HEART FAILURE

National clinical guideline for diagnosis and management
in primary and secondary care

August 2010

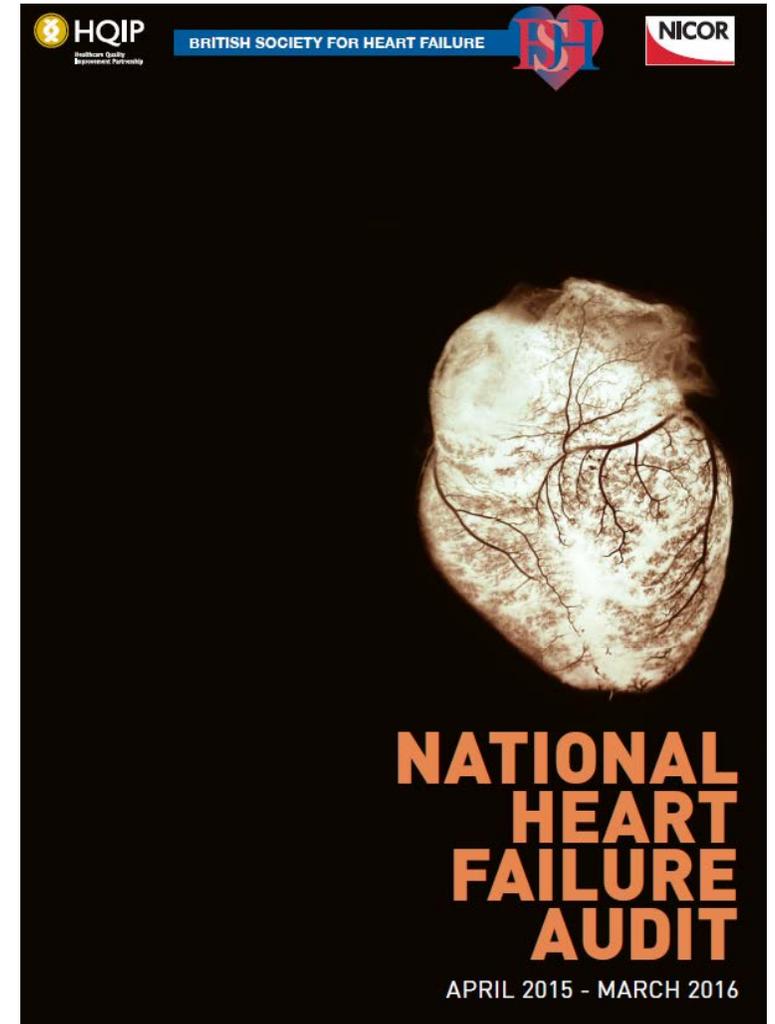


- This inquiry was launched in March 2016. It looked at diagnosis, treatment and care, including palliative care for people living with heart failure in both the hospital and the community.
- It included evidence on the issues and solutions from a wide range of organisations and individuals with expertise in heart failure including patients, their families and carers, clinicians and commissioners.





- Presents findings and recommendations for patients with an unscheduled admission to hospital, who were discharged or died with a primary diagnosis of heart failure
- Modest but important improvements. An 8.9% inpatient mortality cannot be accepted and requires urgent attention
- There is considerable variation in the quality of care delivered
- The data identifies service gaps and limitations in local HF care and delivery





- Move care closer to patient's homes
- Use technology to support better care and a better experience of that care
- Support primary care in taking up a lot of the work that is currently done in hospital



Next Steps on the NHS Five Year Forward View



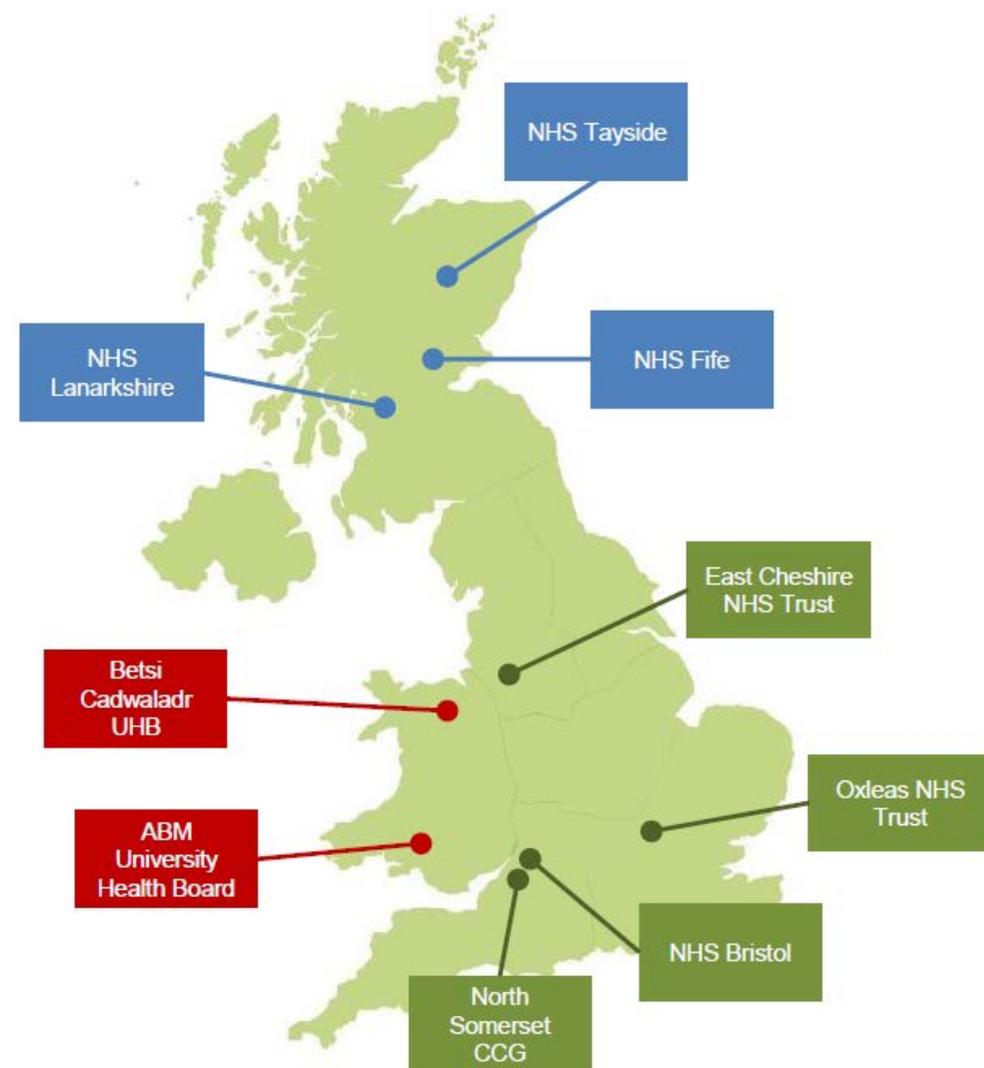


People living with long term conditions such as heart failure require an integrated approach to their care with robust care pathways to meet their needs from diagnosis through to end of life. This should include long term follow up, social support and palliative care



Integrated Care Pilots

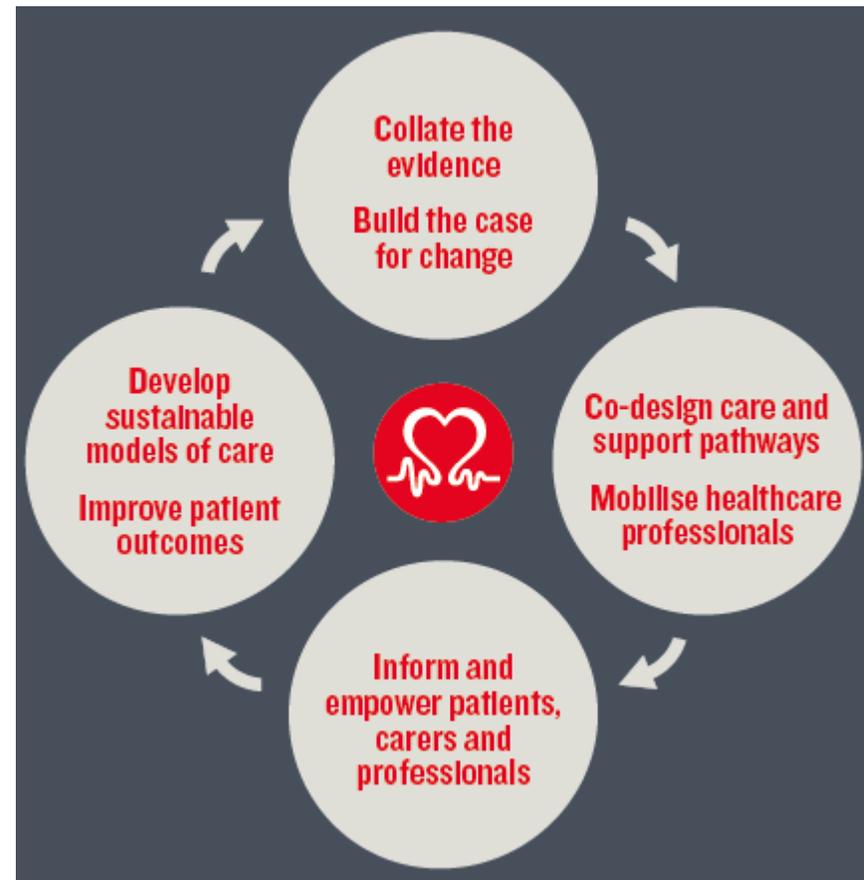
- Over £1 million invested in 9 projects across the UK. Six of the projects were community based heart failure models of care, whilst the others were focused on cardiac rehabilitation and arrhythmia care.
- Aim to add to the evidence base on 'what works' in the vertical and horizontal integration and coordination of services
- Transform our ability to predict, diagnose and treat disease
- More efficient ways to deliver pathways of care
- Address the funding, value and efficiency gap and unwarranted variation in care delivery





Supporting 'New Models of Care'

- No universal model has been identified to achieve integration
- The projects focused on shifting elements of care from secondary to primary care; up-skilling primary care teams.
- Improving systems within primary care to respond to the challenge of implementing integrated care.
- Collaborating across organisational boundaries to facilitate multi-disciplinary working by hosting joint clinics and study days.
- Improving patient experience and ability to manage their conditions.
- Improved pathways, patient identification and diagnosis, and care coordination.
- Cost savings due to system efficiencies such as reduction in hospital admissions and hospital referrals





Case study: East Cheshire

The Challenge 2009-2011

- Fastest **growing elderly population** in North West
- **15.5%** increase in emergency admissions
- **LOS** > National average
- **Duplication** of care
- Need **support and education in primary care** to meet demand
- Chest pain, atrial fibrillation and **heart failure** generating greatest number of admissions

The Solution 2012-2014

- **Expanded remit** of the **generic cardiology nurse team**
- **New pathways** and **community clinics** for chest pain, atrial fibrillation, **Heart Failure** and **IV diuretics in patients homes**
- Identified patients in **ED and AMU**
- **MDT assessments** and long term condition care planning for patients
- Support with social care



How is this being developed?

- Developing generic cardiology specialist nurses
- Expanding remit of heart failure nurses and developing BHF nurses to manage a variety of cardiac conditions
- Cardiology in-reach
- Increasing community clinics
- Day case or community IV diuretics
- Education for GP's, primary care practitioners and palliative care partners
- Development of new protocols and referral pathways
- Enabling and supporting patients to develop skills for self-care



Workforce development

- BHF nurses have undergone intensive professional development including Masters modules in diagnostics
- Advanced Heart Failure Management course in conjunction with local hospice
- Training for district nurses and community matrons on red flags for common cardiac conditions
- Comprehensive training programme for healthcare professionals in both primary and secondary care
- Training with other nurses specialising in LTCs including diabetes, respiratory and palliative care teams
- Training delivered in the hospital, community (nursing homes) and primary care teams
- Clinical leadership and capacity to drive the change across the system



In-reach

- Proactively identifying patients on emergency floor with cardiac conditions – work with Medical Assessment Unit (MAU) and A&E
- Run rapid access chest pain and Acute Coronary Syndrome clinics
- Early intervention and care planning using agreed pathways specifically for chest pain, AF, and heart failure
- Ensure appropriate discharge advice and information provided for patients and carers
- Clear discharge plan and follow up arrangements





Community clinics

- Use and expand upon existing community heart failure clinics to manage all cardiology follow up patients with chest pain, AF and heart failure
- This will provide flexibility in providing extra clinics geographically closer to patients' own homes
- Helpline to enable patients to be booked in at short notice if they develop problems





Community intravenous diuretics

- Collaborative working with HITS to deliver IV diuretics to suitable patients in their own home
- Pathway sets out roles and responsibilities, and parameters for safe management
- Home Intravenous Therapy Service:
 - assess home circumstances
 - Gain IV access
 - Deliver infusion and monitor patient
- Cardiology specialist nurses provide:
 - Clinical input and weekly assessment of patients.
 - Prescriptions
 - Telephone liaison with HITS
 - Consideration of day case IV diuretics for those who fall outside the pathway

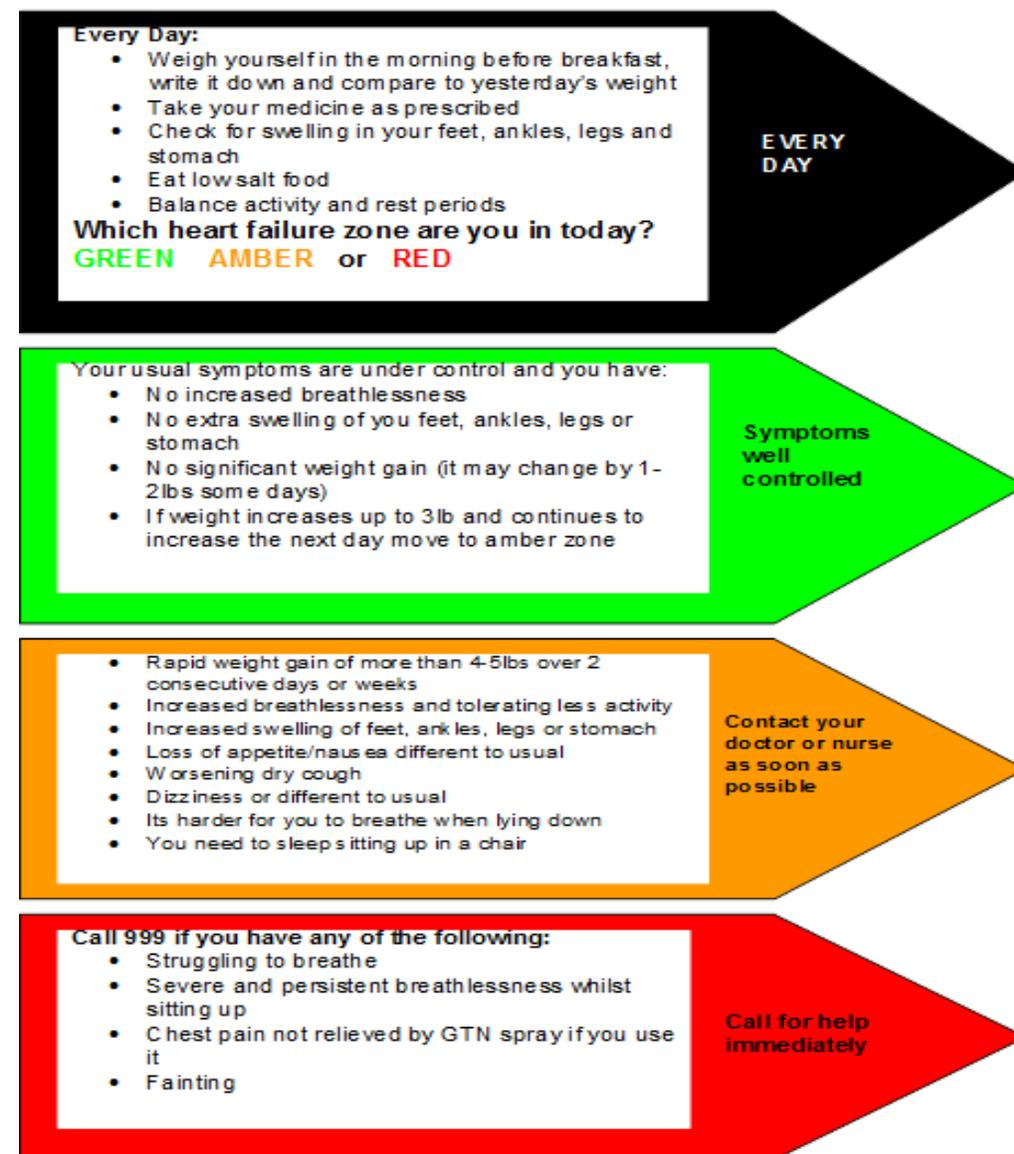




Supported self-management and shared decision making

- Developed shared decision making tool with AQuA (Advancing Quality Alliance)
- Visual Guide for patients to indicate when symptoms may might require further healthcare support
- East Cheshire CCG has joined the Shared Decision Making (SDM) and Self-Management Support (SMS) Programme developed by AQuA

TRAFFIC LIGHTS SELF MANAGEMENT TOOL FOR HEART FAILURE





Outcomes: Home administration of intravenous diuretics to heart failure patients

Benefits

- 1,040 bed days were saved across the 10 pilot sites
- Fewer complications for patients receiving home-based treatment compared with those in hospital
- Significant improvement in patient and carer experiences
- 79% of interventions did not involve hospital admission, preventing 869 hospital bed days over the pilot duration
- Enhanced clinical effectiveness, safety, patient and carer experience and cost effectiveness

Savings

- 77% reduction in costs for 80 successful interventions (defined as nurses administering diuretics through cannulation)
- The approximate cost of delivery was £793 per intervention, compared with £3,796 in hospital, with net savings of £162,740 across the 10 pilot sites.



Outcomes: Integrated heart failure management in the community

Benefits

- Patients seen by an HFSN reported significant increases in quality of life over a one-year follow-up period
- Better patient and carer knowledge reported because more time was spent on education
- Significant improvement in patient and carer experiences reported
- New integrated heart failure teams delivered innovative approaches to heart failure management through hospital in-reach, anticipatory care planning, one-stop heart failure clinics and intravenous therapy in the community
- Pilots demonstrated clinical effectiveness, enhanced patient safety and carer experience and improved cost effectiveness. These are evidence of an effective model for establishing integrated heart failure teams in the community

Savings

- A 35% reduction in hospital admissions, with an estimated £169,000 saved per 1,000 patients, as a result of access to HFSNs across the 26 sites



Mind the implementation gap!

The BHF has piloted and independently evaluated new models of care that can avoid hospital admissions, improve patient outcomes and save the NHS millions of pounds a year.

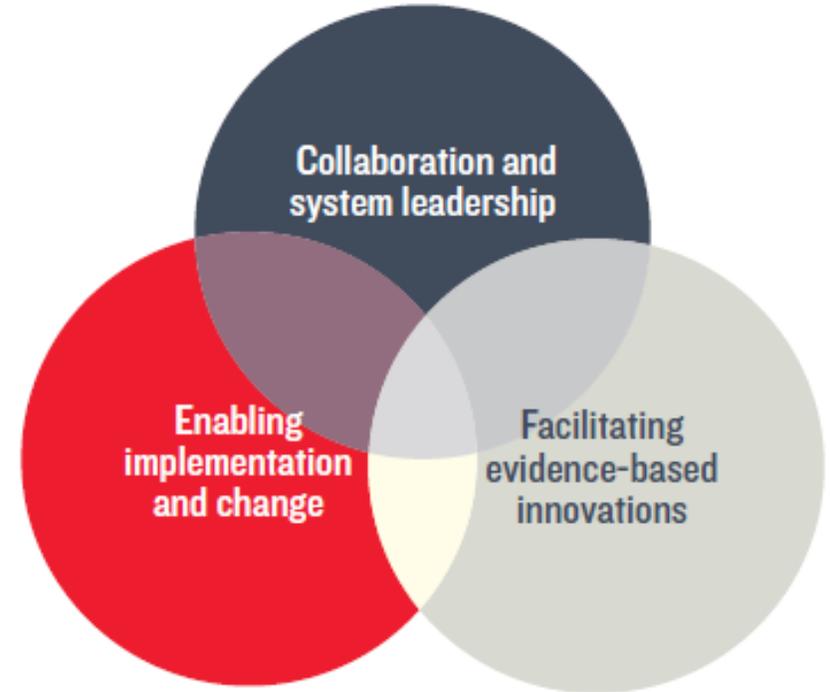
We also support their implementation.





Health Services Engagement Team

In collaboration with NHS partners, we aim to help drive equitable access across England to evidence-based, cost-effective CVD services that demonstrably improve patient outcomes.





Our Support Offer

Educate and Empower

- Activate local clinicians to engage in service improvement and build leadership and system capacity.

Support meetings/workshops

- Agree problems/priorities
- Explore solutions e.g. audit tools, education, workforce/technology solutions
- Develop local key messages, consensus statements
- Develop local professional development programmes – across primary and secondary care

Mobilise support for solutions

- Network, advocate, facilitate, develop business cases etc.

Introduce and spread resources

- Sign post to training and resources for Health Professionals e.g. *How Can We do Better series* (AF,BP)
- Links to national exemplars, innovators, case studies
- Link to wider networks for shared learning/collaboration



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Thank you

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bhf.org.uk/bestpractice