Delivering integrated care with the BHF

Advances in health care mean a longer life expectancy for many patients, however quality of life has not improved proportionately. Sana Zakaria looks at the pressures to provide health care for a rapidly ageing population living with multiple comorbidities.

By 2018, it is predicted that about three million people will be living with multiple long-term conditions, which will cost the NHS and social care an extra £5 billion (Department of Health [DH], 2012a). Cardiovascular disease is a long-term condition affecting around seven million people in the UK, and is often accompanied by a plethora of other conditions in the ageing population. Cardiovascular disease was responsible for nearly 30% of all deaths in the UK in 2013, and is one of the largest causes of disability in the country (DH, 2013).

The NHS Outcomes Framework 2015/16 stressed that further improvement is needed to reduce the ‘under 75 mortality rate’ from cardiovascular disease (DH, 2014) and the British Heart Foundation (BHF) has defined a strategic ambition to reduce this figure by a quarter by 2025, in line with the World Health Organization commitment.

Many services are disjointed and reflect institutional boundaries rather than patients’ needs. People experience delays in accessing treatment and care, and often end up in hospital when they could be better cared for closer to home, in the community. This has contributed to the current pressures in A&E. The latest quarterly figures on NHS performance indicated that the number of patients waiting longer than four hours in A&E has increased by 69% compared to last year’s equivalent quarter (King’s Fund, 2015).

The BHF is calling for further measures to improve access to, and provision of, the integrated health and social care services that people with cardiovascular disease need. The government has mandated the NHS to coordinate a major drive for better integration of care, and The NHS Five Year Forward View sets out a number of models to help achieve this and deliver more efficient and sustainable services (DH, 2012b; NHS England, 2014).

WHAT IS THE BHF DOING?

In 2013, the BHF awarded grants totalling £1 million to nine NHS organisations — a mix of NHS trusts and primary care teams across the UK, with the aim of addressing the gaps in service provision for people with cardiovascular disease and to help implement integration within local health economies.

The focus of the nine pilot integrated care programme sites was on ‘vertical integration’ — improving the interface between primary, community and acute services, allowing a seamless transition through the healthcare system, and provision of care closer to home. There is a further emphasis on healthcare professional, patient and carer education for improved delivery of care and supported self-management. The programme ended in early 2015 and the final evaluation report will be published shortly.

ROUTES TO IMPLEMENTATION AND THE NEED FOR CHANGE

There is no universal solution to achieving integration — approaches need to be developed within the context of the local population demographic, the existing infrastructure and the budget of a local health system.

The BHF integrated care pilots were based in areas of social deprivation and/or where health inequalities exist, and lead to inequitable access to services and treatment of cardiovascular disease. For instance, some areas had no provision for any community heart failure services despite a vulnerable population demographic. Similarly, sites had reported bottlenecks and delays for consultant cardiology appointments, resulting in avoidable hospital admissions, inaccurate coding of patient conditions.
practice registers, low referral rates from primary to secondary care and high rates of hospital re-admissions.

**ORGANISATION OF SERVICES**

A multi-faceted approach was adopted to design and implement services across the nine sites, which centred around heart failure, arrhythmias and cardiac rehabilitation, and some of the common themes that emerged are outlined below.

**General practice disease registers**

Practice disease registers often reflect a discrepancy in the reported and expected disease prevalence levels of an area and such was the case in some pilot sites. The sites also reported a wide variation of knowledge among primary care staff in identification and management of heart failure and atrial fibrillation.

Using validation and auditing tools, the heart failure- and atrial fibrillation-centred projects enabled the validation of disease registers, resulting in improved diagnoses and correction of misdiagnoses — one area reported a rise of 1.2% in heart failure prevalence with over 900 people added to the register and over 400 heart failure misdiagnoses removed.

Reviewing identified patients also ensured that they were on optimal therapy for their respective condition(s). Levels of increased knowledge on patient identification and management were also reported as a result of training sessions. The use of these tools incentivised the GP practices as it allows them to accrue Quality and Outcome Framework (QOF) points (http://qof.hsic.gov.uk).

**Hospital/community clinics and multispeciality clinics**

Nurse-led clinics for managing patients with heart failure (among other conditions) are well established in the UK and have been shown to reduce morbidity and mortality (Stromberg et al, 2003). These nurse-led community and hospital clinics reduced waiting times and bottlenecks. They also improved identification and risk stratification of patients who had ‘slipped through the net’.

The speciality clinics in the arrhythmia diagnosis and management services allowed cardiologists, geneticists, pharmacists and specialist nurses to come together and share their knowledge to develop cohesive care planning for patients with inherited conditions such as familial arrhythmias.

The clinics served as a ‘one-stop shop’ for patients improving education, treatment and management of their condition. As a result of cross-organisational working between primary care, community care and secondary care teams, there was better understanding of disease diagnosis and management, up-skilling of professionals and sharing of wider knowledge. This networking was important for successful implementation of new services.

**Hospital in-reach**

Specialist nurses worked with cardiologists to develop discharge plans with arrangements in place for community follow-up care and management. Hospital in-reach work allowed identification of cardiovascular disease patients in non-cardiology wards such as A&E and care of the elderly wards, resulting in improved disease diagnosis and management as well as uptake of cardiac rehabilitation. This is particularly important in light of the fact that around 50% of heart failure patients are managed outside of cardiac wards (British Society for Heart Failure, 2013).

**EMERGING PROGRAMME-WIDE OUTCOMES**

The results of the BHF Integrated Care programme support the concept of integrating services to promote population health by testing innovative ways of working.

There is evidence of outcomes such as:

- Multidisciplinary team working
- Joint primary and secondary care clinics
- Patients shaping services
- Shared decision-making

There has been a well-documented shift in patient care from secondary to primary and community (see Figure 1) and cost savings of over £1.6 million have been reported as a result of hospital admission avoidance from our programme evaluation. Thus far, the evidence has been crucial in sustaining five pilots with another two undergoing service reconfiguration and expansion.

Chris Annus, NHS policy manager at BHF, says: ‘One common factor in the success of these projects was the drive, determination and clinical leadership of those leading the service innovation to bring practitioners from different specialties together to focus...’
Your Alliance

The British Heart Foundation (BHF) Alliance is a free membership scheme supporting those who work with people affected by, or at risk of developing cardiovascular disease. We seek to grow an inspirational network, maximising the potential of everyone to make a difference.

BENEFITS FOR MEMBERS

- Monthly e-news from the BHF, Alliance members’ stories and clinical CVD news.
- Annual learning and development grant allowance.
- Information and links to relevant external learning and development events and conferences nationwide.
- Free registration to fully funded BHF Alliance regional and national events.
- Access to order branded BHF clothing and resources.
- Access to a bespoke online discussion forum.
- Free subscription to the Heart Matters HCP membership and quarterly magazine.

The BHF’s mission is to win the fight against cardiovascular disease (CVD). We are committed to connecting, supporting and inspiring people like you who work with those affected by, or at risk of developing, CVD to lead the fight to the frontline.

Join the BHF Alliance for free at bhf.org.uk/alliance

To be eligible for membership you will be working with people affected by or at the risk of developing cardiovascular disease, and be a UK resident.

FIGHT FOR EVERY HEARTBEAT

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The projects threw up some important lessons for the future integration of services:

- Training should be provided to multidisciplinary groups rather than individuals, as engagement between key professionals leads to greater commitment to the programme and better outcomes.
- Better networking between healthcare professionals across the sector can be used as a stimulus for change.
- A clear business case, evaluation metrics, strategy and plan for change must be in place, all of which allow for local flexibility.
- Sustainability must be considered from the beginning so that appropriate monitoring and evaluation tools can be built into interventions and key learning fed through to decision makers.

**KEY LESSONS**

**FUTURE FOCUS**

Our pilot sites have presented some examples of how a better integrated local health economy can be achieved without a huge monetary investment and how available resources can be deployed more efficiently. Although the government recently announced an additional £2 billion investment in the NHS as part of the 2014 autumn statement, only £200 million has been earmarked for service redesign (Health Service Journal, 2014).

The BHF pilots are an example of such a change and although not sufficient on their own, could be part of a wider cultural shift towards service and pathway redesign. In order to better integrate health and social care services, changes will also be needed at a national level. Changes to the way services are paid for, regulated and monitored need to be considered. Payment systems need to incentivise delivery of better outcomes for patients rather than performance and encourage joint accountability for outcomes. 

**REFERENCES**


