Integrated heart failure services

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What do we mean by integrated services?

• providing the right care, in the right place, by the right person (WHO 2008)
• patient centered and population orientated, reducing gaps and duplication, better outcomes for service users improving clinical and quality outcomes and delivering cost efficiencies (Monitor 2014)
• standardised care delivery through inter-professional teams, with colocation of services and a recognised structure of governance (Suter 2010)
• “integrate” – origin mid 17th century from latin “ integrat “ made whole” ( Oxford English Dictionary)
Background

The multidisciplinary team approach to heart failure management.
Geraint Morton, Jayne Masters, Peter Cowburn
Heart 2017; 0:1-7
Doi:10.1136/heartjnl-2016-310598
NHS heart failure survey: a survey of acute heart failure admissions in England, Wales and Northern Ireland

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Abstract

Objectives: To obtain national data on demographics, investigation, treatment and short-term outcome for patients admitted with acute heart failure.

Design: Retrospective survey of emergency admissions with acute heart failure from October 2005 to March 2006.


Main outcome measures: Patient demographics, referral source, admission characteristics, admission pathway, patient heart failure treatment on admission, length of stay, short-term mortality, discharge heart failure treatment, specialist follow-up and delayed discharge.

Results: 176/177 (99%) acute trusts responded and 2387 records were reviewed. Patients were grouped...
Background

Development of community HF nurse roles
Better outcomes for patients under cardiology care
Development of a specialist HF MDT
Improving outcomes in Southampton: the introduction of an inpatient HF service

- 211 patients seen anywhere in Trust
- Mean age 72 years (+/- 13.0)
- 13 out of 211 patients died
- Inpatient mortality 6%
- Length of stay 19 days (+/- 18 days)
Impact of the introduction of a specialist inpatient HF team

Survival 1 year post admission

84/196 dead pre-HFT v 57/211 HFT, p<0.01

Engaging stakeholders

Figure 1 - common reasons for non-referral
Stakeholder survey 2014 results

• felt referral mechanism not user friendly
• did not fully understand the role
• did not fully understand the referral criteria
• wanted better and more equitable access to community services
• felt that specialist HF nurses focussed on “single organ pathology” and did not understand the needs of complex frail multi-morbid patients.
• adults admitted to hospital with acute heart failure have input within 24 hours of admission from a dedicated specialist heart failure team.

• adults with acute heart failure have a follow-up clinical assessment by a member of the community – or hospital-based specialist heart failure team within two weeks of hospital discharge
Collaboration

Community services

• how can we influence current practice?
• what do commissioners want?
• should we bid for the contracts?
• can we do that alone? If not who can we work with to achieve our goal?
• outcome - consortium agreement, joint tender, awarded contract regular meetings with commissioners

Results by year 3 = 9% reduction in HF admissions across the CCG
Integrated model - UHS

- HFNs work in the hospital and the community
- co-located, 1 generic email address, helpline common to both parts of the service
- work to the same competencies and educational pathway
- key performance indicators have been matched across both CCGs
- documentation is integrated and shared
- ability to swap/share workloads when required

= increased efficiency
Collaboration

Inpatient services
• how can we improve current practice?
• ~ 40% patients admitted to elderly care
• no elderly care consultant with an interest in heart failure locally
• identification of a registrar (geriatric rotation) with a HF interest
• appointed to clinical fellow role 2017 and trained by HF cardiologists

Achieved best practice tariff
Benefits of an integrated service

• sustainability
• continuity of care
• governance – competencies, training, audit, monitoring, standards
• flexibility
• quality of assurance
• responsiveness
Conclusion

• we are now able to provide the right care in the right place by the right person

• the service focusses on the needs of the patients and carers, and also listens and engages with stakeholders

• by collaborating we have been able to provide a joined up service that has filled gaps in provision, reduced duplication and provided cost efficiencies

• The service model is more sustainable

• co-location of the hospital and community teams improves communication and ensures robust clinical and financial governance

• we can provide the whole pathway and ensure that it works for our local population of HF patients