Health & Care Partnership

Project aim

To commission an integrated Heart Failure service delivered by existing partners with system wide monitoring of outcomes. For West Essex this provides an opportunity to transform and integrate the CVD pathways through from primary, community and secondary care. This will ensure that patients are seen by the right person, in the right place, first time, reducing duplication, improving patient experience, quality and outcomes and supporting system wide sustainability. The CVD programmes main opportunities have been agreed as: Prevention; Better Coordination; Rehabilitation; Elective Care/Outpatients and Post MI/Revascularisation.

ALL TOGETHER, BETTER CARE
West Essex
Integrated Care Partnership

Project team

The West Essex CVD Expert Oversight Group (EOG) is at the centre of all CVD clinical design. It has representation from WECCG, PAHT, EPUT, Stellar Healthcare, Uttlesford Health, ENHCCG and Essex LPC.

Timeline for delivery

From: April 2020 To: March 2025

Measures

There are 7 NICE Quality Standards to be met and key performance indicators have been set out in the service specification.

The integrated heart failure service will be delivered under a capitated budget over five years which shifts the focus from payment by results to commissioning for outcomes. The CVD EOG are developing metrics to monitor throughout the contract which will be designed to facilitate the best clinical practice and measure the clinical effectiveness of the transformation.

Tests for change

As a result of the 'Commissioning for Value' reports produced by NHS Right Care and local evidence (including patient experience), a review of the quantitative and qualitative data was undertaken and recommendations made about the future CVD model of care. Model Hospital & GIRFT reports also provided insight into opportunities to improve care whilst achieving value for money and reducing variation.

The British Heart Foundation study presents the evidence for change to provide an integrated approach to managing heart failure in the community and improving quality of care.

The clinically designed outcomes will allow us to assess the impact of change and take necessary action as a system where the response is not as anticipated.

Results

The transformation of services is underway and each initiative is in a different phase of implementation:

Prevention/Prehab: Education programme for GPs and patients overseen by Integrated Heart Failure Service and the CVD EOG. Alignment to prevention programmes Diabetes, BHF, PHE and NHSE/I.

Integrated Heart Failure Service: Service model ambition to commence in April 2020. There are 7 NICE Quality Standards to be met. The service will establish an expansion of community nurse-led heart failure services , including rehabilitation and adopt a multi-disciplinary team approach with a consultant lead champion. Resulting in better coordination, medicines optimised, reduction in emergency attendances and PAH T consultants focused on most complex care.

Direct Access Diagnostics: Pilot Palpitation Pathway developed by the CVD EOG and launched on the 26th March 2019. Resulting in a reduction in unnecessary outpatient referrals to Princess Alexandra Hospital and aligns to the outpatient strategy. Once established as business as usual the CVD EOG will develop a Murmur Pathway.

Scoping potential for a GPwSI/ER Cardiology Service in Epping and Harlow: West Essex have a successful model in Uttlesford. Reduction in outpatient referrals and would align to the outpatient strategy.

Learning and next steps

Integration has been achieved in pockets of the CVD system primarily based on goodwill and robust relationships from community to secondary care. There is still significant work to do to build upon this and ensure that CVD services are integrated. Particular challenges include overcoming organisational barriers, information governance, IM&T and the decommissioning of services. However there has been valuable learning from Phase 1 ICP service model programmes.

The focus for the remainder of 2019/20 is to finalise the business case and service specification and seek authorisation to proceed to deliver a truly integrated heart failure service. Next steps will be a focus on population health, prevention and opportunities that align to the outpatient strategy.