National projects
Making a difference for your heart failure patients
Contents

Foreword

Introduction

Optimising care for patients admitted to Great Western Hospitals NHS Foundation Trust in acute heart failure
Great Western Hospitals NHS Foundation Trust

Multidisciplinary team working improves the heart failure patient’s journey in NHS Lincolnshire and United Lincolnshire Hospitals NHS Trust
NHS Lincolnshire, United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services

Vertical Integration: Heart Failure Chronic Care Specialist Nurse Assessment
Croydon Health Services NHS Trust, South London Cardiac and Stroke Network

Implementing multidisciplinary meetings for heart failure patients with end of life needs in Mid Yorkshire
The Mid Yorkshire Hospitals NHS Trust, West Yorkshire Cardiovascular Network

Optimising treatment for inpatients with heart failure in North Central London
North Central London Cardiovascular and Stroke Network

Improving choices for patients with end stage heart failure in the community – subcutaneous diuretics for decompensated heart failure
NHS North Staffordshire, University Hospital of North Staffordshire NHS Trust, NHS Stoke on Trent, Shropshire and Staffordshire Heart and Stroke Network, Douglas Macmillan Hospice

Developing a heart failure pathway at the Royal Free Hampstead NHS Trust
Royal Free Hampstead NHS Trust, North Central London Cardiovascular and Stroke Network

Developing a seamless, cross-borough heart failure pathway
Guy’s and St. Thomas’ NHS Foundation Trust, Kings College Hospital, South London Cardiac and Stroke Network

Streamlining outpatient appointments for heart failure patients in Walsall
Walsall Healthcare NHS Trust

Developing an end of life heart failure care pathway in Brent
St Luke’s Hospice, North West London Cardiac and Stroke Network, NHS Brent

Improving end of life care for patients with heart failure in North West Surrey
Surrey Heart and Stroke Network, Ashford and St Peter’s Hospitals NHS Trust, Woking and Sam Beare Hospices, South East Coast Ambulance Service, British Heart Foundation, Surrey Community Health

NHS Improvement Heart Failure Team
Foreword

Historically heart failure has been a ‘Cinderella illness’ with the diagnosis repeatedly missed and patients then presenting with advanced disease, often as hospital admissions where less than ideal care has increased the likelihood of subsequent readmissions, and is associated with high acute and cumulative mortality rates and considerable morbidity. Although heart failure can be difficult to diagnose there has been little awareness of the condition amongst the general population, and a clinical workforce who have arguably been slow to engage with diagnostics advances, effective treatments and other interventions that can transform outcomes. A chronic underinvestment has confounded these problems.

But all is not gloom. In recent years there has been a determination to transform the lives of people with heart failure and current strategies aim to ensure first, an early and accurate diagnosis using natriuretic peptides, early echocardiography and assessment by a heart failure cardiologist, and then, optimal care involving a truly multidisciplinary heart failure team. This team must work effectively across primary, secondary, and community care so that patients receive the best possible care when at home or in hospital, ensuring their needs are met in all circumstances. Happily there is a strong evidence base for this approach reflected in the original and recent update of the NICE Chronic Heart Failure guidance (2010), and the related Quality Standards (2011). The National Heart Failure Audit has become an invaluable tool to inform us of current practice and to drive future change.

We have learnt that whilst standards vary markedly between acute hospitals, in some care is good, including access to dedicated cardiologists and to primary and community heart failure services and improved outcomes. In other heart failure communities, including the acute trusts, there is much work to be done and care far from acceptable.

Nonetheless, there is a documented year on year improvement in the care of people diagnosed with heart failure. As current chair of the British Society for Heart Failure I am impatient to see the rate of improvement accelerate and ensure that best practice has a more consistent implementation. The current financial climate must not negate this agenda. The work and energies of all those involved with the NHS Improvement projects for heart failure are recognised and undoubtedly contribute to improving outcomes.

This publication is designed to highlight exemplars of good practice in the field of heart failure drawn from the NHS Improvement national projects. It is a pleasure to read and reflect upon the practical implementation of the themes emphasised above. I would like to thank all those involved in these projects for their hard work and determination to improve the care of individuals with heart failure, and further thank them for their generosity in sharing their work with others.

Dr Suzanna Hardman, PhD, FRCP
Chair, British Society for Heart Failure
Introduction

In the United Kingdom, heart failure affects about 900,000 people, with 60,000 new cases annually, and is predominantly a disease of older people with all their attendant comorbidities. At least 5% of those aged over 75 years are affected, rising to about 15% in the very old. Given the relative aging of the general population, those with heart failure will continue to consume a major and increasing proportion of clinical and public health resources. Heart failure is a high cost Healthcare Resource Group (HRG) and multiple hospital admissions, a common feature of advanced heart failure, account for a significant amount of this health care expenditure.

There is good evidence that optimal care improves survival and quality of life for the many patients that suffer from heart failure. It is also clear that recent developments in the treatment of this long term condition reduce admissions to hospital and increasingly allow those affected to be monitored and cared for at home. For the year 2009/2010, there were almost 113,000 admissions with heart failure that might be avoided with anticipatory care planning and the provision of community health and social care support. It is vital that there is close collaboration between primary and secondary care if the improved outlook for heart failure patients is to be realised.

In March 2010, NHS Improvement invited organisations to work in partnership on projects dedicated to improving the heart failure pathway, up to and including end of life projects. Projects were submitted from acute trusts, PCTs and cardiac and stroke networks and some with involvement of palliative care services. Whilst our primary aim is to improve patients’ experience and outcomes and remove inefficiencies from the process, it is important that in doing this we also achieve productivity gains with a reduction in bed days, readmissions and interventions, and so reduce the burden on the health service.

The projects had the challenge of making a difference for their heart failure patients in a relatively short eight month project period with the exception of Brent and North West Surrey which commenced their projects in 2009. For most of the projects this represented a starting point on the improvement journey for their heart failure patients.

This publication contains posters produced from the final heart failure project reports, providing a flavour of the work that the project sites have undertaken.

For further information go to: www.improvement.nhs.uk/heart/heartfailure and visit the heart failure resource which has been developed by NHS Improvement to support the implementation of the NICE chronic heart failure quality standard. The resource is a compilation of information, evidence, guidance and case studies and is suitable for clinicians, managers, service improvement teams and commissioners.
NHS Improvement national heart failure project

Optimising care for patients admitted to Great Western Hospitals NHS Foundation Trust in acute heart failure

Project background overview
Swindon and the surrounding area had a high prevalence of ischaemic heart disease and heart failure. There was significant room for optimisation of care and an opportunity to redesign the way heart failure services were delivered at the Great Western Hospitals NHS Foundation Trust.

Goals and objectives
The aim of the project was to review the management of patients admitted with heart failure, identify gaps in service provision and delays in diagnostic investigations.

- Identify existing pathways of care for heart failure patients within the acute trust.
- Monitor their length of stay.
- Increase the number of patients reviewed by the heart failure specialist nurse.
- Identify the percentage of heart failure patients admitted to cardiology.
- Increase the percentage of patients discharged on ACE/ARB, beta blocker and spironolactone.
- Identify the number of patients who had an inpatient echocardiogram and reduce waiting time from admission to echocardiogram.
- Obtain patients’ perspective on current heart failure service.

Project highlights and good practice
- A heart failure care pathway has been developed and agreed by cardiology, general medicine and care of the elderly with work underway to develop a new model of care with direct admission to a designated heart failure unit.
- Length of stay reduced from a median of nine days down to six, which led to a saving of £508 bed days from June 2010 to February 2011. Assuming £250 per bed day, this is a potential saving of £127,000.
- Funding has been secured to trial serum NP in the acute trust.

Lessons learned
- It is advantageous to have experienced informatics services and cardiac network personnel to gather and validate relevant data.
- Clinical audit personnel can play an important part in assisting with the development and analysis of patient experience questionnaires.
- Obtaining funding agreement from cardiac network to pilot BNP testing was relatively straightforward once evidence of need was provided.

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NHS Improvement national heart failure project

Multidisciplinary team working improves the heart failure patient’s journey in NHS Lincolnshire and United Lincolnshire Hospitals NHS Trust

Project background overview

A new pathway to support the management of heart failure patients was produced and tested at Lincoln County Hospital during a four week period in November 2010. The pathway pilot illustrated that there are a number of opportunities available to improve the quality, effectiveness and efficiency of heart failure care, particularly in secondary care.

- Reduce length of stay.
- Avoid unnecessary admissions.
- Improve quality of care.
- Generate audit data to evidence improved care.

A pathway map was developed by stakeholders identifying where delays and opportunities existed.

Goals and objectives

To develop a model of multidisciplinary team working that improves the journey of heart failure patients through primary and secondary care and promotes the continued development of healthcare professionals in Lincolnshire.

- Ensure a mechanism is in place to appropriately manage patients across Lincolnshire equitably.
- Ensure appropriate personnel are managing the patient at the appropriate time with the appropriate skills.
- Use key performance indicators to enhance evidence of achievement and to ensure the work of the heart failure specialist team is audited.

Project highlights and good practice

During the four week pathway pilot:

- >50% increase in referrals for specialist heart failure complex case manager follow up after discharge.
- No heart failure readmission to hospital within 30 days for patients followed up in the community using the new patient pathway.
- Length of stay reduced by an average of 3.74 days.
- Reduced length of stay cost benefit calculation: £250 per day x 3.7 x 38 patients = £35,150.
- Five admissions avoided by direct referral to heart failure complex case managers = £11,610 saving.

Cost Saving for November 2010
Admission avoidance + reduced length of stay = £46,760

Across United Lincolnshire Hospitals NHS Trust investment in this pathway could save in excess of £500,000 per annum after costs of implementation are accounted for.

Lessons learned

Heart failure presentations with arrhythmia, ischaemia or infection are common and these patients are not immediately identified as having heart failure. During the pathway pilot the community heart failure nurses visited the wards daily to identify patients and it is felt that an educational intervention may have made the heart failure pathway more acceptable to the hospital ward staff.

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www.improvement.nhs.uk/heart/heartfailure
NHS Improvement national heart failure project

Vertical integration: Heart Failure Chronic Care Specialist Nurse Assessment

Project background overview
Croydon Health Services NHS Trust was formed on 01 August 2010 through the integration of Croydon Community Health Services and Mayday Healthcare NHS Trust. The move provided an opportunity to re-evaluate the previously discrete heart failure resources to optimise efficiencies and ensure high quality of care, based on individual patient need. A comprehensive assessment tool was developed to achieve this immense task.

Goals and objectives
To deliver high quality, efficient care closer to home for heart failure patients with increased patient choice. By providing a care package that is tailored to each patient’s personal and healthcare needs and location, we increased access to the heart failure service, resulting in reduced readmissions to hospital. The development of a heart failure nurse specialist assessment tool ensures that all patients are comprehensively and uniformly assessed. A standardised heart failure telephone follow up clinic furthers this access to care whilst additionally increasing nurse capacity.

Project highlights and good practice
The integration of community and hospital heart failure services created economies of scale in their resources, which would potentially increase efficiencies and patient throughput. To ensure high quality patient care, systematic assessment was used to support clinical decision making, by pre-determining where patient care should be escalated for an exacerbation. When fully implemented, this tool can potentially reduce unnecessary hospital readmissions.

The Croydon heart failure nurse assessment tool was developed from collaboration across community and hospital settings. It uses a menu-driven approach to ensure that patients receive a standardised care package which has been customised to their personal and healthcare needs, regardless of location.

A standardised consultation form was created for use in telephone follow-up clinics. This will increase heart failure nurse capacity whilst ensuring comprehensive and consistent follow-ups. All clinics will begin using these forms following the full integration.

Lessons learned
Good communication and effective change management is essential when integrating healthcare services. This increases when services that previously existed as separate organisations merge. Open communication and clinical engagement are therefore integral to building the teams, accepting the change and ensuring support in the development of the assessment tools.

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www.improvement.nhs.uk/heart/heartfailure
NHS Improvement national heart failure project
Implementing multidisciplinary meetings for heart failure patients with end of life needs in Mid Yorkshire

Project background overview
It was recognised that patients with advanced heart failure did not have the same access to the care and services that patients with other terminal illness had. The multidisciplinary team approach was seen as a professional, integrated delivery of care model which, when implemented, would reduce the inequalities for patients at end of life.

Goals and objectives
To improve end of life care by introducing multidisciplinary team (MDT) meetings for end stage heart failure patients thought to be in need of palliative care at the end of life.

• Patients are assessed as being end of life with palliative needs.
• Improved quality of treatment and care.
• Equal provision of a gold standard for care of patients with terminal disease irrespective of aetiology.
• Increased number of patients with heart failure dying in their preferred place.
• Increased use of recognised good practice tools such as the Gold Standards Framework, The Liverpool Care Pathway, Advanced Decision to Refuse Treatment, GP Out of Hours handover form and the Do Not Attempt Cardiopulmonary Resuscitation form.
• Long term goal to reduce hospital readmission rates and hospital length of stay.

Project highlights and good practice
• MDT meetings are running at two venues and an increased number of patients from both hospital and community settings are being referred to palliative care as a result of joint working by clinicians.
• Appropriate recognition of the palliative stage in a patient’s condition enables care to be tailored to the patient’s individual needs.
• Knowledge of the recommended tools used in end of life care has increased.
• Hospice care is available for end stage heart failure patients.
• The project has allowed specialist staff to transfer their knowledge to generalist staff, for which end of life care in patients with advanced heart disease is only a small part of their clinical role.
• Patient questionnaire enables the collection of Patient Reported Outcome Measures (PROMS).

Lessons learned
• Deciding which patients to discuss at the MDT meeting requires careful consideration using prognostic indicator guidance and this is an area which may require staff education.
• Use resources that you have available to you – the patient questionnaire was discussed at existing patient and carer support groups to review the questions and the format of the questionnaire.
• Small numbers of patients made analysis of data difficult. Hospital readmission data and length of stay data will be collected on an ongoing basis.

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www.improvement.nhs.uk/heart/heartfailure
NHS Improvement national heart failure project
Optimising treatment for inpatients with heart failure in North Central London

Project background overview
The six hospitals in the North Central London cluster had all agreed to submitting data to the National Heart Failure Audit and to provide their support for improvements to the heart failure services.

- A benchmark was established through data collected between the financial year 2009 and 2010 as a basis for measuring improvements going forward for 2010 and 2011.

Goals and objectives
To influence admission rates, readmission rates, length of stay and the number of patients going home with a confirmed diagnosis of heart failure across North Central London by increasing the prescribing rates of clinically indicated medications.

This was achieved by identifying and diagnosing heart failure patients in a timely manner with input from heart failure specialists to ensure treatment is optimised and patients receive appropriate follow up.

Project highlights and good practice
The six hospitals agreed on a standardised sector-wide ‘score card’ to document and communicate performance. The hospitals are able to see the impact on increasing prescribing rates and other measures by submitting data to the National Heart Failure Audit. Data is analysed monthly by the cardiac network and fed back to the trusts in the form of the ‘score card’.

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<tbody>
<tr>
<td>Median: 9 days</td>
<td>Median: 8 days</td>
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<table>
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<th>What % of patients with LV systolic dysfunction is receiving a follow-up with cardiology?</th>
<th>April 2010 – June 2010</th>
<th>January 2011 – March 2011</th>
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<tbody>
<tr>
<td>Median: 66%</td>
<td>Median 74%</td>
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Lessons learned
- Presenting data quarterly at the task group meetings allowed the group and the individual hospitals to detect and address any issues and problems as they arose, rather than dealing with issues at the end of the year.
- It is important to concentrate on a hospital’s individual improvements, not just the achievement of local measures, to ensure they see the benefits of maintaining and reviewing the data entered into National Heart Failure Audit database.

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www.improvement.nhs.uk/heart/heartfailure
NHS Improvement national heart failure project

Improving choices for patients with end stage heart failure in the community – subcutaneous diuretics for decompensated heart failure

Project background overview
Most patients with end stage heart failure (HF) would prefer to be treated at home during their recurrent and worsening HF symptoms. However current practice is to hospitalise patients with symptomatic HF for intravenous or subcutaneous diuretics delivered predominantly by generalists with little specialist knowledge of heart failure or palliative care. The project was a joint venture with Douglas Macmillan Hospice in Stoke on Trent.

Goals and objectives
To provide community based subcutaneous diuretics to HF patients at the end of life stage, avoiding hospital admissions and increasing the input of the specialist multi-disciplinary HF team with a view to determine:

- Patient and carer acceptance of subcutaneous diuretics administered in the community using a focus group.
- Current usage of the Gold Standards Framework Registry.
- The potential need for this intervention.
- The outcomes following the administration of subcutaneous diuretics in end stage heart failure patients.

Project highlights and good practice

General
- Improved awareness of HF and palliative care issues in the community.

Specific
- Patients (and future potential users of this service) and their carers welcome this intervention.
- The Gold Standards Framework Registry is not currently used appropriately in heart failure (i.e. non-cancer) patients.
- The intervention in 13 patients reduced hospitalisations by 27 and saved a total of 344 bed days i.e. the potential closure of one hospital bed.
- It facilitated patient choice in terms of preferred place of death, as all expected deaths occurred in the community.
- Subcutaneous diuretics delivered in this way to end stage heart failure patients is cost effective (a cost saving of £5,000 compared to usual care for the whole group).

Lessons learned
- Subcutaneous diuretics, administered in the community, are a safe and acceptable alternative to hospitalisation for intravenous diuretics for patients.
- Health professionals unfamiliar with aspects of HF care may require persuasion that alternative routes of administration of standard drugs in a palliative care setting are equally of benefit in cancer and non-cancer conditions.
- The delivery of subcutaneous diuretics in the community has to be married to improved access to specialists in HF and palliative care.
- There is a large unmet need for this intervention and a time lag before patients require it.
- Subcutaneous diuretics delivered in this way reduce costs and hospitalisation. This model sits firmly within the QIPP agenda.

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NHS Improvement national heart failure project

Developing a heart failure pathway at the Royal Free Hampstead NHS Trust

Project background overview
The Royal Free is a busy secondary/tertiary referral centre. It had recently appointed two new consultant cardiologists to add to the existing heart failure team of a consultant cardiologist and a specialist heart failure nurse. The medical assessment unit had also appointed a new lead consultant and everyone was keen and enthusiastic to deliver a world class heart failure service to patients.

Goals and objectives
To provide a comprehensive inpatient heart failure service to the medical assessment unit using a Heart Failure Integrated Care Pathway which provides guidelines on serum NP testing and the early treatment of patients with suspected heart failure.

- Patients to receive specialist review during admission, with the option of specialist follow up if appropriate.
- Timely diagnosis using BNP and echo within 24 hours where appropriate.
- 95% of patients (with LV systolic dysfunction <40%) discharged home on an ACE or ARB.
- 95% of patients (with LV systolic dysfunction <40%) discharged home on a beta blocker.
- A reduction in readmissions within 30 days by 50%.
- Monitor length of stay to identify if any changes occur due to speedier diagnosis, commencing treatment prior to discharge and the option of specialist follow up.

Project highlights and good practice
The heart failure pathway has been developed and is in use on two wards within the hospital.

Prescribing rates have increased during the time of the project:
- In 2009/10, 52% of patients went home from general medical ward with a beta blocker. The 2010/11 project data shows 57% of patients went home with a beta blocker.
- In 2009/10, 68% of patients went home from general medical ward with an ACEI/ARB. The 2010/11 project data shows 73% of patients went home with an ACEI/ARB.
- In 2009/10, 20% of patients went home from general medical ward with a SARA. The 2010/11 project data shows 27% of patients went home on a SARA.

Lesson learned
It is important to have robust data available to demonstrate success.

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NHS Improvement national heart failure project

Developing a seamless, cross-borough heart failure pathway

Project background overview

The aim of this project was to streamline the referral system of the heart failure service across two boroughs: Lambeth and Southwark. Following the vertical integration with Guy’s and St. Thomas’ NHS Foundation Trust (GSTT), there was a clear need to develop seamless working between two tertiary hospitals, Guy’s and St. Thomas’ Hospital and King’s College Hospital, and their community heart failure services.

Goals and objectives

Integrated working with primary and secondary care to develop a seamless pathway across two boroughs (Lambeth and Southwark) so that heart failure patients receive the same high quality, timely care, regardless of where they enter into the pathway. This was achieved by:

- Defining the heart failure pathway
- Improving referral flows
- Managing the Community Heart Failure Team capacity.

Project highlights and good practice

By working collaboratively with Lambeth and Southwark commissioners, the network helped to gain consensus for a shared service specification, referral criteria and outcomes for the community heart failure services; and secure equal resources and funding needed to make it a reality.

A ‘café style’ event and questionnaires provided valuable patient feedback which informed the development of a patient-friendly referral system and the production of patient information leaflets.

A traffic light referral system was developed to systematically risk stratify patients on hospital discharge, and ensures that they are seen in the community as appropriate.

The community heart failure team gained remote access to the GSTT IT system, for direct access to blood results to efficiently make medication changes.

Standardised referral forms developed for both community heart failure services meant that relevant information is sent, in a helpful and useful format.

Lessons learned

Patient engagement (both initial and ongoing) was key, as it significantly influenced the course of the project. Incorporation of this feedback ensured that the changes would be effective and responsive to patient needs. It also ensured that unnecessary project work was avoided.

Having a strong clinical project lead who championed the heart failure clinicians to participate was equally vital. This created a shared vision, with project aims that were important and relevant to everyone.

The cultivation of close links between commissioners and service managers in both boroughs resulted in the approval of equal resources for both boroughs’ community services with shared service level agreements, referral criteria and outcomes. This led to the development of a uniform referral system and a resulting increase in throughput.

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Project background overview

Patients seen in the Open Access Systolic Insufficiency Service (OASIS) were sent home to wait for an appointment to attend the heart failure clinic. Patients consequently had to attend two clinics and had a delay in receiving a diagnosis and a subsequent management plan.

Goals and objectives

- To reduce the time it takes to get a heart failure diagnosis by improving access to echocardiography and serum NP testing for both inpatients and patients attending the OASIS and the heart failure clinics at Walsall Healthcare NHS Trust.
- Reduce readmissions with heart failure.

Project highlights and good practice

The merger of the OASIS (Open Access Systolic Insufficiency Service) and heart failure clinics has improved the patient experience by enabling patients to come to clinic and receive a diagnosis and management plan on the same day. This is supported by a patient satisfaction survey.

The heart failure team are now able to access the serum NP database which assists in the early identification of heart failure patients.

Improvements have been seen in readmission rates.

- Readmissions with heart failure 2009/2010 was 71 patients.
- Readmissions with heart failure 2010/2011 was 54 patients.

Lessons learned

- It is important to get to know all key stakeholders and involve them with setting up the service, including GPs, managers in the trust, porters and all involved.
- Demonstrate what benefit the service will be to other services.
- Understand what you want to do and how much it costs.
- Involve patient and carer groups.
- Understand what transport is available and how people will get to the clinic.

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www.improvement.nhs.uk/heart/heartfailure
NHS Improvement national heart failure project

Developing an end of life heart failure care pathway in Brent

Project background overview

Brent heart failure (HF) patients received an excellent cardiology service but this was not linked into services which could address the needs of patients requiring end of life care. This included the patient’s palliation of symptoms, their holistic needs, preferred priorities of care and the needs of their carers. Many patients with end-stage HF were not having a discussion about preferred priorities of care because there was no agreed mechanism for identifying them or for verifying that they were nearing end of life. Consequently many patients were frequent attendees at A&E and many were dying in hospital.

Goals and objectives

To develop an end of life care pathway in Brent for end-stage heart failure patients.

Working in partnership to provide patient choice and accessible end of life care service provision in hospital and community settings, taking into account the cultural and social diversity within the borough.

Project highlights and good practice

- Joint visits between community heart failure nurse and specialist palliative nurse lead to timely discussions, better communication and increased knowledge of each specialty.
- Developing a ‘trigger tool’ to recognise that the patient is probably approaching end of life. ‘Preferred priorities of care’ provides patients, family members and carers with an opportunity to express their wishes and preferences about the care they receive and where they want to receive it.
- The ‘patient and carer assessment tool’ (PACA) provides assessment of the patient symptoms and carer needs and aids appropriate referral to specialist palliative care support.
- The ‘Advanced Heart Failure Forum’ is a multidisciplinary meeting with community and hospital staff to discuss patients who are identified as a ‘cause for concern’ and provides a platform to include end of life issues.
- The ‘Red Folder’ in patients’ homes containing advanced care planning management, accessible by district nurses, out of hours and the ambulance services.

Lessons learned

Providing high quality palliation for patients is a complex system, which involves numerous organisations, clinical teams and services both in hospital and the community. Maximum improvements in care can only be achieved through working in partnership to provide a seamless service. The Brent end of life strategy provides a platform for sharing the heart failure end of life work developed.

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NHS Improvement national heart failure project
Improving end of life care for patients with heart failure in North West Surrey

Project background overview
In 2009, the North West Surrey community heart failure nurse specialist team identified a need for developing a pathway for patients with end stage heart failure. A robust pathway was already in place for the management of patients that were discharged from hospital with a confirmed diagnosis of heart failure. Multidisciplinary team (MDT) working between the lead consultant cardiologist for heart failure and the community meant the team were able to discuss and seek advice from the consultant about patients on the nurses’ case load. In addition, GPs in the North West of Surrey were confident in the nurses’ management of patients with heart failure in the community, as it was seen as a consultant led service.

Goals and objectives
To work across primary and secondary care, community teams and emergency services to develop a referral pathway for palliative care for end stage heart failure patients.

• Develop a programme to support the education and training around identifying end stage heart failure and having end of life discussions.
• Audit the use of the Gold Standards Framework Registry for patients at end stage heart failure in primary care.
• Develop a formal forum to discuss patients at end of life across heart failure and palliative care teams in acute and the community.

Project highlights and good practice
• Professionals from across the disciplines have an improved knowledge of the management of heart failure patients at end stage following education sessions provided by the heart failure nurse specialist and palliative care lead.
• A multidisciplinary team meeting is held every six weeks between the lead cardiology consultant, Macmillan team lead and community heart failure nurse specialists to discuss patients that should be placed on the end of life pathway.
• A ‘hover’ section has been added to the proforma which is used when discussing patients for those that are not at the stage of being placed on the end of life pathway.
• Advance communication training has been attended by the nurse specialist team to aid discussions around end of life issues.

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<td>21%</td>
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<tr>
<td>Preferred priorities of care (PPC) recorded</td>
<td>7%</td>
<td>55%</td>
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<td>Place of death consistent with PPC</td>
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<td>60%</td>
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<td>Palliative care referral</td>
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<td>63%</td>
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<td>Patient discussed at MDT</td>
<td>7%</td>
<td>50%</td>
<td>89%</td>
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Lessons learned
• The multidisciplinary team meetings have become an excellent source of referrals. Representation from all of the organisations involved in the care of the patient facilitates the decision making process for who should be placed on the end of life pathway.
• It has been quite a challenge informing the ambulance service who is on the pathway. It is proving difficult to develop a system that alerts the ambulance service of patients that are on the pathway.
• The patient’s place of death will not always be consistent with their preferred place of death. What is important is having the end of life discussion with the patient and their carer.
• It is important to have a clinical champion attached to the project.

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PUBLICATIONS LIST 2010-11

Heart
- Anticoagulation for atrial fibrillation
- End of life care in heart failure: a framework for implementation
- Atrial fibrillation in primary care - Making an impact on stroke prevention
- Heart Failure - Quick guide to quality commissioning
- A guide to commissioning cardiac surgical services
- Guide to implementing primary angioplasty
- Continuous improvement to cardiac services 2009/10
- Improving patient experience - developing solutions to deliver sustainable pathways in cardiac surgery
- Pathways for heart failure care: making improvements in heart failure services
- Transforming cardiac rehabilitation - celebrating achievements and sharing the learning from the national projects

Cancer
- Effective follow up: Testing risk stratified pathways
- Risk Stratified Breast Cancer Pathway
- Risk Stratified Lung Cancer Pathway
- Risk Stratified Breast Cancer Pathway
- Risk Stratified Prostate Cancer Pathway
- Models of care to achieve better outcomes for children and young people living with and beyond cancer
- Teenage and young adult aftercare pathways
- Building the evidence - Developing Winning Principles for children and young people
- Providing evidence to achieve improvements for patients: children and young people living with and beyond cancer
- The improvement story so far: living with and beyond cancer
- An integrated approach: the transferability of the Winning Principles - sharing the learning
- Consolidation report: From testing to spread
- From testing to spread: sharing the knowledge and learning from organisations spreading the Winning Principles - case studies

Diagnostics
- First steps in improving phlebotomy: The challenge to improve quality, productivity and patient experience
- Continuous improvement in cytology: sustaining and accelerating improvement
- Cytology improvement guide: achieving a seven day turnaround time in cytology
- Learning how to achieve a seven day turnaround in histopathology
- What a difference a day makes

Audiology
- Shaping the future: Strengthening the evidence to transform audiology services
- Pushing the boundaries: Evidence to support the delivery of good practice in audiology

Stroke
- Commissioning for stroke prevention in primary care: the role of atrial fibrillation
- Why treat stroke and TIA’s as emergencies?
- Going up a gear: practical steps to improve stroke care
- Going up a gear: joining up prevention
- Going up a gear: implementing best practice in acute care
- Going up a gear: improving post hospital and long term care

Lung
- Improving home oxygen services: emerging learning from the national project sites
- Chronic and self management services: emerging learning from the national project sites (Autumn 2011)
- Transforming acute care in COPD: emerging learning from the national project sites (Autumn 2011)
- Driving up quality diagnosis: emerging learning from the national project sites (Summer 2011)
- Improving end of life care services: emerging learning from the national project sites (Autumn 2011)

General
- Bringing Lean to life: making processes flow in healthcare
- Demonstrating how to deliver the QIPP challenge - pocket guide

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