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NHS Hillingdon CCG

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NHS Hillingdon CCG - Executive Summary

Project Name: Service improvement for the detection and treatment of Heart Failure ("HF") in primary care

Joint Working Project Summary:

- The principal aim of this joint working project is to improve the detection and treatment of HF in primary care via an Integrated Care Clinics ("ICCs") solution consisting of a quality improvement program to ensure better awareness, identification, and management of and outcomes for, patients with HF in primary care
- The project will promote a proactive integrated approach to HF care overall, together with a service evaluation, to deliver the benefits to patients of improved management by promoting active HF case finding, and titrating medication to optimal levels

Expected Patient Outcomes for this Project:

This program will include the following:

1. increased accuracy and validity of the defined HF population in GP practices via primary care data cleansing, searches and actively identifying new HF patients and existing HF patients receiving sub-optimal care
2. undertaking a virtual triage to identify patients that require optimised care within the patients' cohort identified according to the databases searches mentioned above
3. in-practice HF Medicines Optimisation Clinics for identified patient cohort that require general HF intervention
4. increased integration and access to specialist HF input and intervention via community-based HF specialist clinics
5. increased awareness, confidence, and competence particularly across 'non-specialist' primary care healthcare professionals in the management of HF patients
6. an algorithm embedded within EMIS-systems (with triggers) to ensure sustainability of the HF patients' management system by providing prompts/reminders for HF patient diagnosis and management
7. in addition, implementation of Multi-Disciplinary Team ("MDT") care for HF patients delivered by HF specialist, HF nurse specialist, GP, Pharmacist, Physiotherapist, Palliative Care specialist, Psychologist, Occupational Therapist and/or Administrators. The MDT will review and deliver integrated patient care which may include interventions such as clinical review, medicines management, cardiac rehabilitation, education, self-monitoring, and management, telemonitoring or telephone support for the patient identified as requiring specialist intervention at the new HF Patient Optimisation Clinics

Start Date & Duration: 31st December 2018, 39 Months

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NHS Hillingdon CCG - Outcomes Summary

Project Name: Service improvement for the detection and treatment of Heart Failure ("HF") in primary care

Project Name: Service improvement for the detection and treatment of Heart Failure (HF) in primary care

Partner Organisation(s): NHS Hillingdon CCG

Completion Date: March 2022

Outcome Summary:

- Improved case finding and coding to increase prevalence and therapy optimisation.
- Increased service efficiency with electronic alerts and virtual multi-disciplinary team (MDT).
- Increase of 3 additional permanent posts within Community Heart Failure Team.
- Greatest percentage reduction in heart failure hospitalisations across London.

Key Project Outcomes Data:

- 28% increase in the number of patients with heart failure diagnosis confirmed by a specialist
- 34% reduction in admissions for Heart Failure (North West London regional average of 21%)
- Uplift in the Quality Outcomes Framework payment by over £93k each year
- 128% increase in Heart Failure with reduced ejection fraction (HFrEF) patients treated with NICE recommended therapies.

Outcomes:

The project was undertaken in 2018 in Hillingdon to identify those patients who were registered to GP practices with stable heart failure (HF) and not optimised on evidence-based therapy. Patients identified were reviewed virtually at MDT meeting with cardiologist, clinical pharmacist and HF nurse specialist and then invited for review either at their own GP practices or at a community nurse led clinic for optimisation of HF therapy. Home visits were offered to those patients who were unable to attend clinic. Further discussion with consultant cardiologist was necessary for those patients who were eligible for device therapy. All patients were offered lifestyle advice and self-management tools as well as referral to cardiac rehabilitation (CR) if appropriate.

In total 365 patient were reviewed across 33 GP practices. Of that number 246 were reviewed at virtual MDT and 56 patients were identified for optimisation of HF therapy. This project has highlighted the importance of early identification of patient with HF to enable optimisation, onward referral for CR and device consideration to reduce risk of decompensation and hospital admission but also improving patients QoL. It has also improved relationship between the community HF teams and our GP colleagues raising the profile of early referral into specialist teams for patients with HFrEF.

It is difficult to identify definitively the number of patients who could have progressed to secondary care with a decompensation, but the project team understand there was a reduction in hospital admission/readmission over this period. From the Hospital Episode Statistics (HES) data, we can see here a 34% reduction in admissions for HF as a primary diagnosis 20/21 vs 19/20 but through the pandemic we know that these types of admissions dropped nationally. The full dataset showed that Hillingdon had the greatest percentage drop in admissions across the whole of London and compared to the North West London average of 21% this was a more significant drop.

The wider outcomes of the project were a 28% increase in the number of patients with a diagnosis of HF since the beginning of the project. Of these 128% increase in the number of HFrEF patients taking an NICE recommended therapies.

Another highlight of the project was the integration of the HF Acute team and the community HF team. We can see from the national heart failure audit, there has been a significant increase in the number of patients referred to the community HF team from the acute team once a patient has been discharged from the hospital setting (60% in 18/19 compared to 78% in 19/20).

Conclusion:

The project team understands that the healthcare system can't help patients if they're not identified. This project supported the identification of patients that were missing within the system. Thus, allowing heart failure therapy optimisation at the right time, in the right setting, which improved the standard of care for heart failure and ultimately reduced heart failure hospital. Admissions. The improvements seen within the project will be sustained by the increased number of specialists within the heart failure team.

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