Leeds Teaching Hospitals NHS Trust, NHS Leeds CCG and Leeds General Practice Confederation Limited

Leeds Health & Care Partnership - Executive Summary

Project Name: The Development of an Integrated Care Clinic service for Heart Failure (HF)

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:

This program will include the following:

1. increased accuracy and validity of defined HF population in GP practices across Leeds via primary care data cleansing, searches and actively identifying new HF patients and existing HF patients receiving sub-optimal care;
2. undertaking of a virtual triage to identify patients that require optimised care within the patients' cohort identified according to the databases searches mentioned above;
3. development of Leeds HF care guidelines and streamlined pathways of care to standardise HF care across Leeds to improve adherence to NICE clinical guidelines and quality standards, reducing variation in management and practice locally;
4. increased awareness, confidence and competence particularly across 'non-specialist' primary care healthcare professionals in the management of HF patients - development of designated "champion for HF" at an individual GP practice or cluster of GP practices level;
5. HF patients to receive regular (six-monthly) reviews in primary care;
6. developed and refined QoF HF Template and HF Care Plan as foundation for six-monthly patient reviews; and
7. increased integration and access to new specialist clinical and MDT decision making including remote access via new virtual clinic/e-consultation

Start Date & Duration: July 2018, 47 months

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Leeds Health & Care Partnership - Outcomes Summary

Project Name: Leeds Integrated Care Clinic Joint Working Project
Heart Failure Service Pilot Project in two Primary Care Network (PCN) sites

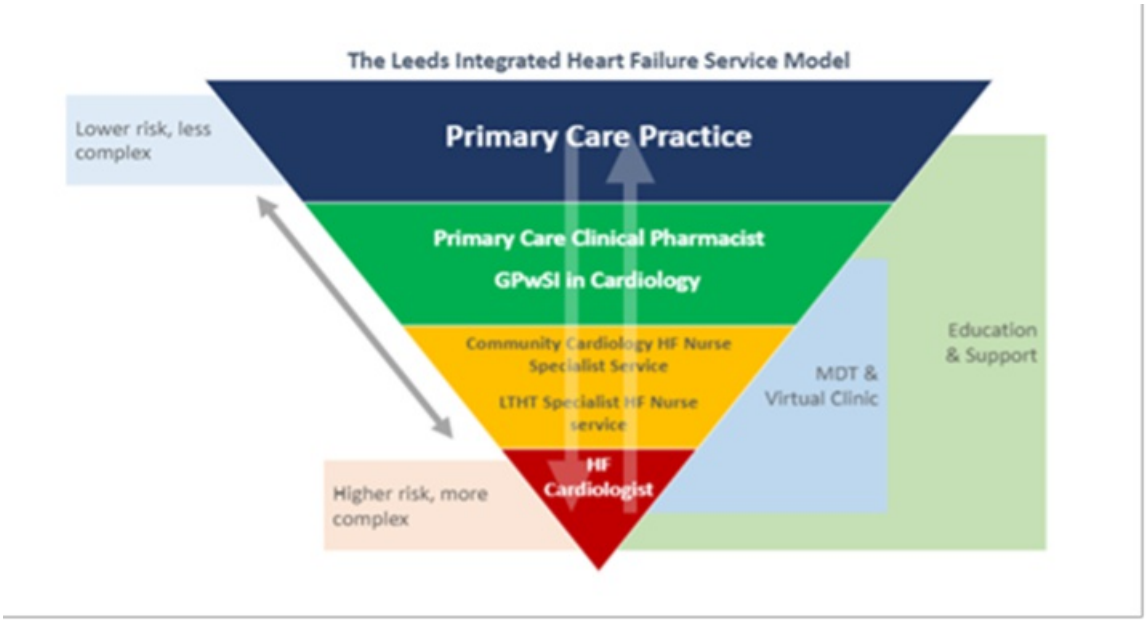
Partner Organisation(s): Leeds Health & Care Partnership

Completion Date: August 2022

Outcome Summary:

The data gathered during the project would suggest that the redesigned service model outlined in Figure 1 can be effective with some delivery in primary care providing the relevant Health Care Professionals (HCPs) are adequately trained and receive ongoing support.

Figure 1: The Leeds Integrated Heart Failure Service Model



Key Projects Outcomes Data:

Following the completion of four training sessions delivered by Leeds Teaching Hospitals Trust (LTHT) cardiology consultants, 60% of pharmacists felt very confident in reviewing people living with heart failure with reduced ejection fraction. 40% felt moderately confident after the training sessions.

Beeston PCN prior to the pilot had a baseline of 21.8% in August 2021 and by the end of the project in June 2022 had a Heart Failure (HF) review percentage of 29.6%. The improvement in %HF reviews represent an absolute increase of 7.8% and a relative increase of 36% from baseline in Beeston PCN. Furthermore, Beeston PCN exceeded the 5% target increase set at the start of the 2021/2022 financial year by the local, Leeds Quality Improvement Scheme (QIS).

Middleton & Hunslet PCN prior to the pilot had a baseline of 31.9% which was below the Leeds ICB QIS average of 42%. However, by the end of the project, 63.5% of HF reviews had been completed. This improvement represents an absolute increase of 31.6% and a 99% relative increase from baseline

In addition to patient education, in 26% of cases, HF medicines were optimised. This was either by starting a new HF medicine (45%), dose increase (41%) or HF medicine stoppage (14%). Other non-HF medicines optimisation took place in 4% of cases. Medicines adherence was addressed by the pharmacists in 5% of cases.

The number of patients on the 4 pillars of HF care increased from 12% to 20%. This improvement represents an absolute increase of 8% with a relative increase of 67% from the baseline. The number of patients on loop diuretics increased by 4.5% to 39% representing a relative increase of 16% from the baseline.

50% of reviews did not require additional multi-disciplinary team (MDT) recommendation and for the reviews that did, 18% of cases were recommended for medicines optimisation, 5% recommended for further referral to cardiology, 7% recommended for referral to the community cardiac nurses and 3% needed heart failure diagnosis reviewing.

The feedback from the pilot team highlighted the immense value of collaborative working between health professionals to ensure a smoother pathway for people living with HF to have ongoing optimisation of their medications and also allow for more frequent reviews of their well being to avoid deterioration and hospitalisation.

The pharmacists in particular felt an improvement in face-to-face HF consultation skills and decision making as a result of the ongoing MDT support provided during the pilot programme.

Outcomes:

Upskilling of clinical pharmacists within primary care in managing Heart failure.

Improved heart failure medication optimisation within the pilot PCNs.

Improved percentage of appropriate 6 monthly heart failure reviews within the pilot PCN sites.

Test and assess effectiveness of new Leeds integrated HF pathways and pilot primary care MDT approach including primary care teams, specialist HF nurses and Cardiologists.

Quote From Partner:

Dr Alex Simms

“The Integrated HF pilot PCN project has been something we have envisioned for some time following the realisation of inadequate chronic heart failure care. It really tried to put the patient at the centre of their care. It was great to see the enthusiasm towards the initial project from the PCN directors but more so from the pharmacists. It was great to be a part of a wider team working beyond institutional barriers (LTHT, PCNs, GP Confed, CCS, Novartis), involved in upskilling and then delivering enhanced heart failure care. It felt like a real shift change in not only in improving care but a change in a system orchestrated by HCPs.

Furthermore, it was really pleasing to see the quality of the long-term conditions HF review and this was further reflected in the questions and case discussions during monthly MDTs. This I felt was a real learning event as well for all of us. I have real pride in the way the “system” was able to come together and very grateful to the PCN pharmacists, but also the MedsOpt pharmacy team who really were able to co-ordinate the process via GP Confed. More so, the project has proven the concept of an integrated model of care for heart failure patients and has set the blueprint and benchmark for a city-wide approach. These are exciting times for heart failure care, but I believe there will also be wider benefits from this project to other disease areas.”

Conclusion:

Primary care HCP workforce with the adequate upskilling and support can deliver more in depth and higher quality chronic disease HF reviews. The project also validates the new model of HF service delivery which has a more primary care focus and collaborative working between service providers to improve health outcomes of people living with heart failure and prevent hospital admissions.

Pharmacists were able to achieve quality targets for QIS and Quality Outcomes Framework (QOF) by undertaking this project. Furthermore, they were able to review more complex HF cases and make critical interventions without additional GP support. This frees up more time & resources.

The project helped shape and identify the challenges and success of working as an integrated model. Effective communication between service providers ensures that collaborative working leads to reduced inefficiencies and duplication of work and improves patient care and outcomes by ensuring the right service providers are available at the appropriate phase of the patient's health journey.

Collaborative partnerships can help improve integration and quality within local healthcare systems. Through information sharing and technology transfer, the PCN pharmacists were able to address a HF prevalence gap.

The MDT approach facilitated significant changes to patient care utilising pharmacological and non-pharmacological management plans. It also allowed more timely access to specialist opinion, advice and guidance. It was well received by the pilot team and its successful implementation suggests that expanding this approach across the city will in the long term create economies of scale of HF expertise across PCNs.

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