Abertawe Bro Morgannwg University (“ABMU”) Health Board (which is now Swansea Bay University Health Board)

Abertawe Bro Morgannwg University (“ABMU”) Health Board (which is now Swansea Bay University Health Board) - Executive Summary

Project Name: AMBU Heart Failure Interface Nurse Project

Joint Working Partners: Abertawe Bro Morgannwg University (“ABMU”) Health Board (which is now Swansea Bay University Health Board)

Project Period: December 2017 – August 2021

Joint Working Project Summary:

This JWP which will run for 36 months; it specifically aims at introducing a HF service via the establishment of a hospital-based specialist HF interface team with the purpose of optimising the care of HF patients admitted to Morriston Hospital and Singleton Hospitals for treatment through A&E or into other non-cardiology departments.

The HF service will focus on prompt diagnosis, optimal treatment, rapid access to specialist care and coordination for post-discharge monitoring and follow-up.

Expected Patient Outcomes for this Project:

- Targets for measurement and expected outcomes Moriston Hospital:
- number of HF patients admitted to Cardiac Ward: 80% of HF total admissions in a 12 month period;
- HF patients seen and managed by inpatient HF nurse: 80% of HF total admissions in a 12 month period;
- Primary diagnosis HF 30-day re-admission rates: 25% reduction as compared to baseline

Singleton Hospital:

- number of HF patients admitted to Cardiac Ward: 80% of HF total admissions in a 12 month period;
- HF patients seen and managed by inpatient HF nurse: 80% of HF total admissions in a 12 month period;

Start Date & Duration: December 2017 (44 months duration)

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Abertawe Bro Morgannwg University (“ABMU”) Health Board (which is now Swansea Bay University Health Board) - Outcomes Summary

Project Name: Heart Failure Interface Nurse Project

Partner Organisation(s): Abertawe Bro Morgannwg University (“ABMU”) Health Board (which is now Swansea Bay University Health Board)

Completion Date: August-2021

Outcome Summary:

The data shows that the majority of patients admitted with a primary diagnosis of heart failure are on the non-cardiology wards.

Patients referred to the heart failure service had very different outcomes compared to those not referred. Poor access to the specialist heart failure team was associated with poor patient outcomes and high rates of mortality. The national mortality rate without specialist input is 13.2%4, this was higher within Morriston Hospital.

Key Project Outcomes Data:

During the period that the Advanced Heart Failure Nurse Practitioner (ANP) and in-reach nurse were within the hospital (Sep 2018-Mar 2020), the numbers of patients seen by the team on cardiology wards (88-91%) and non-cardiology wards (43-46%) were higher. Fewer patients were seen when there was no HF specialist nurse within the hospital (Apr-Aug 2020), 70% were seen in cardiology and only 19% on non-cardiology wards.

From September 2020 with one ANP and the loss of the in-reach HF nurse, 86% of HF pts on the Cardiology ward and 38% of HF pts across other wards were seen by the team. Thirty day and twelve month re-admission rates were much higher during the period of time there was no responsive community heart failure team and particularly when there was no in-reach service within the hospital reviewing patients on the non-cardiology wards. In-patient mortality more than doubled when there was a lack of specialist involvement, and 12 month re-admission rates were higher the majority of time.

Outcomes:

Lack of involvement of an inpatient heart failure team is associated with high mortality rates.

Patients referred to the heart failure team had better patient outcomes.

The team promoted early access to diagnosis, and regular review to support in optimization of standard medical therapy and ensured a smooth, co-ordinated transfer of care to the Community Heart Failure Team.

The loss of nursing support from March 2020, clearly has a negative impact on the number of patients seen within the hospital with heart failure.

Quote from Partner:

"The Joint Working Project with NOVARTIS has transformed the way we deliver care to heart failure patients within our hospital, facilitating an outreach service and hospital wide heart failure ward rounds. This has enabled the provision of early intervention and optimal management from a dedicated specialist heart failure team and a seamless co-ordination of care on discharge.

It has been an incredible experience to work in a team that is endlessly flexible, resourceful and exceptionally patient focused. I would also like to thank NOVARTIS for their encouragement and support over the last few years in this successful project".

Delyth Rucarean

Conclusion:

A business case has been submitted to expand the team to include the ANP role, with a further five

nurses/physician assistants and a one HF Consultant.

This will inevitably further improve patient outcomes. A responsive Community HF Team will facilitate integrated working of hospital and community specialist teams and will improve outcomes.

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