January 2019

Janaury 2019

Accordion:
The Development of an Integrated Heart Failure ("HF") Service with Cardiff and Vale University Health

Project name: The Development of an Integrated Heart Failure ("HF") Service

Joint Working Project Summary:

The principal aim of this joint working project is to deliver the benefits to patients of improved access to optimal diagnosis and treatment, more equitable and consistent access to care and an enhanced experience for patients and their carers who live with HF. This will be achieved through an extension of the current hospital-based specialist HF service through the deployment of an "in-reach" nurse with the purpose of identifying and triaging HF patients so they can be appropriately referred to the relevant Cardiology service and receive specialist HF input, and subsequently coordinating the discharge of patients and liaison with community teams to ensure continuous appropriate care for HF patients after their discharge from hospital.

Expected Patient Outcomes for this Project:

The following main measures, among others, will be evaluated by CVUHB:

1. development of an in-patient strategy/protocol and implementation procedures of the same to govern the clinical operations of the HF Service
2. Patient satisfaction linked to the HF Service (PREMS)
3. positive increase against the following baseline percentage measures as stated in the most up to date NICOR HF audit (whether published or not) for the CVUHB of:
    - input from Consultant Cardiologist
    - input from HF specialist
    - HF patients who received discharge
    - planning
    - HF patients referred to HF nurse for
    - follow up upon discharge

Outcomes are to be reviewed at 6, 12, and 18 months after the HF Service have commenced.

Start Date & Duration: January 2019, 24 Months

NHS Hillingdon CCG

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, 18 Months
