Northern Care Alliance

Northern Care Alliance - Executive Summary

Project Name: Northern Care Alliance Joint Cardiorenal Service Joint working

Project Summary:

The Northern Care Alliance NHS Foundation Trust is the largest foundation trust in the country, created from a merger of Salford Royal Foundation Trust and the Pennine Acute Hospitals NHS Trust. This covers over 1 million patients from Greater Manchester and beyond, with an estimated 14,000 with HF and 39,000 with CKD.

These patients often are seen in both the HF and CKD services, which inconvenience patients, who must have two separate appointments. The duplicate appointments add to existing backlogs in both services.

In particular there is general unease around management of HF patients in the community primarily caused by a lack of confidence initiating innovative medicines for these patients in the community. Therefore, primary care refer these patients into secondary where they add to the backlog. By addressing the complex CKD/HF patients, an estimated 2000 clinical slots will be freed up.

Greater Manchester is also wanting to improve access to specialist care as part of the HSCP Plan, this project would support that aspect of their ambitions, including improving and standardising place based care across the Northern Care Alliance. QoF 2022 will have focus on identifying HF patients in the community, creating capacity in the HF service, which will ensure patients have access to care once identified.

This project would create a Cardiorenal Care pathway, which would be the first dedicated Cardiorenal pathway in the country to bring together multiple disciplines in an innovative way to improve patient care. The outputs of this project will allow other areas to replicate the case for change, funding and the blueprint for a Cardiorenal Care Pathway of which there is currently a gap nationally.

Milestone	Date	Description
1	Project Kick-off meeting May 2022	Agree project terms of reference, define plan to begin clinical ops, Project Kick off
2	1 month after the completion of milestone 1 (kick-off meeting)	Support service manager in place, database live, clinical governance agreed
3	3 months after completion of milestone 2	Nurse team in place and clinical ops begin PROMs tool in place Report on baselines
4	3 months after completion of milestone 3	Completion of 3 months of clinical operations, 3-month measurements collected
5	3 months after completion of milestone 4	Completion of 6 months of clinical operations, 6-month measurements collected
6	3 months after completion of milestone 5	Completion of 9 months of clinical operations, 9-month measurements collected
7	3 months after completion of milestone 6	Completion of 12 months of clinical operations, 12-month measurements collected
8	1 month after completion of milestone 7	Submission of a Business case for the HF/ CKD joint service
9	1 month after completion of milestone 8	Completion of the Joint Working Report

Expected Benefits:

Anticipated Benefit to Patients

- Shorter waiting lists
- Streamlining of patient care
- Less duplication of appointments
- Faster access to innovative medicines

Anticipated Benefit for the Organisation(s)

- Increase in capacity for HF and CKD clinics
- Recognition for creating for HF/CKD Clinic in the UK and creating a solution which could be rolled out nationally
- Increase the overall quality of care and improve equity of access to specialist care for patients with HF and CKD

Anticipated Benefit to Novartis

- Improved access to NICE approved innovative therapies for the treatment of HF
- Enhanced reputation as partner of choice in working in collaboration with the NHS

Start Date and Duration: May 2022, duration 18 months

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Northern Care Alliance - Outcomes Summary

Project Name: Northern Care Alliance Joint Cardiorenal Service Joint working

Completion Date: December 2023

Outcome Summary:

The 'Northern Care Alliance Joint Cardio-Renal Service' project has created a dedicated joint Heart Failure (HF) and chronic kidney disease (CKD) clinic, which is the first of its kind in the UK. The rationale behind running a joint HF/CKD clinic is that more than half of patients with HF also have CKD, meaning a single clinic making care more efficient and eliminating conflict in care plans and challenges in communication between both services.

Key Project Outcomes Data:

Our collaboration has had the following impact;

- Reduced demand on the individual heart failure and renal services.
- Increased capacity across the two services by 200 additional available patient appointments over the course of the project.
- Increase in number of patients receiving input from cardiorenal service; 8 patients per week at baseline increased to 32 patients per week at final milestone at 12 months.
- Percentage of patients on all four pillars of therapy increased from 7.5% at baseline to 63% at final milestone at 12 months which potentially will lead to reduction in future events.
- Increase in number of patients with post discharge review-activity not carried out prior to project therefore baseline of zero, increasing to 149 at final milestone at 12 months. (142 remote and seven face to face)
- Business case submitted and accepted for on-going funding of nurse support.

Outcomes:

Prior to initiation of this project the clinical team at The Norther Care Alliance undertook a pathway mapping exercise in order to ascertain the optimal resources required for Heart failure and chronic kidney disease patients. The resulting changes were identified as being required;

- Consultant led HF/CKD clinic.
- Advanced Nurse Practitioner (ANP) 45/45 HF Clinic
- ANP led HF/CKD Drop-In Clinic
- HF/CKD Multidisciplinary Team Meeting (MDT)
- On-line advice and guidance (A&G)

It was also uncovered that additional nurse resource would be required.

As a result of the implementation of the joint cardio-renal service the following benefits to patients and the organisation have been seen;

- Increased capacity in both the cardio and renal individual services with the implementation of a new joint cardio/renal service
- Convenience for patients being seen at one, rather than two appointments.
- The combined clinic led to an elimination in conflict of care plans with the streamlining of patient care and faster access to optimal medications, if required.

Conclusion:

This project created the first dedicated cardio-renal care pathway in the UK, bringing together multiple disciplines in an innovative way in order to improve patient care. The success of the project can now be utilised as an exemplar allowing other areas to replicate the case for change, funding, and the blueprint for a cardio-renal care pathway of which there is currently a gap nationally.

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