KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Integrated Heart Failure Service Southwark and Lambeth

One Year Project Review

Guy's and St Thomas' NHS Foundation Trust and **King's College Hospital** NHS Foundation Trust are working together to develop integrated heart failure services for people living with heart failure in Southwark and Lambeth.

The project was launched in spring 2016 with the aim to help people with heart failure live longer with a better quality of live in their homes.

Our goals

1. **Early and accurate diagnosis of heart failure**: to ensure more patients are diagnosed and receive the treatment they need as soon as possible

2. **Equitable access to specialist care**: to ensure patients have access to specialists and be prescribed evidence based treatment

3. **Good long term condition management and patient centred holistic care**: to ensure all of a patients' needs are met in the most efficient and effective way

4. **Avoiding unnecessary hospital admissions**: to keep people at home in their communities wherever possible

KING'S College LONDON

NHS Guy's and St Thomas' NHS Foundation Trust

NHS King's College Hospital NHS Foundation Trust

NHS South London and Maudsley NHS Foundation Trust

Vision for the Integrated Heart Failure Service

Some good relationships and cross working

No cardiologist involvement in community

Spring 2017 - Integrated service stage 1

Cross site meetings and collaborative team working moving towards an integrated King's Health Partners (KHP) service

Southwark and Lambeth's 5 localities have named locality cardiologist, HF clinical nurse specialist, and 2 clinical pharmacists to cover all areas

Locality teams visit GPs to review the care of HF patients in 'virtual clinics' ensuring patients are receiving optimal care and treatment

Autumn 2017 - Integrated service stage 2

Standardised processes and patient management documentation in place with regular cross site team meetings and joint working

Cardio-respiratory joint working to better coordiante care for patients with 2 long term conditions (LTC)

Spring 2018 and beyond - Integrated service stage 3

One single KHP Integrated Heart Failure service with robust standardised protocols for excellent patient care

Agreed care processes and plans for patients with 3 + LTCs and joint working between HF locality teams and other locality specialists to coordinate patient care

Heart Failure Key Facts

900,000 people are estimated to be living with heart failure in the UK

11 days is the average length of stay for a heart failure admission

£3,000 approximate cost per heart failure hospital admission

30-40% of patients diagnosed with heart failure die within a year

Locally **9,000** people are estimated to be living with heart failure in Southwark and Lambeth but **less than 3,000** are known to services.

Heart Failure Service Outcomes

2015/16

- **34** GP practices visited by HF team for virtual clinics
- **0** cardiologist-led virtual clinics
- **679** patient records reviewed
- **567** patients referred to the community based heart failure team

2016/17

- **38** GP practices visited by HF team for virtual clinics
- **17** cardiologist-led virtual clinics
- **605** patient records reviewed with **409** interventions made such as changes to medications or referral to specialist clinics
- **644** patients referred to the community based heart failure team

2017/18 Quarter 1

- **5** GP practices visited by HF team for virtual clinics
- **5** cardiologist-led virtual clinics
- **132** patient records reviewed with **97** interventions made
- **178** patients referred to the community based heart failure team

What we have achieved and our vision

	Then: 2015/16	Now: 2016/17	Autumn 2017	Spring 2018 and beyond
Early and accurate diagnosis	HF is often diagnosed late or misdiagnosed as a respiratory disease. Many GPs and other healthcare professionals are unclear of the diagnosis pathway. There is a breathlessness assessment algorithm in place to help GPs assess breathless patients for possible HF but there is low awareness and use of the tool →	HF pathway tool and new breathlessness assessment algorithm co-designed with GPs. Tools are user friendly aids for diagnosing and managing HF. Awareness day events held with communication campaign to raise awareness of signs and symptoms of HF and new educational materials in place →	GP breathlessness assessment algorithm and HF pathway in use in all local GP practices and embedded on GP decision support IT system, improving local diagnosis rates →	All GPs and clinicians in Southwark and Lambeth are familiar with the signs and symptoms of HF and regularly use the diagnostic pathway tools. GPs find it easy to refer patients to a one stop diagnostic clinic at the 3 local hospitals and HF is diagnosed quickly for all patients. HF pathways are embedded in local estate strategy, working towards a model where each local care network has a community hub, improving access to specialist HF diagnostics

	Then: 2015/16	Now: 2016/17	Autumn 2017	Spring 2018 and beyond
Equitable access to specialist care	Varied patient access to specialist care →	All GPs have access to specialists via phone or email 5 days a week →	All GPs have access to HF pathway with clear instructions for referring to specialists. GPs have begun to implement 6 monthly reviews →	All patients receive a 6 monthly review by either a GP or HF specialist dependent on complexity
	No cardiologist presence in the community. A lack of understanding amongst hospital specialists of local GP roles, priorities and functions →	5 HF locality teams launched in January 2017 – each locality in Southwark and Lambeth has a named HF clinical nurse specialist, cardiologist and 2 pharmacists cover all localities Cardiologists join nurses and pharmacists to visit GPs for virtual clinics to review complex patients and deliver education →	Specialist locality teams are familiar with local GPs, have visited practices and delivered training at GP events. Specialist teams understand GP roles and functions →	Locality HF teams work alongside local GPs and other specialists to provide coordinated virtual clinics to review complex patients with multiple long term conditions
	GPs have varied awareness of service and varied experience of accessing specialists for advice →	3 GP champions and project team raising awareness of the HF service →	Local GPs know how to contact specialists for advice →	Single point of access for Integrated HF service making referral and access to specialists advice easy

What we have achieved and our vision

High quality care: good long term condition management and patient-centred holistic care

Then: 2015/16	Now: 2016/17	Autumn 2017	Spring 2018 and beyond
2/3 HF patients have more than 2 other LTCs and a third of patients experience anxiety and depression. Care is often not coordinated and within HF care patients often see different clinicians as processes are not standardised i.e. pharmacists, cardiac rehab, elderly care, palliative care	Joint working with mental health and other LTC specialists in place. Initial work in progress to identify ways to improve cardio-respiratory pathways and trial a lead specialist model to coordinate care for people with multiple conditions	Protocols in place to standardise delivery of care and avoid duplication with other LTC specialist teams and elderly care teams Standardisation ensures all appropriate patients are offered cardiac rehab, patient's mental health needs are assessed as part of routine care and end of life considerations are consistently assessed	HF specialists are equipped with the skills they need to provide holistic patient management Agreed processes in place for managing patients with multiple long term conditions, including introducing a named HF clinician where HF is the primary concern, and clear plans in place for transfer of care between teams. Integration underway with social care services and mental health is assessed as standard. All clinicians up-skilled to provide low level psychological interventions where needed
Lack of systematic patient feedback to improve services	Regular patient workshops, interviews and surveys in place with systematic processes to respond to patient views	Work underway to develop sustainable process for engaging with patients	Sustainable process for engaging with patients through patient support groups in place
Variation in the care provided by HF specialists Different local guidelines, pathways, clinical models and processes used in each of the 3 separate teams	Standard Operating Procedure (SOP) developed by HF clinical nurse specialists HF medication prescribing guidelines & KHP HF clinical nurse specialist competency framework in place to standardise patient care and facilitate continuous professional development	Protocols for medical management of HF agreed across KHP Standardised proactive pharmacist intervention with patients under specialist teams to help ensure adherence to medication and that they are titrated to maximum tolerated doses	Standard Operating Procedure for HF clinical nurse specialists and protocols for medical management implemented across KHP Regular audits in place to monitor adherence to best practice pathways and delivery of high quality coordinated care for patients with HF
Variation in GP and other healthcare professional knowledge and confidence in managing HF patients	Comprehensive education plan and education pack co-designed with specialists and GPs with annual GP and community pharmacist education evenings in place, and 4 nurse study days held	Comprehensive education plan rolled out, reviewed and updated Education and training sessions introduced for nursing home nurses	Comprehensive education library in place with sustainable education programme for generalists and other specialists including accredited nurse study days

What we have achieved and our vision

	Then: 2015/16	Now: 2016/17	Autumn 2017	Spring 2018 & beyond
Unnecessary hospital admission avoidance	No regular evaluation of causes of emergency HF admissions in place No rapid access to cardiologist review for patients deteriorating at home	Route cause analysis carried out for emergency admissions to better understand why patients are admitted to hospital and if these can be avoided Regular multidisciplinary review of all patients who are readmitted to hospital within 30 days of discharge and reflection on areas to improve	Ambulatory unit pilot in place at both sites to help reduce length of stay for patients who are admitted to hospital and help avoid admissions for patients who are deteriorating in the community and require a cardiologist review and treatment to help keep them out of hospital	Ambulatory unit includes new processes to help avoid A&E attendances. Ambulatory units evaluated and implemented if successful with rapid access cardiologist review in place for patients deteriorating in the community
	Unclear pathways with the local admission avoidance service hospital @home	Work underway to review @home pathways to optimise use of the admission avoidance service	New @home HF management pathways in place	All HF staff are familiar with @home HF management pathways and use regularly where required
	Variation in discharge planning and unclear processes including transfer of care	Standard Operation Procedure for clinical nurse specialists includes standardised specialist input into discharge planning, transfer of care and post discharge follow-up appointments	Known HF patients admitted to hospital are flagged to HF specialist team for review HF patients admitted to hospital have specialist management plan included in their hospital discharge plan. All HF patients receive a phone call within 48 hours of discharge.	KHP discharge checklist in place for optimal transfer of care following a hospital admission
	Variation in patient self-management advice and education	Sound Doctor patient education films launched, new patient education resources and ID card with symptom checker launched to aid patient self-management	All patients are provided with an ID card with symptom checker to help identify the warning signs of deterioration and have contact details for their healthcare professional	All patient education resources streamlined with a checklist in place to ensure every patient receives comprehensive education across the service

Integrated Heart Failure Team

What has worked well?

"I think we have successfully managed to raise the profile of the HF team across Lambeth and Southwark. The pharmacists have managed to become an integral part of the heart failure service; the number of medicines related queries we receive from the team has significantly increased over the last year.
Gayle Campbell, Senior Heart Failure Clinical Pharmacist

"Since the project has been initiated, there has been a real coming together of the hospital and community team. Staff are working together and thinking about how to improve processes. It has also been really excellent having multi-disciplinary team meetings running at both sites."
Lynda Blue, Senior Nurse Advisor

"Working within a large integrated service has been challenging but inspirational. There has been increased sharing of knowledge and experience which has not only enhanced existing services but will help us innovate further into the future. It has proven invaluable in improving patient experience and care."
Carys Barton, Lead Clinical Nurse

"Having GP champions and the support of the community cardiologists has really worked well to improve the service we provide to local GPs"
Clare Thomson, Senior Heart Failure Clinical Pharmacist

"We have improved access to HF cardiologists for our GPs and community nurses. Working with other teams involved in caring for patients with multiple long term conditions via our new community focused virtual clinics & multidisciplinary team meetings has also worked really well."
Julia Decourcey, Consultant Nurse for Cardiac and Heart Failure Service

"Developing new prescribing guidelines and pathways with our GP champions have been a real success. We've also learnt a lot from going out to GP practices for virtual clinics. The large scale GP education sessions have also been extremely useful to help upskill generalists and help specialists understand how to improve our services to best fit with what GPs need."
Dr Gerald Carr-White, Consultant Cardiologist and Clinical lead for Cardiology

"It has been fantastic working collaboratively with secondary care colleagues to understand, appreciate and resolve problems associated with delivering care to our patient population. Having a truly integrated approach has allowed a common voice to improve overall patient experience and equity of care. This approach has allowed for a uniform message to all providers."
Dr Sumeeta Dhir, GP Heart failure Champion, Southwark

What would you do differently?

"I would have identified clearer roles and responsibilities, with robust goal setting and timescales. This may have helped us improve the management of the many challenges and measurement of outcomes."
Carys Barton, Lead Clinical Nurse

"In hindsight, I would have set up GP champions earlier; tried to drive more integration across Southwark and Lambeth Clinical Commissioning Groups, and focused on integration with elderly care clinicians early on to streamline care for elderly or frail patients with multiple conditions."
Dr Gerald Carr-White, Consultant Cardiologist and Clinical lead for Cardiology

“Ideally, we should have adopted a robust IT reporting and monitoring tool with clear patient quality measures to track achievements and improvements to care. We will ultimately know how well we are doing when we track improvements in length and quality of life across the population.”
Julia Decourcey, Consultant Nurse

“It is exhausting improving services alongside a day job and that needs to be recognised and rewarded every step of the way. I would have reflected on our achievements more regularly and made sure everyone celebrated the work of others. I would also make sure all team members had clear responsibilities that they owned from day one. I think this would help embed and sustain service improvement.”
Amy Clark, Integrated Heart Failure Service Project Manager

"Being involved in the service redesign has been a huge learning curve. In an ideal world I would have joined the team earlier to better understand the multiple layers of integration and change from the outset, and how change affects staff's well-being and morale"
Lindsay Ip, Principal Clinical Psychologist, Three Dimensions for Long Term Conditions 3DLC

What have you learnt?

“There’s lots of information out there about how change works – people say for example that half way through a service transformation programme is the ‘worst bit’ as people may have lost initial motivation. I would communicate this so the team know ups and downs are normal and then discuss how to overcome the downs. I would also say never underestimate the power of a good team meeting, especially when clinical leads are there to set direction & bring everyone together. Similarly the power of quality data – prioritise this!”
Amy Clark, Integrated Heart Failure Service Project Manager

“I have learnt how valuable it is to engage enthusiastic healthcare professionals from the start”
Professor Theresa A McDonagh, Consultant Cardiologist

“Change management is hard! I have learnt to keep focussed and encourage the rest of the team.”
Clare Thomson, Senior Heart Failure Clinical Pharmacist

“I’ve learnt that good practice from each individual site was transferrable and how valuable the contribution of our elderly care teams are for older patients”
Julia Decourcey, Consultant Nurse

"The role of psychology/psychiatry in this integration project is more than offering clinical consultation and treatment. Working together with the project manager and clinical leads, we were able to include mental health in most aspects of the integration project, such as breathlessness pathway development, rehab, patient and GP education, virtual clinics, and analysis of frequent admissions for example.”
Lindsay Ip, Principal Clinical Psychologist, Three Dimensions for Long Term Conditions 3DLC

What are you most proud of?

“The whole team! I’m also particularly proud of the sound doctor films for patient education we have produced and the work we have done integrating with psychological care and across other long term conditions.”
Dr Gerald Carr-White, Consultant Cardiologist

“The passion from staff and really putting the patient first!”
Lynda Blue, Senior Nurse Advisor

“I am extremely proud of the team’s ability to cope with so many changes and innovations over a short period of time. The positive reputation of the HF team has grown and is reflected in the referrals to our service and the greater local/national awareness of the HF service provide. The relationship with our Primary care colleagues is enhanced so that we can work cohesively to improve the care we deliver.”
Carys Barton, Lead Clinical Nurse

“Being part of a team that is so dedicated to improving patient care - in all discussions the focus is consistently clear: making sure people with heart failure live for longer with a better quality of life. We’ve had some significant achievements over the last year like launching a new GP pathway and standard operating procedures – hearing praise for these achievements is great. One GP recently said “the service is leading the way in trying to integrate with other long term conditions!”
Amy Clark, Integrated Heart Failure Service Project Manager

“Recently, we put posters up on all wards and in A&E reminding teams of the acute diagnosis pathway. There were 2 patients in A&E that were picked up via this diagnosis pathway that previously would have been sent home. As a result, we managed to get them on appropriate medical therapy & improve their quality of life, this was a proud moment”
NasaMarie Emode, Heart Failure Specialist Nurse

"Being part of such a dedicated and friendly team and together producing a comprehensive GP education pack. This will really improve the primary and secondary care interface for the management of our heart failure patients."
Dr Naomi Stent, GP Heart failure Champion, Lambeth

“The enthusiasm shown by all members of the team to work towards reducing patient and carer burden by 1) adopting one stop diagnostic clinics 2) ensuring that once diagnosed patients are seen quickly by community HF nurses either at home or in clinic and 3) making sure all patients have a key HF nurse for support and that each nurse has direct access to the wider HF team for advice and supervision.”
Julia Decourcey, Consultant Nurse

"I am very proud of the whole team for their devoted focus on patient centred care amidst change, including the champions who advocated for creating a heart failure service that is also psychologically informed. A number of heart failure clinics are now screening for depression and anxiety routinely, treating it as another vital sign"
Lindsay Ip, Principal Clinical Psychologist, Three Dimensions for Long Term Conditions 3DLC

“Great progress has been made in the past 12 months, we’ve had a successful year of Virtual Clinics visiting 38 local GP practices to improve patient care. With our medication adherence work we also have the opportunity to be national leaders and are looking to set up a randomised controlled trial.”
Gayle Campbell, Senior Heart Failure Clinical Pharmacist

“Having the new heart failure pathways and prescribing guidelines approved and disseminated across South London has been very encouraging. I personally have learnt a great deal and feel very proud to be a part of the integrated Heart failure service with individuals who are dedicated to improving patient care.”
Dr Sumeeta Dhir, GP Heart failure Champion, Southwark