University Hospitals Coventry and Warwickshire NHS Trust

Health Innovation WEST MIDLANDS

Kirkland S, University Hospitals Coventry and Warwickshire

Kuehl M, University Hospitals Coventry and Warwickshire

Richards P, Health Innovation West Midlands and University Hospital Birmingham NHS Trust

Heart Failure at Home – A Palliative Care Approach

Background

Coventry and Warwickshire ICB already had a Hospital at Home service to include heart failure (HF) patients. However, they wanted to develop heart failure at home services further by adding in a palliative/supportive care component, which was inclusive of patients discharged from hospital, hospital at home services and patients within the community who have advanced heart failure.

Therefore, they sought funding for the NHS Managing Heart Failure @ Home programme. Managing Heart Failure @ Home aims to support people to manage their heart failure condition and keep well at home, using remote monitoring, supported self-management and education to minimise unnecessary face-to-face appointments and reduce avoidable hospital admissions.

Purpose

The purpose was to provide seamless care for particularly vulnerable patients who are at high risk of either dying or being readmitted.

The objective of the proposed service was to educate patients with heart failure and their relatives about the patient's condition, develop advanced care planning, expand the integrative approach to existing community palliative care services and provide extra heart failure supportive care for the end of life phase.

The aim of this service is to:

- Improve the patient's satisfaction and quality of life
- Reduce admission and readmission rates
- Reduce healthcare costs
- Provide carer's support
- Increased preferred place of death

Discussion

Although this project is still currently running, there have been many lessons learnt so far including;

- Having one solely designated project lead to review heart failure patients has led to standardised approaches to care but is a heavy caseload on one person.
- Stakeholder engagement with primary care has not necessarily led to more patients being referred.
- Remote monitoring in this group of patients is not always appropriate as they are very unwell and have multiple comorbidities. Patients reported feeling a reassurance that they were being monitored, but sometimes found it a burden daily.
- Having a designated heart failure palliative care nurse has led to more patients having advanced care plans in place and patients feeling satisfied that someone is monitoring their deterioration.
- Due to the patient cohort, this approach has not always avoided hospital admissions.

Conclusion

In the absence of a designated heart failure palliative care team, many heart failure patients do not normally have the option to plan their last few months of life. This approach has enabled patients to have one point of contact to advise them on that planning as well as work with them to improve their symptom control. However, remote monitoring and monitoring project outputs through questionnaires has been challenging with this cohort of patients. It has been difficult to prove whether this approach does reduce hospital admissions, again due to the cohort of patients, however we hope that patient education was deemed important to enable these patients to have a personalised care approach to the final stages of their life. The project is ongoing and will be fully evaluated by the NHSE national team.

Methods

- We appointed an advanced care practitioner with heart failure experience to lead and develop the new heart failure palliative care at home pathway and to review the patients.
- We engaged with primary care clinicians, palliative care team and existing heart failure nursing teams to determine referral pathways into the service.
- We developed a four-visit pathway to include education, assessment, self-management tools and advanced care planning.
- We introduced a virtual monitoring platform, Docabo, to allow us to track the symptoms and clinical observations of patients to assist in the clinical assessment.
- We onboarded admin support to enable us to develop patient information packs, send questionnaires and to provide audit support.
- We gained project support from Health Innovation West Midlands project manager that sought out appropriate resources, contacts and data that enabled us to learn from other areas.

Results

This project is ongoing. However, outputs identified so far have been;

- 54 patients onboarded onto project.
- Docabo virtual monitoring system introduced to 15 patients.
- Patient education packs provided to patients.
- 47 hospital admission avoidance interventions were undertaken, saving the system approximately £60,000 in six months after removing costs of project.
- 39 patients had advanced care planning discussions.
- Eight patients had RESPECT forms completed.
- Most referrals received from existing heart failure care team.
- 10 patients died whilst on project, six of these in their preferred place of death and seven had RESPECT forms.

Pathway of project

Early Identification

Referral Criteria:

1. Severe and persistent symptoms of heart failure despite optimal treatment
2. Two or more unplanned hospital admissions in the past six months
3. Expert opinion when anticipated prognosis in 1-2 years of life

Comprehensive Assessment

Visit 1: Introduce palliative care elicit patients' understanding of their illness, baseline holistic assessment and form management plan. On-board with telementoring. Complete baseline questionnaire.

Visit 2 (approx. 2 weeks later): Holistic assessment and review management plan, review and re-reinforce self-management topics.

Visit 3 (approx. 2 weeks later): Holistic assessment, review management plan, introduce discussions around advanced care planning, resuscitation status and preferred place of death.

Visit 4 (approx. 2 weeks later): Holistic assessment, review management plan, document 'Advanced Care Plan', completion of outcome related questionnaires.

Anticipatory Care Planning

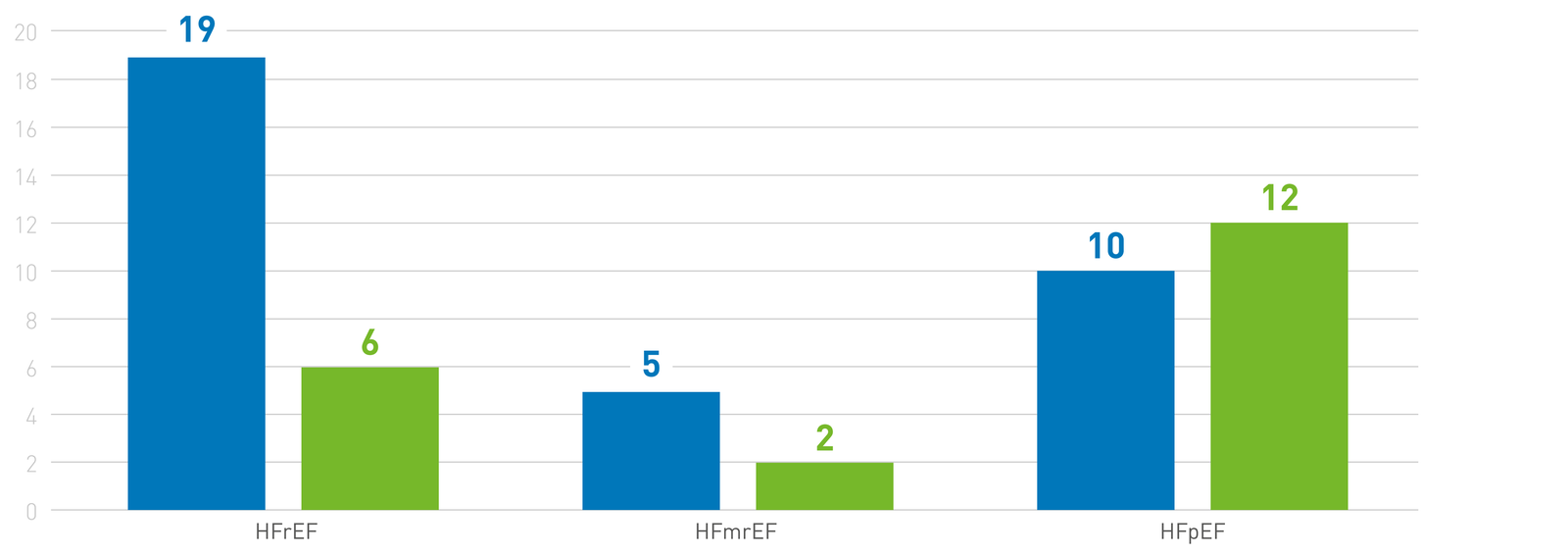
Ongoing reviews / Patient initiated follow up

With or without telemonitoring

End of life care

Cohesive Collaborative Multidisciplinary working

Graph showing gender and types of HF recruited



Resources:

To find more information on heart failure, please scan the QR codes.

Managing Heart Failure @ Home, **NHS England**

Heart Failure, **Health Innovation West Midlands**

Managing Heart Failure at Home in Primary Care

Stephenson J,
Wargrave, Belmont and Cantilupe PCN

Vaicekausekaite A,
Taurus Healthcare

Taylor E,
Wargrave, Belmont and Cantilupe PCN

Southerby S,
Wye Valley Trust

Kuriakose D,
Wargrave, Belmont and Cantilupe PCN

Richards P,
Health Innovation West Midlands and University Hospital Birmingham

Background

The Wargrave, Belmont and Cantilupe (WBC) primary care network (PCN) within Herefordshire and Worcestershire integrated care system (ICS) identified that their prevalence of heart failure was below the average of their ICS and had decreased over time. They had no community heart failure service and admissions for heart failure within the ICS had risen from 245 to 403 in one year.

Therefore, they sought funding for the NHS Managing Heart Failure @ Home programme. Managing Heart Failure @ Home aims to support people to manage their heart failure condition and keep well at home, using remote monitoring, supported self-management and education to minimise unnecessary face-to-face appointments and reduce avoidable hospital admissions.

Purpose

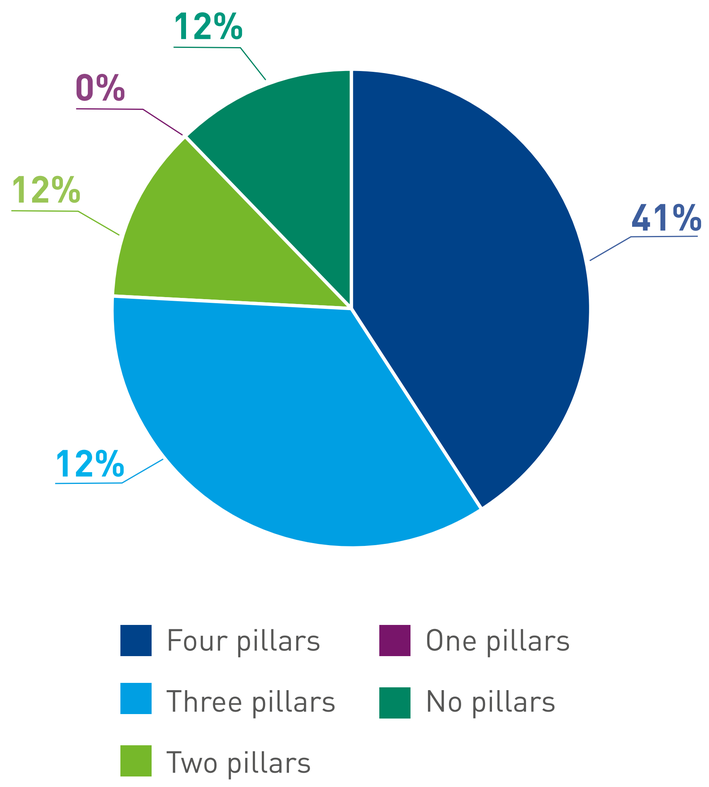
The aims of the WBC PCN Managing Heart Failure @ Home programme are:

- To improve identification of heart failure patients.
- To improve management and self-monitoring of heart failure patients.
- To demonstrate innovation in home monitoring of primary care patients.
- To improve self-escalation of heart failure patients.
- To improve discharge pathways for heart failure patients from the acute trust to primary care.

Methods

- We commissioned the West Midlands Health and Wellbeing Innovation Network to run a series of design thinking workshops to bring stakeholders together to identify the needs of our heart failure patients and to design an onboarding pathway.
- We appointed a project manager, which enabled a project plan to be developed, a steering group to be established and relevant stakeholders to be brought in at appropriate times.
- The PCN proactively selected stable heart failure patients in the community with a NYHA scale one and two only to support clinically. This was done by undertaking a robust case finding exercise using 'Oberoi consulting' clinical audit systems.
- We established an internal SWAT team which included a GP, RGN, ANP, Pharmacist and Care Coordinator to form a MDT approach for the patient.
- The PCN built links with Health and Wellbeing Coaches and Social Prescribers to be able to offer recruited patients additional input and support on an individual basis.
- We introduced a virtual monitoring platform, Docabo, to enable recruited patients to share clinical observations and to provide feedback through questionnaires.
- We gained support from Health Innovation West Midlands project manager that sought out appropriate resources, contacts and data that enabled us to learn from other areas.
- We gained support from the ICS data team to enable us to develop a dashboard that enables us to monitor progress.

Number of patients optimised to four pillars of heart failure medications



Feedback we received

> Pleased with all the care from health professionals. Big thank you to Dr Stevenson who has been with me right from the start. I feel less stressed and anxious after seeing Dr Stevenson.

> Esther has helped more than any. Mandy checks on me by phone every three months. Esther makes me feel more confident when I see her. Thank goodness for nursing professionals.

Challenge statements

Results

This project is ongoing. However, outputs identified so far have been;

- Casefinding exercise resulted in prevalence increasing from 1% to 2%, therefore improving capability to recall patients for clinical reviews.
- Recruited 20 stable heart failure patients from one practice within the PCN, inviting them in for clinical review, medication review and education, and providing them with a Docabo virtual monitoring device for them to submit clinical observations whilst titration of medications were happening.
- A pharmacist technician was available for some onboarding input, and 15 patients have had medication reviews and are in the process of being optimised.
- Patients have been identified earlier that require specialist input from the secondary care service.
- Presented project at various ICS forums to promote spread and adoption.
- Have attended secondary care heart failure MDT meetings which has been a good avenue to discuss complex patients.
- Education provided to other pharmacists within ICB which has led to them also attending MDT sessions.

Discussion

Although this project is still currently running, there have been many lessons learnt so far including;

- Having a designated workforce to review heart failure practice enables change.
- Appropriate stakeholder engagement events have been a catalyst for the implementation of the project, resulting in an enthusiastic project team accelerating actions and reviewing progress.
- Remote monitoring usage within primary care can be useful to enhance reviews, but difficult without appropriate designated resource and is very dependent on patients capability, and requires adequate staff training on its use.
- Collaboration between secondary care and primary care improves care pathways. However, data sharing agreements between providers is a barrier.
- Case finding exercises improve registers to enable timely reviews.
- Onboarding of patients by having a specific criteria was more challenging due to the complexity of the patients.
- There is plentiful enthusiasm and interest for this to be spread across other PCNs, but workforce capacity is a barrier.

Conclusion

In the absence of a community heart failure service, the implementation of Managing Heart Failure @ Home within a primary care setting has enabled an area to improve its provision of heart failure care. It has provided opportunities for primary care staff to develop in a speciality, and to receive education in remote monitoring. Patients have had evidence based medications added or changed, and some have been identified appropriately for specialist care input. This model of care could have extremely positive outcomes for patients and for the health economy of a system, however additional resource in both time and workforce is required for the longer term benefits to be achieved. A full evaluation commissioned by NHSE will be available following full completion of the project.

Resources:

To find more information on heart failure, please scan the QR codes.

Managing Heart Failure @ Home,
NHS England

Heart Failure,
Health Innovation West Midlands