Introduction

There is a sense in which discussing heart failure leads to a feeling of heart 'sink'.

We know what good treatment looks like\(^1,2,3\), yet too often the care that patients receive is sub-optimal\(^4\). We know that sub-optimal care results in poor outcomes for patients, including high rates of morbidity and mortality. We know that sub-optimal care is costly for the NHS, and leads to lengthier stays and more frequent readmission to hospital\(^5\).

It’s time to focus on the ‘triple value’ gained from improving care for patients with heart failure and commission services that deliver better outcomes, better patient experience and better productivity. It’s a value that can only be released by sharing care between patients, the GP and the hospital.

This paper examines the levers that clinical commissioning groups can use to get a grip on heart failure, and was developed from a one-day meeting of clinicians and commissioners convened by Achieving Commissioning Excellence.

Introduction contd.

On November 7, 2013, Achieving Commissioning Excellence convened a panel of clinicians and commissioners to explore what commissioners need to know about commissioning heart failure services and redesigning the pathway.

**SUBJECT MATTER EXPERTS**

- Dr Mark Dancy, consultant cardiologist and clinical lead, NHS Improvement, Heart Failure
- Dr Peter Macdougall, GP, Mansfield and Ashfield CCG
- Jennifer Gove, heart failure specialist nurse, Central Manchester University Hospitals Foundation Trust

**ACE GROUP**

- Michael Sobanja, director of policy, NHS Alliance
- Richard Alsop, chief commissioning officer, Nene CCG
- Hugh Janes, head of strategy and service development, Fareham and Gosport CCG
- Dr Donald Hynes, co-chair NHS Alliance, GP
- Professor Ursula Gallagher, nurse executive, North West London CCGs
- Julie Wood, director, NHS Clinical Commissioners

ACE is a partnership between NHS Alliance and Novartis Pharmaceuticals UK Ltd.

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**KEY FACTS**

- Heart failure is the most frequent cause of emergency hospital admission (5%).
- Heart failure accounts for one million inpatient bed days a year, 2% of the NHS total.
- It is present in 10% of patients.
- It affects around 700,000 people in the UK.
- 9.4% of acute heart failure patients likely to die in hospital.
- 24.6% die within one year of admission.

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**THINKING POINTS**

- For every 100,000 population, you can expect 40 new cases each year.
- Around 1,440 people per 100,000 suffer from heart failure and need access to appropriate care.
- 16% of chronic heart failure patients are readmitted to an emergency within 30 days of discharge, 40% of them within seven days.

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**Find the shared agenda**

From a patient perspective, heart failure services feel disjointed. Patients interviewed for the Cardiovascular Outcomes Disease Strategy** reported:

- Feeling abandoned once they had left hospital.
- That they were not offered emotional or practical support.
- That they either had insufficient or contradictory advice on which to base choices.
- That they did not know who to contact for help.

Heart failure services are improving, but remain highly variable. The 2012/13 National Heart Failure Audit** attributed year-on-year falling in hospital mortality and improving post-discharge survival to improved access to specialist care. Despite this progress, there remains wide variation in care depending on what type of ward and in which hospital patients receive their care.

The 2012/13 audit showed that if a patient admitted to hospital with heart failure is treated on a cardiology ward the likelihood of survival to discharge is far greater than if a patient is admitted to other wards — in 2012/13 only 7.9% died if admitted to a cardiology ward compared to 11.3% on general medical wards and 14.4% on other wards. Patients not treated on a cardiology ward were 54% more likely to die in hospital than their cardiology counterparts. For all patients who survived to discharge in 2012/13, those not treated on a cardiology ward were 14.6% more likely to die within the audit year, when confounding factors are taken into account.

Only half of the 43,894 patients included in the 2012/13 audit were treated on cardiology wards; although 79% were seen by a nurse or doctor with a heart failure specialist.

This variation has an impact not just on patients but also on finances. NHS Improvement heart failure pilot sites have shown there is potential to reduce admissions, length of stay and readmissions by improving the heart failure pathway, resulting in significant savings.

Redesigning heart failure services can deliver on the triple agenda: getting the best outcomes for patients, the best experience for patients and the best value out of the resources spent.

"We are doing better. Five years ago, my patients were much sicker. Now I see patients with an echocardiogram diagnosis of LVSD (heart failure) who are managed better and have never compensated. But we still need to do more.*

Jennifer Gove, Heart Failure Specialist Nurse

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**UNDERSTAND YOUR LOCAL SITUATION**

- Do you know how many patients receive a heart failure diagnosis following hospital admission with acute decompensation?
- Do you know what proportion of those are treated on a cardiology ward by specialists?
- Do you know how many of those patients have access to specialist nurses, both in patient wards and post-discharge?
- Do you know how many heart failure patients are readmitted within seven days, 30 days and one year?
- Do you know the one year and three year survival rates of heart failure patients?
- Do you know the number of hospital deaths where heart failure patients in your practice compare to the national average?
- Do you know what proportion of all patients are prescribed the evidence-based medicines suggested in national guidelines?
- Are you able to identify patients at imminent risk of hospital admission for heart failure?
- Do you know what heart failure specialist skills and capacity exists within your community nursing services?

There is a wealth of national and local data available to help understand how practices in your CCG are performing, this includes:

- National Heart Failure Audit to understand the big picture
- HES for national data
- QOF for local data
- GRASP heart failure tool** to mine your patient register
- Prescribing data for local and national comparisons

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**THINKING POINTS**

- Why, locally, needs to share this agenda? Ideally, this should be CCG leadership and member practices, local acute providers and the health and wellbeing board who need to ask themselves: are services organised in a way that would answer patients’ needs? If not, how can they be redrafted to meet patient needs and deliver optimal, evidence-based care?

One of the key discussion points was whether general practice should concentrate first on optimising treatment for patients with diagnosis heart failure or on finding the underdiagnosed patients. There is no right or wrong answer to this but consideration of capacity and capability may inform any decision.
Understand the role of generalists & specialists

The National Heart Failure Audit underscores the need for rapid diagnosis followed by specialist treatment in a cardiology unit including access to specialist nurses. There is a lack of clarity about where these specialist nursing skills lie. Some work in hospitals; some have joint responsibility across hospital and community settings; some work in the community; some work in hospitals providing educational outreach and support to general practice. In addition, the British Heart Foundation has emphasised the need for GPs to have access to consultant cardiology advice as they manage patients in primary care.

The general principle is that:

“Sicker patients need to be managed by specialists.”

Dr Mark Dancy, Consultant Cardiologist

With this in mind, do you understand the specialist provision in your area?

• How many heart failure patients are treated in cardiology wards?
• Do inpatients have access to heart failure specialist nurses?
• In primary care, do you risk-stratify patients to find those who require specialist nursing support?
• Do heart failure specialist nurses work in your community?
• If not, do your community nurses and practice nurses have access to specialist nurse advice and/or education and training?

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In April 2013, Central Manchester University Hospitals Foundation Trust, in collaboration with the local CCG, seconded a heart failure specialist nurse to work in one of four localities with eight GP practices, examining the QOF register to identify patients who already have a heart failure diagnosis and also to identify those who may have undiagnosed heart failure, but are thought to be high risk; for example, people with diabetes or hypertension.

CASE STUDY

In 2007, Central Manchester GPs were invited to take part in a scheme to undertake training to diagnose and treat left ventricular systolic dysfunction – one common form of heart failure – in primary care. So far, 18 out of 40 practices have attended with dramatic reductions in admissions and readmissions of their patients.

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Once patients have been identified, they are referred as indicated to hospital for investigations such as echo and outpatient follow up. The specialist hospital teams work closely with the GPs who have undertaken the LVSD training and with active case managers and advanced nurse practitioners to ensure patients receive active, ongoing management.

“Be careful not to set up services that mean generalists refer everything to specialists.”

Dr Donal Hynes, GP

There are a number of models that can be considered for providing specialist nursing support, including those described in the NHS Improvement pilot sites. Some CCGs are now paying a sessional fee to consultants to provide advice to GPs. Others have set up practice-to-practice referral to better manage patients in primary care.

“The issue of information provision at handover is not one that seems to have been examined in great detail in the literature and is not, in any case, unique to heart failure. However, it could certainly be borne in mind during work to redesign pathways.”

Jennifer Goss, Heart Failure Specialist Nurse

THINKING POINTS

• What is the “service” provided in general practice – how variable is it and can that variability be reduced?
• Can some services be moved closer to the patient’s home, for example, providing intravenous diuretics in the community?
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Handover is considered the highest risk point in any patient pathway. In heart failure services, the main handover points are admission to hospital, either from general practice or in an emergency, and discharge from hospital.

At the meeting, there was agreement that general practice does not always receive full information about inpatient treatment in discharge summaries, particularly when heart failure was not the primary diagnosis. Likewise, acute providers did not always have full information about a patient’s history or medications on admission, especially when that admission was an emergency.

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When redesigning pathways for patients with heart failure, attention also needs to be paid to:

- Rehabilitation
- Psychosocial support
- Managed self care
- End of life care
- Use of PREMS and PROMS

RESOURCES

NICE guidelines for commissioners of services for people with chronic heart failure, 2011
http://www.nice.org.uk/usingguidance/commissioningguides/chronicheartfailure/chronicheartfailure.jsp

End of Life Care in Heart Failure: a framework for implementation. NHS Improvement, June 2010
http://www.improvement.nhs.uk/LinkClick.aspx?fileticket=KBUUEsR0mms%3D&tabid=56

The Gold Standards Framework in end of life care
http://www.goldstandardsframework.org.uk

The AMBER Care Bundle
http://www.ambercarebundle.org/homepage.aspx

http://www.rcpe.ac.uk/sites/default/files/leslie.pdf

“Florence” or “Flo” is an NHS owned, low cost web app designed to enable many thousands of patients to take responsibility for the monitoring and management of their own condition or treatment. Flo allows multiple healthcare teams to share patient information and assist patients in the management of their own care for a single or multiple conditions.

“There is a clear business case for supported self care.”
Dr Peter Macdougall, GP

“We can hit the triple value objective of improving outcomes, improving patient experience and improving productivity in heart failure. The evidence of what works is there, the mechanisms for collaboration between primary, secondary and community providers and commissioners – while imperfect – now exist in the NHS, as does the flexibility around finance. Not to work together to achieve the triple value objective for patients who make up such a large proportion of NHS care, and whose chances of living longer and living better quality lives, is an indication of system failure and is unacceptable.”
Mike Sobanja, NHS Alliance
About ACE

Achieving Commissioning Excellence is a partnership between NHS Alliance and Novartis Pharmaceuticals UK Limited, which aims to support the development of NHS clinically-led commissioning of healthcare services. This publication has been funded by Novartis, but all editorial content has been created by NHS Alliance and invited experts.

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