NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Bringing Early Attention To Heart Failure

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Introduction

In 2019/20 , 5,322 people had been identified by NHS Blackpool and Fylde & Wyre (BF&W) Clinical Commissioning Group (CCG) practices as living with Heart Failure (HF).[1] This equates to 1.5% of the BF&W's total population compared with the National Average of 0.9%. This figure is even higher as 20% of patients identified as having HF during an admission were not registered with their GP.

Initial Assessment

A review of national data highlighted that:

- 80% of patients with HF are not identified until the point of non-elective admission
- 40% of those patients having reported symptoms to their GP in the 5 years prior
- 90% having seen a clinician in Primary Care within the previous 12 months

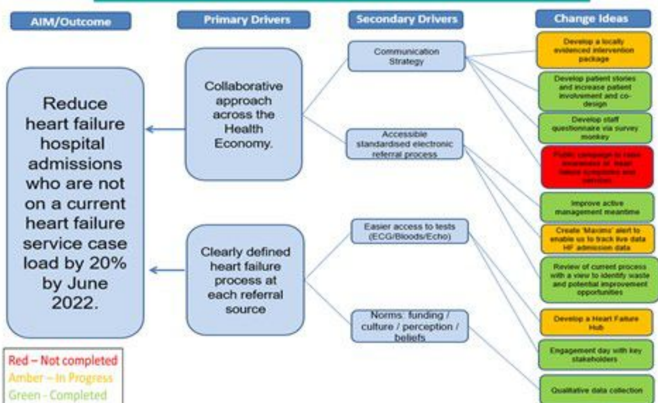
A review of local data from the Trust highlighted that:

- In 2019/20, there were 740 emergency hospital admissions with HF
- Patients admitted had an average length of stay of 12 days
- In 2019/20, at any one time, 25 beds were occupied by a patient with decompensated HF
- In 2020/21 that had risen to 35 beds

With these figures in mind, it was identified that **earlier, elective, diagnosis** would greatly improve patient care. Once a patient from BF&W is registered with the HF Team, the care they receive is associated with a lower admission rate than most CCGs in the country (6th & 10th of 106). Therefore, by improving diagnosis, admissions could be reduced, better care provided for patients and more beds available at a time when there is significant pressure on beds.

The project team decided that every heart failure admission, without prior escalation to the HF team via the elective route, should be viewed as a patient harm. Potentially a missed opportunity.

Aim & Driver Diagram



What matters to you

Conversation Tool
Ask patients 'What Matters to You?'

I asked......
What matters to you?
What is important to you today?
How can I best support you?
Is there anything worrying or annoying you?

They said...
Independence
Living
To be pain free
Staying alive
Being able to walk my dog
....mattered to them

We did....
Early Intervention and diagnosis leads to better outcomes for our patients which in turn leads to an Improved quality of life.
#BEAT-HF QIK

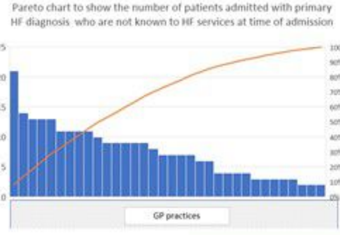
Throughout the project patient views & experiences were considered. Patient survey results indicated that:

- **50%** visited their GP about HF on multiple occasions
- **50%** reported that their GP had not discussed their referral to the HF team
- **75%** reported symptoms for up to 3 months prior to seeking support from GP
- **75%** reported staying alive as what mattered to them
- We will continue to ask patients: **'What matters to you?'**

Method

Baseline data in relation to our aim reported that in the six months prior to the project initiation, **65% of patients facing non elective admission had not been referred to the HF team electively**, they were not on the active caseload of the HF team.

A change idea was agreed; to have this data reported live informing the HF team of the impact of their interventions. A new Maxims tool that allowed 'tagging' of HF patients according to their HF service status, will facilitate live data reporting to our aim and also supporting a future 'virtual ward' vision. **This live data will be reported as live run chart by August 2022**

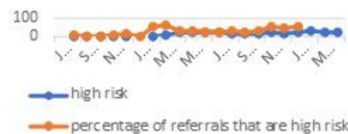


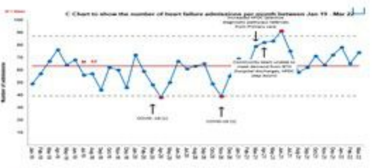
Analyses of the available data, adjusted for population size, helped to confirm that some practices had high numbers of elective referral and/ or non-elective admission.

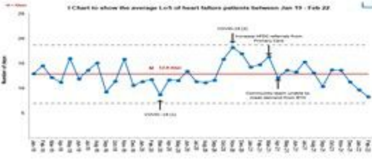
With the help of funnel plots, a common not special cause for the issue was agreed and the need to focus on process and system barriers to improvement highlighted.

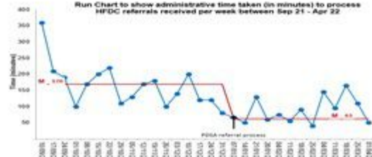
Various tools were used including: process maps, the 'last 10 patient' tool, qualitative interviews & surveys with service users and colleagues. Pareto analysis was used at different stages, E.g. to identify key stakeholders to work with, such as high frequency referrer GP practices.

Results & Lessons Learned









Data reports an encouraging increase in diagnostic referral via elective routes

- The increase may be associated with a plateau and then fall in the post-covid admission rates 3 months thereafter (admission rate acting as proxy measure pending live data reporting to our aim)
- The HF team are monitoring balancing measures and find areas of concern;
  - **Data has shown an increase in 'elective' referrals to Community team** - the elective admission avoided referrals means additional pressure on community teams
  - **The hospital team are stepping fewer hospital discharges to the Community team** – they are carrying burden of an increased caseload.
  - **LOS is reduced** (recognised marker of less specialist supervision of inpatient care)
  - **Readmission rate is increased** and perhaps linked to a consequent increase in admission rate (Sep 21)
  - **Increased SHMI/ HSMR**

Learning so far has included:

- Electronic systems can be used more effectively to help with improvement projects ; evidencing impact and maintaining improvements
- Implementing an e- triage process for HFDC referrals can provide more efficient care for patients ; ACP clinical time (155 min/week) and administrative time (107 min/week) saved, protecting time for patient care.
- Efficient triage encourages timely feedback to referrer encouraging appropriate referral practices
- E-processing uses less paper and saves money

Next steps

- As the current service is not adequately resourced to manage an electively referred high risk population alongside the demands of the non elective population, such ambitious service improvements may need to be delivered at a pace that protects those already dependent on our service
- Continuous data monitoring, ideally sighted by service users (referrers) and Trust leadership, is essential to help maintain service improvements and ensure further progress with organisational support
- The HF team will continue to work with the Trust's Directorate, Division and Exec team to invest in our community-based service in line with NHSE priorities or accept a significant increase in admissions, readmissions and mortality risk for our patients (business case with options appraisal)
- Gain business intelligence support for a HF service dashboard
- Deliver 1° care network workshops
- Relaunch twitter account and develop comms strategy
- Use a 'planned experimentation' approach to care for HF patients at highest risk of admission

References

1) NHS Digital. Quality and Outcomes Framework, 2019-20. https://digital.nhs.uk/pubs/qof1920 (accessed 11.07.2022)

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