Integration in Heart Failure across KHP

KHP Cardiovascular Heart Failure Work Stream

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Examples of Integration

- HFpEF Pathway and Guidelines
- Virtual Clinics
- Palliative Care
- Acute Heart Failure Pathway and Guidelines at KCH
- Consultant Triage for 100% of GP referrals
- Cross site Mortality/Morbidity and MDT meetings
- Joint Clinical Research meetings

Key Individuals Enhancing Heart Failure integration

- HF Consultants/Registrars from GSTT, KCH and PRUH
- Consultant Geriatricians
- HF Pharmacists
- HF Specialist Nurses
- Cardiac Physiologists
- Admin/Secretarial Staff and Managers
- @ Home Team
- Older Persons Assessment Unit
- Psychiatrists/Psychologists
- Acute Medicine
- Accident and Emergency Team
- Palliative Care Team
- General Practice
- 3DLC
- Project Managers
- Patients

Transforming the HFpEF Service

- HFpEF diagnostic and management pathway completed and SOP developed, including best practice guidance managing comorbidities
- HFpEF working group applied for funding from LTC Challenge Fund for innovative dedicated, multi-disciplinary service for HFpEF patients

Heart Failure with Preserved Ejection Fraction

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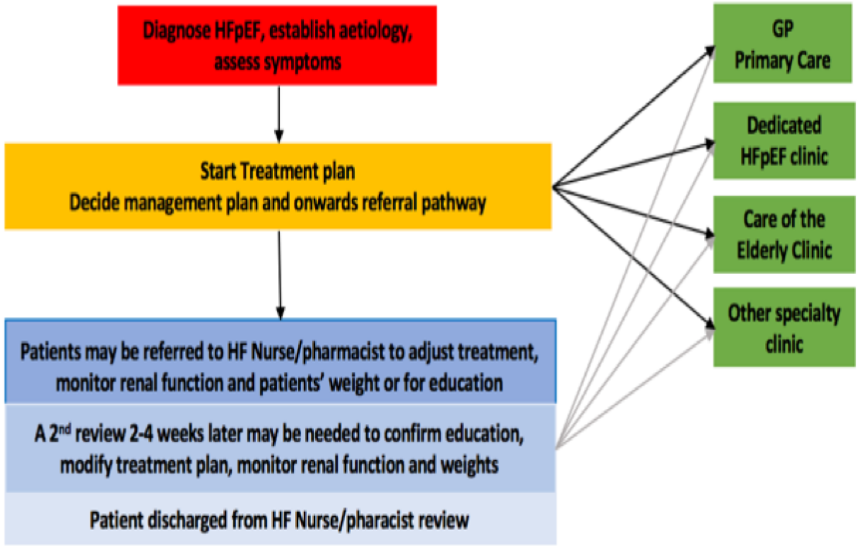
Who should be seeing patients diagnosed with HFpEF?

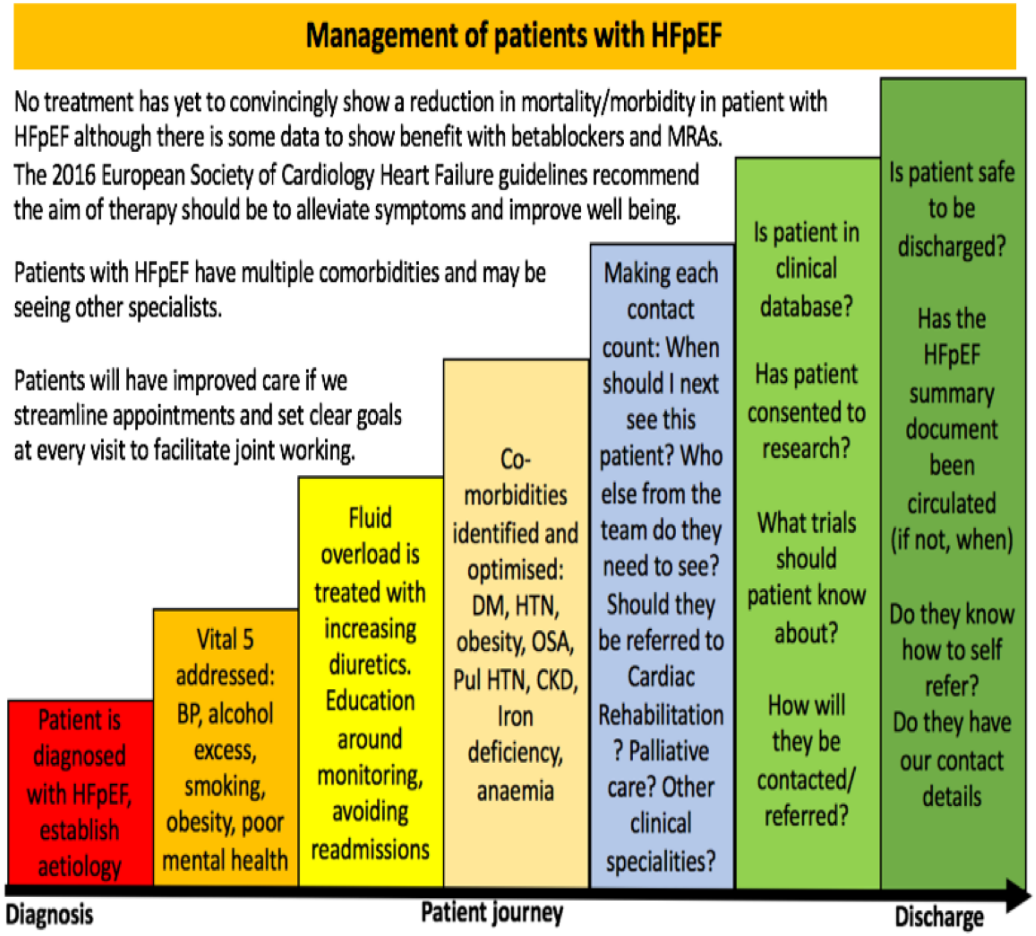
Patients with HFpEF need to be seen by a multidisciplinary team who can diagnose their condition, establish their symptoms and start treatment, assess if treatments are effective and decide on an onwards management plan. Some patients will be seen in a dedicated HFpEF clinic (for example, younger patients or with recurrent HF hospitalisations), more elderly patients in a Care of the Elderly clinic*, and some other patients in another speciality clinic with input from the HF team (for example those most symptomatic from other comorbidities). Patients who are stable will be referred back to primary care with a clear management plan, with details of what should happen if the patient were to deteriorate again, and contact details from their discharging team.

* COTE HF referral guidelines 2019

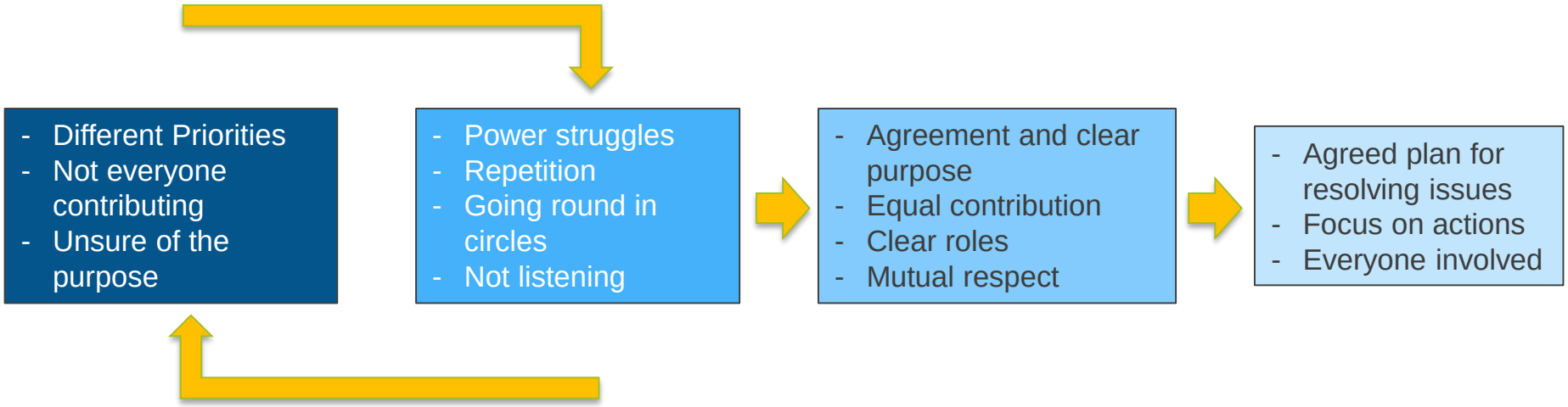
Patients with HFpEF may be referred to a specialist HF nurse or pharmacist to adjust treatment, monitor renal function and the patients' weight or for education, . A second review may be organised to consolidate knowledge and for review, before discharge.



Heart Failure with Preserved Ejection Fraction



The Process….



Enablers	Hinderers
Steering Group	Lack of time
Project management	Having to travel between sites
Face-to-face meetings	Limited video conference facilities

Transforming Communication Between KHP and GPs: Virtual Clinics

- Multidisciplinary review of all patients on the GP practice HF register by KHP consultant, nurse, pharmacist and GP
- Forum to discuss patients already diagnosed, optimisation of treatment, "holistic" LTC management, onwards referral/signposting
- Promote the diagnostic pathway and facilitate accurate diagnosis for those with unconfirmed HF
- Closer working relationships with primary care : reduce admissions or unnecessary hospital appointments – locality team available for advice and queries
- Key points:
    - Not new, but has taken time to embed into routine practice
    - Standardisation of pathways across KHP was essential – one team, one message
    - Job planning
    - Ongoing analysis and review of the service is key to drive further changes and improvements

Strengthening Palliative Care in Heart Failure

- ICD deactivation guidelines signed off at GSTT and KCH, shared between South London providers
- Presented at Grand Rounds, reciprocal teaching events, shared teaching events for SpRs, HFSN
- Work started on bereavement pathways for HF patients
- Reciprocal presence at MDTs between HF and palliative care

Streamlining Admissions in Acute Heart Failure

- Collaboration between A&E, acute medicine, @Home and HF Cardiology
- An agreed & evidence-based pathway for the investigation & management of AHF
- Clear referral / discharge criteria and pathways
- Ensures timely & appropriate investigations
- Incorporates frailty, @Home and discharge criteria, to ensure patients are managed in the correct environment
- Automated reporting of NT-proBNP to HF teams as a safety net
- Guidelines for special groups, including pregnancy
- Benefitted from sharing and collaboration with GSTT

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KHP Acute Heart Failure Pathway: Diagnosis

Diagnose and treat life-threatening cardiac emergencies

Acute coronary syndrome, hypertensive crisis, acute arrhythmia, tamponade, pulmonary embolus

Initial assessment of suspected AHF[1] should include ECG, CXR and NT-proBNP[2]

[1] Click here for symptoms/signs of AHF

[2] NT-proBNP should be an add-on test only; <300 pg/ml rules out AHF; click here for differential diagnosis

Is this the first presentation of AHF?

N

Y

Echo done in last 12 months & available to view?

N

Request echocardiogram (should be done <48 hrs)

Y

Triage to appropriate clinical area

For PRUH guidelines click here

Is there a life-threatening emergency?

Y → **Refer to cardiology SpR ± ICU**

N

Is the NT-proBNP >2000 pg/ml?

Y → **Refer to cardiology SpR**

Cardiology SpR will refer to HFU if appropriate. If not primarily HF, SpR will admit under general cardiology or refer to medics

N

Is the patient dry & well perfused

Y → **Ambulatory pathway for early ED discharge**

Details available here (inc. HFU/@home referral/new vs. decompensated)

N

Is HF the primary reason for admission?

LVEF <40% (measured using 2D echo)
Significant mitral or aortic valve disease
Significant LVH
Under cardiology follow-up

Y → **Refer to medical SpR & HFU referral for review on specialty ward**

N

Refer to appropriate specialty & online HFU referral for review on specialty ward

Including renal failure, respiratory cause of HF symptoms, new stroke, frailty ± multiple comorbidities*

- Refer to HFU via EPR
- Patients who are taken over by the HFU will be reviewed daily until they are transferred
- Click here for advice on special groups (pregnancy, ICC etc)

***Consider frailty pathway when...**

Details available here

All patients*

Detailed history and examination, FBC, U&E, LFT, glucose, HbA1c, lipid profile, HIV, ferritin & TSATs, ECG, TTE**

**Tests available as part of HFU order set*

****Please request TTE at point of first medical contact unless done in last 12 months & available for review**

Investigate underlying aetiology (new presentations) and/or causes of decompensation (known diagnoses)

Click here for possible causes and suggested investigations

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Guy's and St Thomas' NHS

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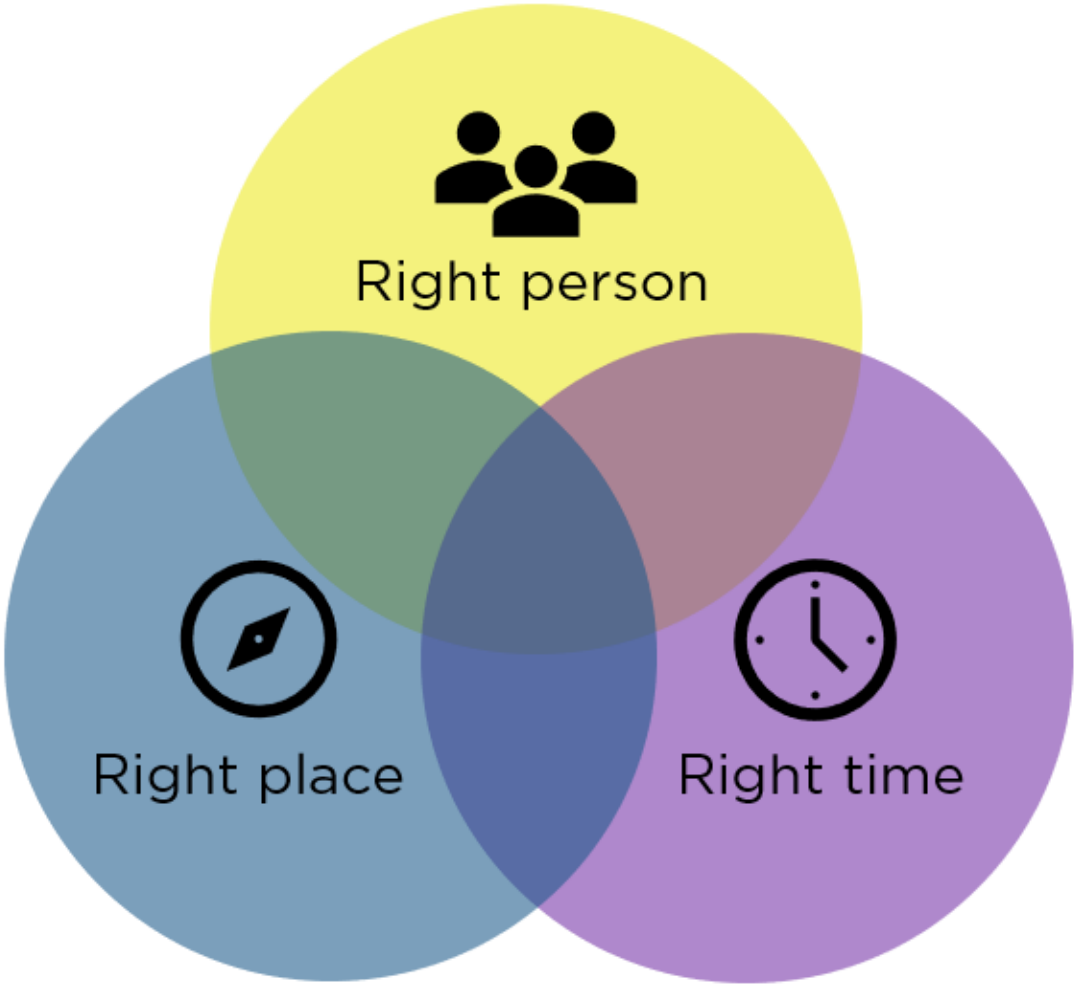
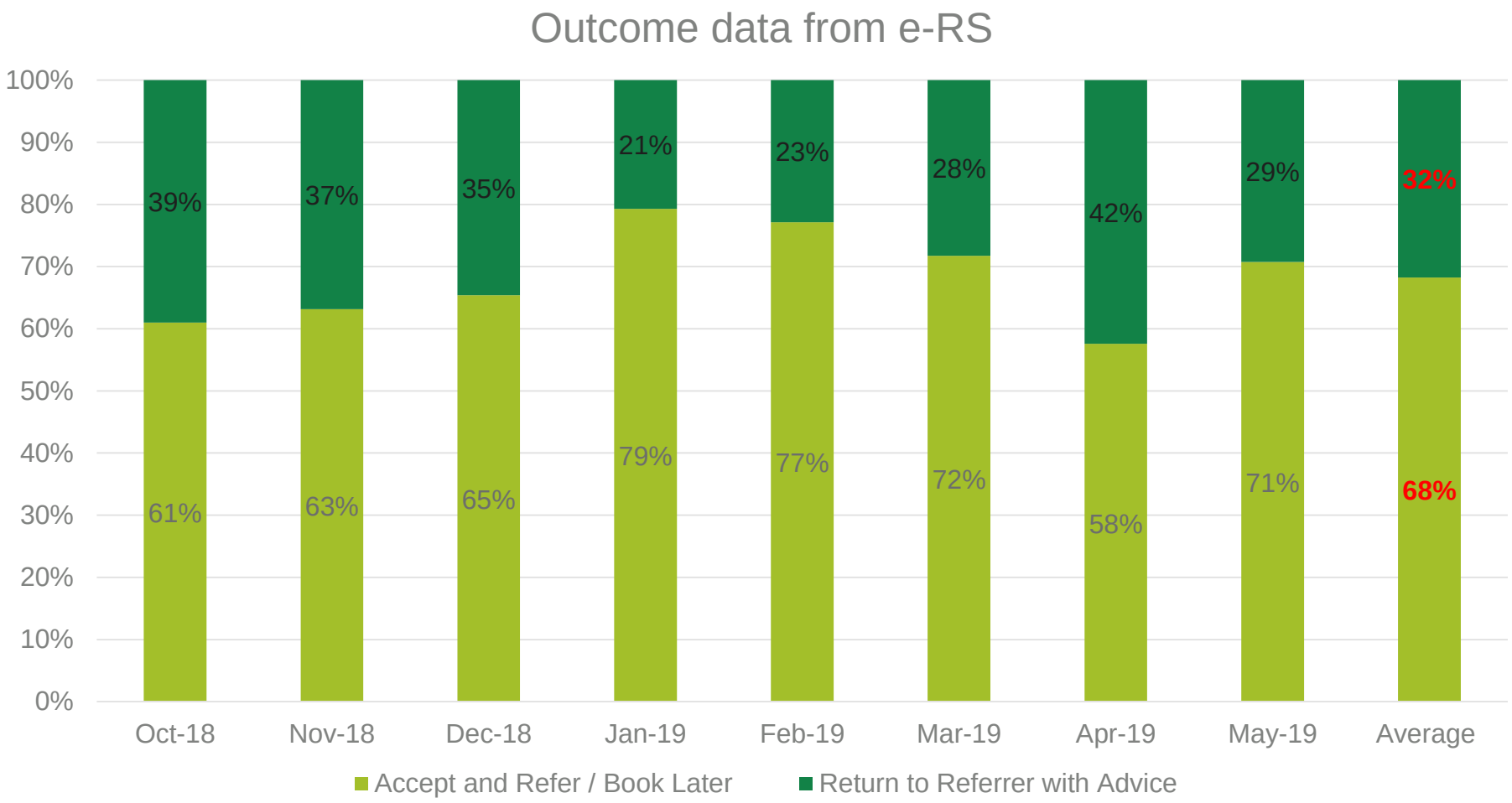
South London and Maudsley NHS

Improving Referrals - Consultant Triage



Heart Failure Triage at KCH

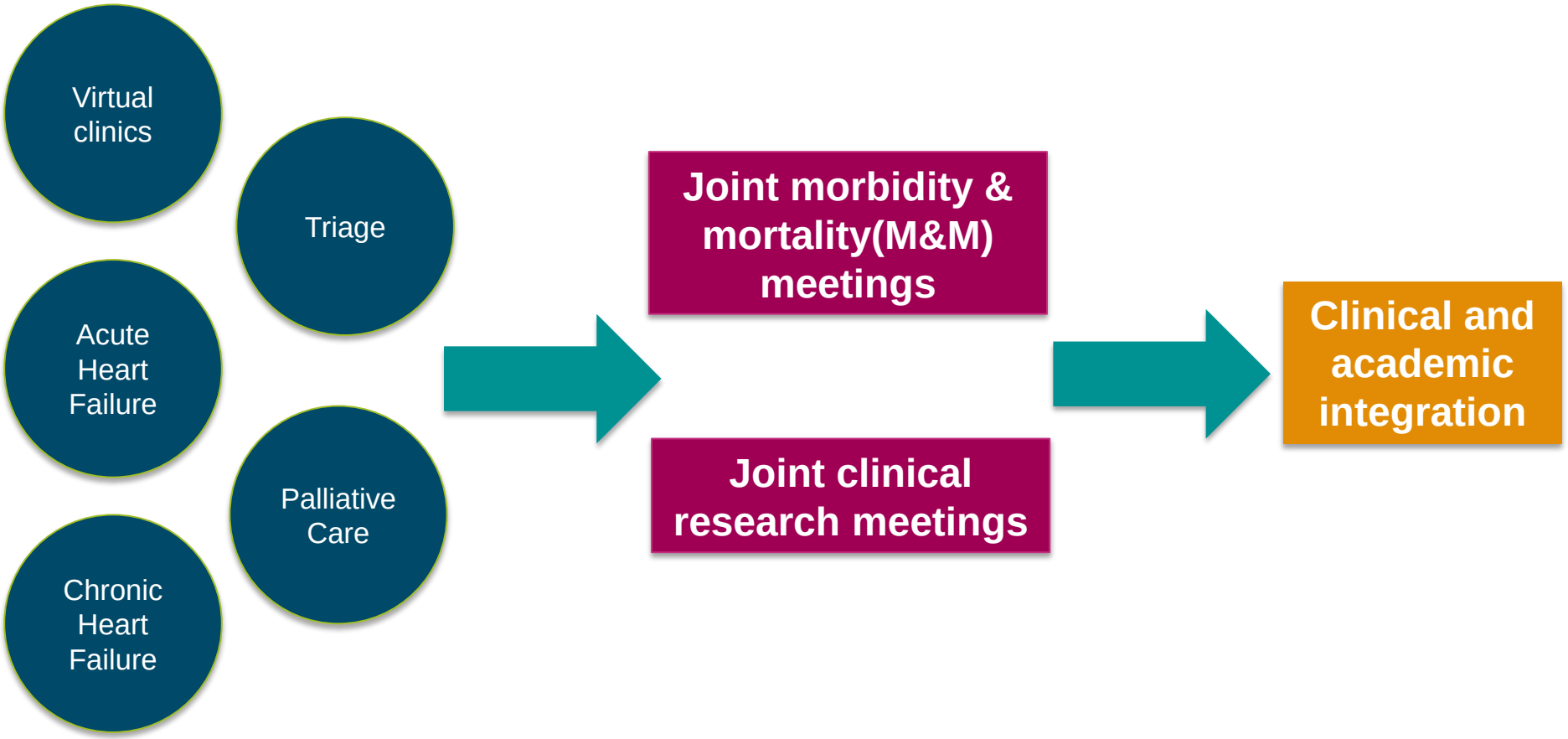


Heart Failure Triage at KCH

What have we achieved?

- Reduction in inappropriate referrals
- Average time from referral to triage reduced from 7 days to 1 day
- All new patients have an echo before their clinic appointment
- Urgent (2 week) referrals contacted by telephone
- 'One stop' clinics
- Triage direct to Geriatrician HF Clinic when appropriate
- Review of triage/booking processes across KHP for all cardiac clinics.

Further Integration of the KHP Heart Failure Teams



Key Success Points

- Strong steering group
- Key stakeholder involvement to agree priorities and help resolve differences
- Clear goals
- Accept there will be differences
- Use project managers effectively
- Acknowledge that progress will take time
- Small steps can sometimes lead to big change

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