North Central London
CardioVascular
& Stroke Network

North Central London Joint Health Overview and Scrutiny Committee

Title	**Heart Failure Community Clinic Pilot**
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Report of	**NCL Cardiovascular and Stroke Network**
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Paper for	**Information**

1. Introduction

This paper provides a summary of the intention to pilot a community based heart failure clinic in South Camden.

2. Background

It is estimated that Heart Failure affects 1 – 2% of the population in the UK and the incidence and prevalence of heart failure increase significantly with age. Although there has been a decline in mortality from coronary heart disease, there has been a subsequent increase in patients living with heart failure. As this is a condition which mainly affects older people, it will become more prevalent with the aging population[1].

The prognosis for heart failure is not good, with 14% of newly diagnosed patients dying within the first six months[2] and the average life expectancy approximately 3 years following diagnosis[3]. The effects of heart failure on a patient's quality of life can be significant, mainly due to the physical limitations of the condition which then leads to social limitations and possibly anxiety and depression.

In recently published data from the National Heart Failure Audit, the mean length of stay in the UK was nine days following a heart failure admission, much higher than the European average. Mortality from heart failure admission is also significantly higher in the UK than in Europe.

The expenditure for heart failure is high and accounts for approximately 1 – 2% of the NHS budget. This equates to approximately £625 million, of which about 60% is inpatient costs. In addition, heart failure accounts for approximately 5% of admissions, and readmissions within three months have been estimated up to 50%[4]. Heart failure also places a burden on primary care, with patients needing 11 to 13 contacts per year with a member of the primary care team.

[1] Bridging the quality gap: Heart failure (2010)
[2] Heart, vol 95, pp 1851 – 56 (2009)
[3] Managing chronic heart failure: learning from best practice (2005)
[4] National Heart Failure Audit. Second report for the audit period between July 2007 and March 2008 (2008)

3. Heart Failure in North Central London

According to the Quality Outcomes Framework (QOF) data for 2009/10, there are approximately 1.38m patients registered with North Central London GP practices. It should be expected that, for the NCL Cluster, 16,600 patients are on the GP practices' heart failure registers (based on an estimated prevalence of1.2%). However, the OQF data also shows that in 2009/10 there were only 7599 patients recorded on disease registers, leaving approximately 9,000 undiagnosed. This is significant as early diagnosis and initiation of medication is crucial to increase life expectancy and improve quality of life. This also has an impact on the financial burden on the NHS as health costs associated with the most severe symptoms are between 8 and 30 times greater than those with mild symptoms[5].

Cluster-wide, a small to moderate increase in those over 65 diagnosed with heart failure is expected between 2010 and 2016[6], and, recent calculations by the NCL Cardiovascular and Stroke Network predict that the Cluster should expect approximately 1024 new cases of heart failure per year. Standardised Hospital Episode Statistics data for 2008/09 shows that admissions rates for heart failure were higher for the NCL Cluster, than London and England. Mortality rates for 2006 – 2008 were also higher in NCL Cluster than London and England, according to the Office of National Statistics.

In spring 2010, work began on an exemplar heart failure pathway and service specification for NCL, but was halted due to lack of capacity and a restructuring within the NHS. Furthermore, new NICE Guidance was published in August 2010, which recommended new ways to deliver integrated care to patients with heart failure, including diagnosis and assessment by a heart failure specialist and the provision of care by a multi-disciplinary team to ensure the best possible clinical outcomes.

4. Proposed Change

The current model of heart failure services in NCL, in which provision of care is across three sectors, results in duplication of some services, inefficiency, and a narrow perspective. Many patients with heart failure do not require access to technology only available in secondary care and the overwhelming majority can be managed using echocardiography and blood tests in a community setting. Therefore, there should be no barrier to providing the majority of heart failure services within a primary care or community context.

In light of this, and the latest published NICE Guidance, the project team within the NCL Cardiovascular and Stroke Network are currently developing a business case to undertake a pilot which would transfer the patients seen by a heart failure specialist in UCH into a community based clinic. As recommended in the NICE Guidance, the clinic will be staffed by a multi-disciplinary team led by a heart failure specialist. In addition to a consultant cardiologist, this team will consist of a GP with a specialist interest in heart failure, heart failure specialist nurses, phlebotomists and cardiac technicians, as well as administrative staff. The service will integrate primary and secondary care services, ensuring patients receive 'joined up' care and are less likely to 'slip through the net'. It will aim to ensure patients are managed in the community and their medication is optimised to avoid unnecessary admissions. This new model of care, together with an

[5] European Journal of Heart Failure, vol 3, pp 283-91 (2001)
[6] North Central London Strategy Plan 2010-2014 (2010)

increased uptake of NT-proBNP testing in primary care, should also lead to an increase in early diagnosis of patients with heart failure.

Echocardiogram facilities will be available on-site to diagnose new patients with a raised NT-proBNP or confirm heart failure for patients whose diagnosis has not been previously confirmed by an echocardiogram. Patients will be assessed by a heart failure specialist to determine severity and aetiology and a management plan will be developed with the MDT together with patients and carers. Medication will be initiated and up-titrated until optimised. Once optimised patients will be offered a referral to cardiac rehabilitation and other relevant support services, such as, social care or palliative care. All patients will be given information about their condition and lifestyle advice on diagnosis and this will continue to be promoted at further appointments. Patients will be discharged back to their GP with their management plan for continued monitoring when this is clinically appropriate. However, following discharge GPs will still be able to access specialist advice from the clinic or arrange a face to face review by a member of the team if required.

The Heart Failure Pathway Redesign is already within the NCL Cardiovascular Disease (CVD) QIPP Programme and expects to transfer heart failure care across the Cluster into a community setting. It may, however, be unwise to do this with a high risk patient group. A pilot would provide an opportunity to test the service model with a smaller group of patients and make amendments (using a PDSA approach) before rolling the pathway out across the Cluster. The pilot will be evaluated after six months to ensure it is safe, producing the best possible clinical outcomes, improving patients' perceived quality of life, improving access to services, improving patient experience, is working towards reducing health inequalities and is providing value for money.

If the business case is approved, it is expected that the clinic will be operational at the beginning of January 2012 and will be evaluated after six months.

5. Impact

It is anticipated that the proposed service will have a positive impact on the health of the NCL Cluster population. The model promotes early detection and diagnosis of heart failure, which leads to improved clinical outcomes for patients. Transfer of care into the community and greater integration with primary care will mean patients will have much easier access to specialist heart failure knowledge, care and support. Having access to a multi-disciplinary team will mean that patients are seen by the clinician most appropriate for their needs and will be easily referred on to appropriate support services.

An Equality and Diversity Impact Assessment has been undertaken and will be submitted to the NCL Board for approval with the business case. This demonstrates that there should be no detrimental effects on and does not discriminate against any groups with protected characteristics.

6. Stakeholder Engagement

Key stakeholders have been involved with the development of the pathway and service specification through the NCL Heart Failure Task Group, whose membership includes secondary care clinicians, heart failure nurse specialists, public health representatives and members of the NCL Cardiovascular and Stroke Network. Primary care and

commissioning representatives have attended to participate in discussions around the pathway and specification. Patient representatives will be included on the membership at future meetings.

At the time of writing, a Steering Group is being established which will take this project forward. The Steering Group membership will include a UCLH heart failure consultant, NCL commissioning representatives, a GP, a heart failure nurse specialist, representatives of the Camden and Islington Local Presences and UCL Partners.

It is also planned to provide information for discussion to the NCL Patient Advisory Panel at their meeting on 12th September 2011. The Panel will be presented with a consultation paper in advance of the meeting and will be asked to feedback on a number of points. The project manager will attend to receive these comments and also to facilitate an open discussion. The feedback will then be incorporated in to the service model and specification before these are approved.

7. Next Steps

Action	Timescale
Business case for pilot agreed by NCL Senior Leadership Team	30th September 2011
Service specification approved	30th September 2011
Service operational	2nd January 2011

8. Conclusion

The Committee is asked discuss the proposal and provide feedback on the proposed changes.