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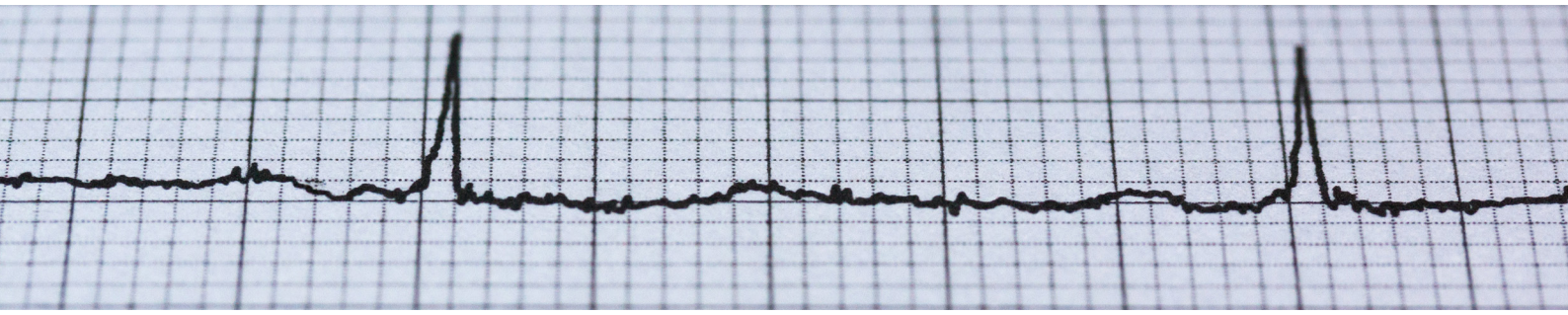

> “The quicker a patient can have their heart failure medication optimised, then the better outcomes can be achieved. This means an improved quality of life and successful long term disease management.”

Mandy Houghton and Jane Jukes, heart failure specialist nurses, explain how the heart failure specialist nursing service in Barnsley has recently adopted innovative new approaches to help meet increasing demand.

Vital work to extend lives

Heart failure is a chronic, progressive condition in which the heart muscle is unable to pump enough blood through to meet the body’s needs for blood and oxygen. Basically, the heart can’t keep up with its workload. The service provides support to more than 2,000 patients in Barnsley who have been diagnosed with heart failure following an echo-cardiogram investigation. Heart failure specialist nurses work with patients to make sure that their medication is right and that they gain an understanding about their condition. They create a care plan to effectively manage and support the patient’s diagnosis.

Challenges

Until recently the service was solely delivered through one to one patient interventions being delivered in a clinic or within the patient’s home. Rising demand for the service and limited resource mean that changes were needed to make sure that those needing care received it in an appropriate and timely manner. A commissioning decision to withdraw tele-health equipment from patients’ homes locally has also had an impact on capacity.

Aside from pressures within the local system, it’s known that receiving a diagnosis of heart failure can create anxiety and be very frightening for people. So it was acknowledged that the service should look at what more could be done to look after the wellbeing of patients.

Heart failure service changes

1. Switch to group education sessions

The team has changed heart failure education from an hour long one-to-one intervention to a group session wherever possible.

Feedback from patients has been favourable as many remarked that being in an environment with others who were undergoing the same experience was comforting.

There’s also been a significant gain in terms of efficiency which can be used to deliver increased follow up clinics. Although not all patients are receiving group sessions, the changes have created, on average, time for an extra dozen 30 minute follow-up appointments per month

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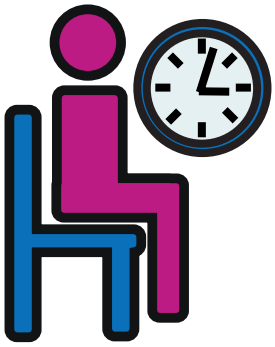
2. Introducing blood pressure monitors and regular telephone calls
At group education sessions, patients are shown how to take their own reading using a blood pressure monitor. Nurses then phone patients for their vital sign readings and provide any required support via the phone based on the patient's response.

This solution has helped fill the gap left by the decommissioning of care navigation / telehealth across the borough.

Benefits include:
- Time taken for follow up appointments halved in some cases
- No need for some patients to attend clinics
- Reduction in DNA's as the patient may accept the call wherever they are
- Increased flexibility of appointments.
- Increased emphasis regarding patient self-care and greater patient awareness of their condition.
- Potential ability for early diagnosis of ill health meaning patients can be treated accordingly before they get worse.
- Potential for reduced home visits being required resulting in decreased travel time and associated costs.



If just 30% of patients receive a 15 minute telephone call rather than an 30 minute face-to-face visit, that's an extra 40 hours gained per month, equating to 80 additional follow-up appointments.

A change for the better

These efficiencies mean that the service is able to cope better with increasing demand. Encouraging self-management not only creates additional capacity but builds resilience.

By freeing up extra time, the team can offer follow up medication management appointments sooner to patients following a diagnosis. This is really important as the quicker a patient can have their heart failure medication optimised, then the better outcomes can be achieved. This means an improved quality of life and successful long term disease management.

In a nutshell

With limited resources and a significant rise in the number of heart failure patients, the service introduced changes to enable newly diagnosed patients to be seen quicker while ensuring existing patients are suitably supported through increased self-management and enhanced service provision.