A DECLARATION OF JOINT WORKING

BETWEEN

Northern Lincolnshire and Goole NHS Foundation Trust

AND

ASTRAZENECA UK LTD

"Heart failure @home"

GB-47653

Executive Summary

Northern Lincolnshire and Goole NHS Foundation Trust and Astra Zeneca have entered into a Joint working to undertake a CCG wide transformation of heart failure care in North Lincolnshire for both out-patient and inpatients commencing July 2021. Additional resource are being placed to support the Heart failure @ home project in the form of 2 heart failure nurses, consultant supervision and some admin support. The Joint working is part of a wider service supported by pharmacist, GPwSi, and a recently commissioned database development. The entire programme is termed 'The Connected Health Network'.

Hypotheses

This programme is commissioned to reduce treatment gaps in heart failure patients ensuring maximum use of guideline indicated treatments, namely – ACE's, beta-blockers, MRA's, and SGLT2's.
It is estimated that more than 4,000 patient appointments will be made available as a result of this project.

Benefit to the Patient

- The ability to reduce treatment gaps in heart failure patients ensuring maximum use of guideline indicated treatments namely – ACE's, beta-blockers, MRA's, and SGLT2's.
- Increased accessibility to Heart Failure review for those patients who may struggle to access the existing services by offering remote appointments as well as face to face.
- Targeted appointment times, which will allow for more individualised care
- Better Control of their condition by treatment within Local and National Guidelines and review by a Heart failure Specialist.
- More appropriate treatment to prevent progression of the disease and Prevention of Hospitalisations and 'Enhanced patient education'.

Benefit to the NHS

- Common Guidelines
- Common databases with full interoperability
- Common budgets
- Seamless movement of patients at 'click of a button'
- Wide use of PCN pharmacists with input from consultants
- Collective investment in services rather than displacing costs to other Providers.
- Single clinical governance arrangement
- Overarching Governance

Benefit to Astra Zeneca

- The project will identify additional heart failure patients therefore the total market is expected to expand. AstraZeneca manufactures medicines for the treatment of heart failure and diabetes, therefore, the prescribing of these medicines may increase. This project is not reliant upon prescribing of AstraZeneca medicines and the decision to prescribe will remain with the clinician in line with local protocols and guidelines
- Astra Zeneca will have access to anonymised data generated in the project.

Outcomes

The Registry of HF patients was cleansed with a new total of 3107 patients identified
This was further broken down to 1100 identified as rEF patients and 2000 as pEF patients.
The primary efficacy outcome was a reduction in admissions into hospital with heart failure / death

The secondary outcomes

Proportion of patients successfully enrolled in the service
89% accessing at least one education medium.

Patient reported outcomes of satisfaction at the 6-month time point
Over 80 % of patients on 'maximum tolerated dose' of ACE / ARB / BB / MRA / SGLT2.

Average of Patients on an Ace on Discharge from 54% to 98% in project locality
Average of Patients on an Ace & ARB on Discharge from 62% to 98% in project locality
Average of Patients on an Ace, ARB, MRA Beta Blocker on Discharge from 36% to 82% in project locality
Average of Patients on an SGLT2 On Discharge from 29% to 57% in project locality
Average of Patients received a Consultant Cardiologist input in project locality 51% - 43%

Accessing vulnerable and hard to reach groups
Equality of access to care is a central tenet of all CCGs, but also the cardiology operational delivery network for the Humber, Coast, and Vale.
The entry routes into the programme were driven primarily by need rather than patient or carer advocacy. Using these criteria very few patients missed the opportunity to benefit from the programme.
The mechanism for delivering interventions were structured in a broad ranging spectrum and suited to the patient's level of understanding and degree of digital literacy. Clinical systems have learnt during the pandemic that digital literacy is often underestimated even in much older patients, and frequently carers and relatives (such as children) will involve themselves with functions around education about their parents' condition and welcome opportunities to be involved in consolidating that learning. That's said – there is now significant capability to deliver education and care using either face to face or telephone advice, which will always suit a proportion of patients.
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Patient Care Setting:

- Priority 1 patients were seen face to face as in-patients.
  From there – all were offered telemonitoring, with an uptake of 75% (in line with UK data of uptake rates). Each year 200 patients were entered into the telemonitoring pathway.
  Follow up will be at 2 weeks, 12 weeks, 24 weeks, and then ad hoc and will be virtual.
- Priority 2 patients were risk stratified – patients with an ongoing loop diuretic requirement (and tendency towards oedema) were offered follow-up at 12 weeks then every 24 weeks virtually.
- Priority 3, 5, and 6 patients were risk stratified in the same way.
- Follow-up at 2 weeks, 12 weeks, and then every 24 months virtual.

Legacy
The legacy of this project is undecided as phase 2 of the project has yet to be commissioned.