CPIP Heart Failure Pathway

This end-to-end heart failure pathway denotes ideal access and further considerations for the entire patient journey.

NHS North London Cardiac Operational Delivery Network

NHS South London Cardiac Operational Delivery Network

Prevention

Discrete CPIP delivery programme[1]

NHS LTP

Detection

Settings[2]
- Primary care
- Case finding (e.g., register reviews) (NHS LTP)
- Community services (e.g., community matrons, district nurses, community COPD/diabetes etc)
- A&E /urgent care
- Secondary care specialties
- Ambulatory care / @Home services
- Diagnostic hubs / cardiac imaging

Access to:
- Advice and Guidance (GIRFT)
- Regular educational sessions delivered by specialist team

Diagnosis

Essential Tests (NICE CHF/AHF)[3]
- Natriuretic peptide testing (standardised units / reference ranges)[4].
- Relevant blood tests
- 12 lead ECG
- Echocardiography[5]

Systems / processes
- Electronic referral systems
- Standardised referral templates
- Triage by HF specialists (GIRFT)
- Accurate coding

Settings/Pathways
- Dedicated specialist HF clinics[6]
- Dedicated pathways for patients presenting acutely to A&E/Urgent care (NCEPOD)

Management and treatment

HF specialist core team
- HF consultant lead (GIRFT) (NICE CHF)
- HF specialist nurse[7] (NICE CHF/ GIRFT)
- HF specialist pharmacist (NICE CHF)
- HF MDT[8]
- Primary care team
- Integrated secondary and community services (NHS LTP/NICE CHF)

Treatment
- Dedicated HF inpatient services (NCEPOD)
- Guideline Directed Medical Therapies (GDMT)
- Advanced HF management pathways
- Palliative and end of life care pathways

Plus access to
- Device implantation
- Specialist imaging services
- Specialist MDTs (e.g., oncology, renal, frailty, respiratory)
- Psychological services

Patient led self management
- IAPT
- Remote monitoring (NHS LTP)
- Self management tools[9]

Discharge and follow up

Discharge
- Review of patient within 2 weeks post discharge from hospital (NICE AHF)

Follow-up
- 6 monthly review as per NICE guidelines (HF team and/or primary care)
- PIFU

Re-referral
- Referral back to the original team if there has been a change in symptoms with a repeat NTproBNP

Rehab and recovery

Cardiac rehab (NHS LTP)
- Heart failure dedicated programme[10] (GIRFT)
- Access to pulmonary rehabilitation programmes for those with concurrent lung disease

Data – Monitoring for continuous improvement of quality outcomes (NICOR (GIRFT), QOF, PROMS, PREMS, HES)

Digital – Leveraging technology in all tools, processes, and protocols with appropriate information / clinical governance

Education – To facilitate self management in patients / carers. To maintain knowledge and clinical skills in those managing patients

Research and Innovation – Access to new therapies and trials

CPIP Heart Failure Pathway: Notes

NHS North London Cardiac Operational Delivery Network

NHS South London Cardiac Operational Delivery Network

This end-to-end heart failure pathway denotes the ideal opportunities and considerations across the entire patient journey.

Prevention

1) There is a national CPIP prevention workstream, addressing this aspect. The North London ODN has a separate workstream for this. The South London ODN will support the ICS who will lead on this.

Detection For all settings, please see processes required under Diagnosis.

2) Patients with suspected heart failure may be identified via presentation of symptoms or through case finding via register / list reviews in a variety of settings. Pathways for referral to specialist services should exist for all potential channels of detection.

Diagnosis

3) All primary care pathways should use NTproBNP for suspected new diagnosis of heart failure.
4) Patients presenting in an outpatient setting with suspected heart failure and NTproBNP 400 ng/l – 2000 ng/l should be referred for specialist assessment and echocardiography within six weeks, Patients with suspected heart failure and NTproBNP >2000 ng/l should be referred for specialist assessment and echocardiography within two weeks. Those presenting acutely to A&E /urgent care should have access to a natriuretic peptide result within 4 hours to allow for appropriate triage.
5) Patients presenting acutely and requiring admission should have an echocardiogram within 24hrs (GIRFT)
6) Services should offer dedicated HF outpatient clinics. These should be appropriately templated and job planned to allow extended appointments (NICE)

Management

7) Community HFSN 2-4 per 100,000 population (BCJN 2019, BSH, GIRFT)
8) Please refer to the BCS guidance on HF MDT (in progress). All MDTs should have the ability to be performed in a hybrid manner, with both F2F and virtual participants. HF MDT should be appropriately job planned (GIRFT)
9) Self management tools may include digital technologies, PIFU etc

Rehab and recovery

10) Heart failure specialist programmes may be in person, virtual, or self managed, such as the REACH-HF offering.

NICOR – GIRFT: audit teams are appropriately resourced to provide weekly uploads of data to the national cardiac registries

CPIP Heart Failure Pathway: References

NHS North London Cardiac Operational Delivery Network

NHS South London Cardiac Operational Delivery Network

- **GIRFT**
  - https://www.gettingitrightfirsttime.co.uk/medical-specialties/cardiology/
- **NCEPOD**
  - https://www.ncepod.org.uk/2018ahf.html
- **NHS LTP**
  - https://www.longtermplan.nhs.uk
- **NICE CHF**
  - https://www.nice.org.uk/guidance/ng106
- **NICE AHF**
  - https://www.nice.org.uk/guidance/cg187

Authors: Dr Sue Piper, Dr Carla Plymen. Approved by London Cardiac Strategic Clinical Network and North and South Cardiac Operational Delivery Networks May 2022