The Recovery Plan

Planned recovery phase of essential heart failure services during Covid-19 pandemic

A position statement from the British Society for Heart Failure

Background

We have moved to the 'Planned Recovery' stage of the pandemic. Patients with heart failure not prioritised in the highest risk category during the emergency phase, now need review for initiation and/or optimisation of therapies, in order to prevent acute admission to hospital, reduce mortality and improve their quality of life.

Planning care and managing patients appropriately will provide stability and a better position to restore services fully. During the acute phase of the pandemic many specialist services were significantly disrupted due to redeployment of staff. This has had far reaching consequences for community services and the management of heart failure in primary care. Understandably, the pressure for timely discharge from acute care did not always address concerns and consider the implications for colleagues in the community. This has highlighted existing concerns that integrated heart failure care is poorly understood and highly variable. Development of community services is necessary to relieve the burden on secondary care.

As heart failure teams begin to regroup, we must now prepare for the impact of interrupted care over the longer term. Truly integrated care should provide more than a specialist secondary care service with outreach to the community. If community heart failure services were better established within our health care system, the whole patient pathway would be better protected for future waves or major incidents. We now have an opportunity for change.

We have seen innovative solutions to healthcare provision over the past few months with services working more collaboratively and harmoniously. We need to maintain this momentum, supporting services to work with colleagues across the whole system and to use it as a platform to ensure that heart failure is at the top of the national policy agenda, through and beyond the pandemic. Access to specialist heart failure care will be more important than ever in the coming months and years and it is important that it is accessible at all key points in the pathway.

Recommendations

This document is intended to provide practical advice and guidance to help identify and prioritise the next group of patients who should now be considered for review. This guidance is intended for a multi-disciplinary audience across both primary and secondary care. It would be further supported by identifying a named lead clinician(s) that local health care professionals can contact for advice.

In the first position statement BSH advised that patients at highest risk should be prioritised during the peak of the pandemic. Patients at **intermediate and highest risk** must now be prioritised to ensure initiation and optimisation of their disease modifying therapies and to prevent deterioration of their condition. Pro-actively managing patients who have experienced delays in appropriate treatment, will not only improve their well-being and long-term prognosis but also better prepare services to safely manage future waves of coronavirus infection.

In addition to patients identified in the emergency response (appendix 1), the following intermediate risk patients should now be prioritised for review following triage by a heart failure specialist:

- Patients placed in the 'virtual waiting room' pending appointments
- Patients with NTproBNP 400-2000pg/ml
- New patient referrals
- Symptomatic patients who require optimisation of pharmacological therapy
- Patients for consideration of cardiac device therapy
- Patients with Left Ventricular Ejection Fraction (LVEF) <35% post myocardial infarction*

**treatment optimisation for these patients undertaken by Cardiac Rehab, HF Nurse, GP, or Pharmacist as per local protocol*

General Principles - Optimisation of heart failure therapy, minimising face to face contact with virtual and telephone consultations. Planned management of patients utilising remote and virtual technology where appropriate will ensure readiness and resilience in the event of a second surge of infection.

Heart Failure Specialist Triage	Strongly recommended if not currently implemented
Protected environment	Patients should be reassured of a safe environment for face to face review, ensuring appropriate provision for shielded patients. Precautions as recommended in Public Health guidance.
Investigations and review	Access to and use of NTpro BNP, ECG and echocardiography in the community or hospital. Virtual review where the required clinical information is available e.g. blood pressure, heart rate and renal function/electrolytes
Medicine optimisation	Maintaining optimal fluid balance (euvolaemia) if necessary, on high dose loop diuretics or combination therapy. Optimise evidenced based oral therapies.
Community self-care	Home blood pressure monitor (BP and pulse) and weighing scales. Use of telemonitoring or cardiac device diagnostics where available and indicated. Education in self-management can be undertaken virtually supported by electronic patient literature (see links below)
Ambulatory care	Admission prevention measures such as ambulatory treatment lounges. Planned care for interventions such as device implantation under local provision guidelines
Rehabilitation services	Engagement of cardiac rehabilitation services
Palliative care	Advanced care planning and DNACPR, access to community support services and collaborative working

Pumping Marvellous Foundation https://pumpingmarvellous.org/

British Heart Foundation https://www.bhf.org.uk/informationsupport/support/practical-support/living-with-heart-failure

Cardiomyopathy UK https://www.cardiomyopathy.org/

These recommendations can be adapted for local use

BSH reiterates their strong recommendation that a **lead heart failure clinician** should be identified in every locality across the UK, to provide support and advice to clinicians in both primary and secondary care, ensuring high quality and geographically equitable care.

As heart failure services evolve during the pandemic, using new ways of working and available technologies, it is important to capture vital data and feedback from patients and staff across the whole system during this planning phase. This will enable evaluation of new care models which will inform future service redesign and prepare for the full restoration of robust services. The above measures will facilitate integrated heart failure service provision and improve long term outcomes for patients. Preventing admission and shortening the length of hospital stay where admission is necessary, will be both clinically and economically beneficial for patients and for the NHS.

Appendix

We recommend that these patients are reviewed at all stages of the pandemic:

New referrals of symptomatic patients with NTproBNP >2000 pg/ml from primary care or recent A&E attendance
Known HF patient with symptoms of decompensation
Recently discharged patients following admission with acute heart failure
Patients with advanced care plans and receiving palliative care in the community

Endorsed by: