

# Star Poster – Examples of changes

North Trent CHD Collaborative

**NHS**  
Modernisation Agency

## Match demand and capacity

### ONE STOP HEART DYSFUNCTION CLINIC DONCASTER & BASSETLAW NHS TRUST

In April 2001, patients with suspected heart failure in Doncaster did not have access to specialist services either through dedicated clinic time or nurse support. In addition, they had to attend the local hospital twice for diagnostic tests to be performed and then for a final diagnosis to be made

and treatment initiated. Now, through the CHD Collaborative, suspected heart failure patients attend a single one-stop dedicated clinic to have both their tests/results and initiation of treatment made on the same day. Follow up support is then provided through a nurse-led clinic.

## Co-ordinate the patient journey

Patients who attended A/E with chest pain, and diagnosed with Angina, were discharged with a referral to Cardiology. They waited up to 1 week to get a fixed appointment through the post for 13 weeks later. The criteria for RACPC now permits a direct referral from A/E and the patient leaves with a

booked appointment for that clinic. The appointment has been negotiated with the patient and is within 7-14 days. The result is that patients sent home from A/E, having presented with chest pain, can now see a Consultant Cardiologist within 14 days instead of 14 weeks.

## Enable people to see themselves as part of the same system

Patients were previously advised to address risk factors when placed on the waiting list for surgery, but often received no follow up until pre assessment clinic, which was often too late, and surgery sometimes had to be cancelled at short notice. Patients now have risk factors assessed and targets agreed in outpatients. The patient is sent home with an individualized plan, and proformas outlining risk factors,

targets and action needed, are sent to CHD Lead Practice Nurses and GP's to facilitate follow up and revision of practice CHD registers. Named secondary care nurses provide link back to Consultant for earlier review if patient fails to meet targets.

## Improve patient and carer experience

Feedback from the discovery interviews with Carers, identified the distress that carers endure whilst asked to wait in a separate room, during the period that the patient has Thrombolysis. To elevate this distress at the Doncaster Royal Infirmary, Carers, with the patients consent, remain with the patient at the bedside.

## Optimise care delivery

### PROGRESSIVE CARE UNIT THE SOUTH YORKSHIRE CARDIOTHORACIC CENTRE, SHEFFIELD TEACHING HOSPITALS TRUST

A DEDICATED post-surgery care unit is speeding the pathway for cardiac surgery patients. Critical care capacity was a major constraint on throughput. Capital funding enabled the conversion of two four-bedded bays in the cardiothoracic ward into a specialist six-bed progressive care unit (PCU). Associated re-organisation of theatre recovery has enabled the team to provide post-operative care for up to two CABG patients a day. Following extubation graft & valve patients fitting

pre-agreed clinical criteria are admitted onto the PCU later the same day. The collaborative worked with staff on the development and small scale testing of the protocols and procedures developed during the commissioning period leading to the opening of the unit in September 2001. The introduction of the new unit has increased flexibility within the heart centre and reduced elective cancellations caused by CICU bed shortages.