Review of the Heart Failure Service

September 2010
# Project Information

<table>
<thead>
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<th>Workstream</th>
<th>Cheshire &amp; Merseyside Cardiac Work Programme 2010/11</th>
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<tr>
<td>Network Project Lead</td>
<td>Anne Porter</td>
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<tr>
<td>Programme Lead</td>
<td>Judy Arslanian</td>
</tr>
<tr>
<td>Network Director</td>
<td>Jan Vaughan</td>
</tr>
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## Version History

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1. Executive Summary

The Cheshire and Merseyside Cardiac and Stroke Networks (CMCSN) conducted a review of Heart Failure. This review took 2 months to carry out, involving all the Heart Failure Teams, both in the Community and Acute Trusts.

The aim of the review was to establish an understanding of the current database and dataset and other relevant issues relating to the delivery of Heart Failure Provision.

All 16 Heart Failure Nurse Specialists (HFNS) Teams in both the Community and Acute settings were included in this review. Information was obtained by a questionnaire, which was completed in a scheduled meeting, arranged with either the project lead or the Clinical Nurse Lead for the Network.

In addition, meetings took place with individuals, who had volunteered to take part in assisting to achieve the outcomes of the Network, which were documented in the Work Programme in A3 Heart Failure (Appendix 1) and A2 Cardiac Rehabilitation (Appendix 2). As the work progressed, it became apparent for the need to establish a Network Wide Working Group to improve the service to identify areas of good practice and areas for improvement. The role of the group was to support Identified areas for improvement in patient management across the primary secondary and tertiary settings.

One major theme highlighted that all the HFNS were being asked to collate different series of information and there appeared to be no standardisation of processing data across the Network. In addition, in many areas, the requests have not been done in direct consultation with the HFNS, who deliver the services, and this had led to a feeling of disempowerment.

The review highlights areas of good practice in addition to areas of HF services which need improvement. The process also identified training needs.

Finally the review outlines some key considerations for planning services for Heart Failure for 2011.

I would like to thank all the participants for their involvement, through the course of the review and for their contribution to the production of this report.

Anne Porter
Service Improvement Manager
Cheshire and Merseyside Cardiac and Stroke Networks
2. Introduction

Heart failure, which is associated with significant morbidity and mortality, is a complex clinical syndrome of symptoms. The most common cause of heart failure in the UK is coronary artery disease, with many patients having suffered a myocardial infarction (heart attack) in the past.

Heart failure affects about 900,000 people in the UK, with almost the same number again who have damaged hearts but as yet no symptoms - and that number is increasing as a result of improved prognosis of coronary artery disease, ageing of the population and better treatments for heart failure. Heart failure has a poor prognosis: 30-40% of patients diagnosed with heart failure die within a year - but thereafter the mortality is less than 10% per year. Heart failure accounts for a total of 1 million inpatient bed days - 2% of all NHS inpatient bed-days - and 5% of all emergency medical admissions to hospital. Hospital admissions because of heart failure are projected to rise by 50% over the next 25 years - largely as a result of the ageing population. With these issues in mind Heart Failure is one of the Network priority areas in the work programme this year.

As part of the Cheshire and Merseyside Cardiac and Stroke Networks (CMCSN) Work Programme (2010/11) A3 Heart Failure (HF) (Appendix 1) a work stream was identified, which set out the aims:

- To improve knowledge and communication around HF
- To increase the identification of HF patients and their inclusion upon practice based registers in order to allow for optimisation of therapy
- To support the Acute and Primary Care Trusts HF Teams in their efforts to deliver efficient and effective HF care, delivered through an integrated approach, across the whole pathway from diagnosis through to end of life stages, and palliative care.

Following a scoping exercise carried out by Christine Gardener (Heart Failure Specialist Nurse, Liverpool Community Health, and Clinical Lead Nurse for the CMCSN) in April 2010, involving all the 16 Acute and Primary Care Heart Failure Teams, it outlined the need to look at database and datasets.

This subsequent review focussed on:

a. How data is captured, audited and extracted in the Acute and Community HF Settings.

b. Establishing a clearer picture of the delivery of care to the HF patient

c. The provision of Cardiac Rehabilitation for HF patients – Appendix 2 CMCSN Work Programme (2010/11) A 3 Cardiac Rehabilitation

QIPP & WCC

Given the importance for patient care and the high costs involved as mentioned in the introduction above the review reflected the need to assess services in line with the QIPP agenda (Quality, Innovation, Productivity and Prevention) and the World Class Commissioning Competencies.

The Review timescale

The review was conducted from July – August 2010 from initiation to reporting. Given this tight timescale, it was vital to ensure that the goals, of gaining a clearer understanding of the current service provision for HF, and the scoping of current community database and dataset, must be achievable.

1 See Appendix 4 for further details
2 CMCSN Work Programme A3 Heart Failure Action 6
The Review Process

1) Background research and information gathering.

2) Discussion with Christine Gardner, the Network's Clinical Lead Nurse re the HF Scoping Exercise - April 2010

3) Development of a Questionnaire

4) Meetings scheduled with each Heart Failure Nurse Specialist (HFNS) Team

5) Follow up registrations of interest to deliver the Work Programme

6) Commence the development of a Network Wide Working Group (NWWG)

7) Follow up other related issues as they presented, in relation to problems in service delivery

8) Collation of information necessary to produce the final report

9) A strategy for the care of HF patients

3. Objectives

The overall objective of the review was to identify the current services offered to HF patients and identify any support required for the HF teams to enable them to improve the services across Cheshire and Merseyside.

- Provide a greater understanding of current provisions.
- Identify gaps, strengths & weaknesses of the current service.
- Outline any future work required

4. Current Services

The Heart Failure Service is currently provided by 8 Acute and 8 Community settings across the Cheshire and Merseyside Cardiac Network.

<table>
<thead>
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<tr>
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<tr>
<td>Arrowe Park (Wirral)</td>
<td>St Catherine’s (Wirral)</td>
</tr>
<tr>
<td>Countess of Chester</td>
<td>West Cheshire PCT</td>
</tr>
<tr>
<td>Liverpool Heart and Chest Hospital</td>
<td>Liverpool PCT</td>
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<tr>
<td>Royal Liverpool and Broadgreen</td>
<td>Sefton</td>
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<tr>
<td>Southport Acute Hospital</td>
<td>Southport and Ormskirk</td>
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<td>Warrington General Hospital</td>
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<tr>
<td>Whiston and Halton</td>
<td>St Helens and Halton</td>
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</table>

5. Guidance /Drivers

- NSF for CHD – Standard 11(2)
- NICE Clinical guideline 108 Chronic Heart Failure, quick reference guide, August 2010
- Institute of Innovation and Improvement – Focus on: Heart Failure Jan 2009
- NHS Improvement - Heart Failure (previous Heart Improvement Team)
- National Heart Failure Audit 2008/09
- Heart Failure Rehabilitation links with Cardiac Rehabilitation Cardiac Work Stream (A2)
6. The Questionnaire

6A Provider Engagement

An interview was carried out with 16 HF service providers and a questionnaire was completed with those listed below in Table 1. A sample of the questionnaire is in Appendix 3. Questions related to data, reports, audit and prescribing.

<table>
<thead>
<tr>
<th>Name</th>
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<th>Name</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alison Bethel</td>
<td>Countess of Chester</td>
<td>Sarah Ellison, Diana Astbury</td>
<td>West Cheshire PCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Diane Taylor</td>
<td></td>
</tr>
<tr>
<td>Lorraine English</td>
<td>Liverpool Heart and Chest</td>
<td>Chris Gardner</td>
<td>Liverpool PCT</td>
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<td></td>
<td>Hospital</td>
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</tr>
<tr>
<td>Barbara Flowers</td>
<td>Southport and Ormskirk</td>
<td>Sharon Forrester</td>
<td>Southport and Ormskirk PCT</td>
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<tr>
<td>Vikki Ludgate</td>
<td>Arrowe Park Wirral</td>
<td>Barbara Stephens</td>
<td>St Catherines Wirral</td>
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<tr>
<td>Ann Cottom</td>
<td>Warrington General</td>
<td>Sandra Dunne</td>
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<tr>
<td>Kirsty Morgan</td>
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<tr>
<td>Carole Roscoe and Angela</td>
<td>Whiston Hospital</td>
<td>Amanda Leyland and Paula</td>
<td>St Helens and Halton</td>
</tr>
<tr>
<td>Jones</td>
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<td>Peacock</td>
<td></td>
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<tr>
<td>Angela Colquehoun and Jenny</td>
<td>Aintree Cardiac Centre</td>
<td>Nicky Trotter and Jane Hartley</td>
<td>Sefton Community HF Team</td>
</tr>
<tr>
<td>Leigh</td>
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<tr>
<td>Pamela Aimson</td>
<td>Royal Liverpool and BroadGreen</td>
<td>Elaine Gossage</td>
<td>Knowsley/LHCH</td>
</tr>
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Table 1 HF Service Providers

6B Summary of the Questionnaire:

1) What system do you use for inputting data? All 16 providers used different systems:- data collection ranged from entering no data; only just started entering Central Cardiac Audit Database (CCAD); using own devised excel spreadsheet; Trust IT system; Lorenzo; stand alone databases; Meditec; Patient Administration Systems (PAS); Advancing Quality (AQ)

2) Do you have any problems/issues with inputting data? If yes, what are they? 10 providers stated that they experienced problems:- such as restricted access to a PC; lack of time; restricted/lack of admin support; issues with initial coding errors as a result of incorrect diagnosis on admission; having to duplicate information; systems not being user friendly; systems not being comprehensive – some are based on old “Key Performance Indicators” (KPI’s); lack of input into what data is collected/required – decided at Trust level – no local engagement with HF teams in some areas

3) Do you have any problems/issues with reports which are generated? If yes, what are they? 14 providers stated that they had problems such as the Inpatient(IP) activity only is reported and not Out Patients (OP); time spent indirectly for the patient is not taken into account; patient seen in OP by a Consultant and then referred to a HF Nurse cannot be recorded, as only one activity in OPD can be counted; reports are mainly quantitative; reports do not accurately
reflect what the nurse actually does for the patient; the report does not reflect what the HFNS does in the average working day; (AQ) is 5 months behind – not real time; retrieving and understanding the reports is time consuming; more IT/Audit support required; apart from feedback from AQ, some HF Teams receive no other feedback about their performance; some don’t receive any reports at all.

4) What type of report would you like? What info would you like it to contain?

| A record which states the number of patients discharged and the level of optimisation of care achieved as per Nice Guidance; one which reflects the actual length of time spent with the patient in order to manage them effectively; a record of time spent dealing with other services, including telephone contact on behalf of the patient; when palliative care support received; one which highlights when readmissions are prevented; the number of patients on the active register and the percentage seen within 10 days; a report which accurately reflects the diagnosis of HF admissions and discharges each month; reports to link with GP registers; ratio of new to follow up in clinic, which reflects the differing requirements of the patient. |

5) Do you currently record details on Prescriptions issued by yourself?

| 25% do not prescribe; 12.5% prescribe and keep their own records in addition to documenting it in the notes; 62.5% prescribe but do not keep their own records – they document it in the notes and follow local policy. |

6) Is there a standard proforma for completing these details?

| All 16 providers stated that there wasn’t a standard proforma. |

7) Please could you provide details, where known, of your IT and Audit Personnel?

| Local details, where known, are available in Appendix 5 |

Table 2 Summary of Responses to the Questionnaire - (Completed responses in Appendix 5)

6C Result of questionnaires

Good Practice identified

1. Liverpool (Community Health) are entering data and can access reports, which is starting to truly reflect the work they do; they are recording actual time spent with the patient and all the related non client linked activity, which is necessary for each effective patient episode; the dependency levels for each patient, which often demonstrates the amount of clinical or non clinical aspects of care (high, medium or low patient dependency); some aspects of clinical effectiveness linked to NICE guidance and including changes in drug therapy by way of recording Snowmed codes (Appendix 6) at each patient review. The system they use is essentially Lorenzo (Appendix 7), but they also use a stand alone database for some aspects of clinical effectiveness and their electronic diaries for daily activity coding, which is linked into the service specifications (i.e. direct clinical and indirect non clinical work, education support to others)

2. Whiston Hospital (Acute) uses a stand alone database, and an Excel spreadsheet, which they have devised themselves. It collects information on patient demographics, referrals, hospital number, follow-ups – clinic reviews or community reviews, GP, diagnoses. They also collect data for (CCAD). Reports can be produced on request

3. New York Heart Association classification of Heart Failure
4. Some areas are starting to use a supportive register within the GP surgeries and the data regarding the point at which palliative care support is received, will be collected.

5. There is a funded post for a Palliative Care HF Specialist Nurse, in St Helens, for patients in Whiston. This post is not common and will definitely support the implementation of the Gold Standards Framework for End of Life Care for patients with HF.

Gaps and Problems identified by questionnaire

1. There is no standardisation of data entry across the Network.

2. With the exception of Liverpool Community Health and Whiston Hospital, the data which is being collected, does not appear to support the role of the HF Team or reflect all the work they do with HF patients.

3. Lack of time, inadequate staffing levels and lack of admin support were identified by 7 practitioners as a problem associated with inputting data.

4. Collection of data for Advancing Quality (AQ), which is an essential requirement for those participating Trusts, can appear to be a paper exercise because it does not compliment the data required for CCAD.

7. Gaps and Problem Identified as a result of the interviews

a) Collection of data is affected when the primary diagnosis was not Heart Failure.

b) The HFNS spends a huge amount of time, in establishing the correct diagnosis within Acute Trusts, either whilst the patient is still in hospital or once they have been discharged. This aspect of their work is not accounted for, nor is it reflected in their workload or logged onto any system.

c) Incorrect coding could unexpectedly delay treatment or the patient is lost and does not receive treatment at all. Both Warrington and Southport Acute Trusts noted this as a recurring problem. If the patients are not seen by either a Cardiologist or a Heart Failure Specialist Nurse in the first instance, then there is a higher possibility of incorrect coding.

d) The age profile of the Southport area contrasts significantly with that of England and Wales. (See Table 3 – Mid year 2009 population from the Department of Health). Southport has a much higher proportion of older people at retirement age: 25.3% aged 65+ males and Females 60+. This is 6.5 percentage points above the national average of 18.8% of the population at retirement age. This has significant implications for providing health and social care for the elderly. HF becomes more common with increasing age. About 1 in 15 of people aged 75-84 and just over 1 in 7 people aged 85 and above have HF. However, prevalence of HF amongst patients attending GP practices in Southport is 1.2%, which appears low, which may suggest that patients are either missed or miscoded. Given the potential number of patients involved, it is essential to ensure a smooth pathway to guarantee all HF patients are recognised and treated correctly. This may involve further interventionalist work, as NICE guidance recommends Implantable Cardioverter Defibrillator (ICD) implantation for appropriate HF patients.

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4 Network Work Programme A3 Action 8
5 NHS Technology Adoption Centre – Cardiac Resynchronisation Therapy Project 2009
6 Randomised controlled trial of Specialist Nurse Intervention in Heart Failure BMJ.com 7th April 2005
7 Sefton Council Website
8 British Heart Foundation (BHF)
9 QOF Data
Table 3: Mid year 2009 population (Dept of Health)

e) Reports from 8 HF practitioners suggest that their expertise, knowledge, decision making and skill level was not always recognised by others and this has made them feel disempowered. This lack of empowerment has created frustration and an apparent lack of worth.¹⁰

f) On 2 occasions, community patients with HF, who had an ICD, at the end of their life, had to be transported, by a paramedic ambulance, to the nearest Acute Trust, to have the ICD deactivated, then returned home.¹¹ Training has been provided in the past, by the CMCN, to facilitate deactivation in the Community, as required. This will be discussed further in Section 10 (Recommendations)

g) Although efforts are being made for Heart Failure patients to be able to access Cardiac Rehabilitation, the provision is currently quite fragmented¹²

¹⁰ NHS Institute for Innovation and Improvement – Quality and Service Tools - Empowerment
¹¹ The Decision to Withdraw Implantable Cardioverter Defibrillator (ICD) Therapy in an Adult Patient CMCN
¹² NICE Chronic Heart Failure – quick reference guide 2010
8. Network Wide Working Group (NWWG) Registrations of Interest

On receipt of the CMCSN Work Programme June 2010 – 2011, a number of practitioners and clinicians registered an interest in working with the Network to improve services across Cheshire and Merseyside for patients with HF. From undertaking the work, it became apparent that a multidisciplinary network wide working group was paramount to help to improve these services.

The role of the NWWG will be to facilitate, disseminate information and support the group. Those who volunteered are fully aware of their CMCSN commitment to this group. Initially the constitution of this group will be to represent specialties across the Network, in Acute – Secondary and Tertiary Care - and the Community. When appropriate, representatives from other specialities will be sought.

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<th>Name</th>
<th>Place of Work</th>
<th>Contact Details</th>
</tr>
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<tbody>
<tr>
<td>Consultant Cardiologist (Tertiary Setting)</td>
<td>Archi Rao</td>
<td>Liverpool Heart and Chest Hospital</td>
<td><a href="mailto:Archana.rao@lhch.nhs.uk">Archana.rao@lhch.nhs.uk</a></td>
</tr>
<tr>
<td>Heart Failure Specialist Nurse</td>
<td>Barbara Stephens</td>
<td>Wirral Community</td>
<td><a href="mailto:Barbara.Stephens@wirralpct.nhs.uk">Barbara.Stephens@wirralpct.nhs.uk</a></td>
</tr>
<tr>
<td>GPSI – Cardiology</td>
<td>Phil Jennings</td>
<td>West Wirral Group Practice Irby Surgery</td>
<td><a href="mailto:philip.jennings@nhs.net">philip.jennings@nhs.net</a></td>
</tr>
<tr>
<td>Heart Failure Nurse</td>
<td>Carole Roscoe</td>
<td>Whiston Hospital</td>
<td><a href="mailto:Carole.Roscoe@sthk.nhs.uk">Carole.Roscoe@sthk.nhs.uk</a></td>
</tr>
<tr>
<td>Principal Pharmacist</td>
<td>Dave Thornton</td>
<td>Aintree Hospital</td>
<td><a href="mailto:Dave.Thornton@aintree.nhs.uk">Dave.Thornton@aintree.nhs.uk</a></td>
</tr>
<tr>
<td>Director of Public Health Outcomes</td>
<td>Ewan Wilkinson</td>
<td>Liverpool PCT</td>
<td><a href="mailto:Ewan.Wilkinson@liverpoolpct.nhs.uk">Ewan.Wilkinson@liverpoolpct.nhs.uk</a></td>
</tr>
<tr>
<td>Consultant Cardiologist (DGH)</td>
<td>Jason Pyatt</td>
<td>Royal Liverpool and Broadgreen</td>
<td><a href="mailto:Jason.Pyatt@rlbuht.nhs.uk">Jason.Pyatt@rlbuht.nhs.uk</a></td>
</tr>
<tr>
<td>Public Health Development Manager</td>
<td>Ruth Du Plessis</td>
<td>NHS Sefton</td>
<td><a href="mailto:Ruth.duplessis@sefton.nhs.uk">Ruth.duplessis@sefton.nhs.uk</a></td>
</tr>
<tr>
<td>Clinical Information Analyst</td>
<td>Ruth Grainger</td>
<td>Cheshire and Merseyside Cardiac and Stroke Networks</td>
<td><a href="mailto:Ruth.Grainger@cissu.nhs.uk">Ruth.Grainger@cissu.nhs.uk</a></td>
</tr>
<tr>
<td>Palliative Care Heart Failure Specialist Nurse</td>
<td>Rebecca Telfer(^{13})</td>
<td>Whiston and St Helens</td>
<td><a href="mailto:Rebecca.Telfer@sthk.nhs.uk">Rebecca.Telfer@sthk.nhs.uk</a></td>
</tr>
<tr>
<td>Commissioner</td>
<td>Sue McGorry</td>
<td>Liverpool PCT</td>
<td><a href="mailto:Sue.McGorry@liverpoolpct.nhs.uk">Sue.McGorry@liverpoolpct.nhs.uk</a></td>
</tr>
<tr>
<td>Cardiac Rehab Specialist</td>
<td>Sophie McIntosh</td>
<td>Countess of Chester and Community Care Western Cheshire PCT</td>
<td><a href="mailto:Sophie.McIntosh@coch.nhs.uk">Sophie.McIntosh@coch.nhs.uk</a></td>
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<tr>
<td>Practice Based Commissioning Programme Manager</td>
<td>Stephen Astles</td>
<td>NHS Sefton</td>
<td><a href="mailto:Stephen.Astles@sefton.nhs.uk">Stephen.Astles@sefton.nhs.uk</a></td>
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Table 3 Network Wide Working Group for both Heart Failure and Cardiac Rehabilitation

\(^{13}\) Network Work Programme A3 Action 8
9. Conclusion

This review has provided:

- An awareness of the variation of data collection and the systems used by HF teams and the problems this is causing

- The rationale behind setting up a Network Wide Group.

- The evidence that further work needs to be carried out to improve HF service. There is both acknowledgement and a desire to improve the HF service in Cheshire and Merseyside supported by the enthusiasm of the HFNS and membership of the Multidisciplinary Team

- Examples of areas of Best Practice and where there are gaps/weaknesses in service delivery

- The HF service variables and staffing issues experienced

- A platform to support the base line for the next work programme 2010/11 for the Network.

- Insight into empowerment training needs for the HFSN’s. There is a need to more closely involve HFSN in service changes, as effective delivery is linked to improved communication between members of the Multidisciplinary Team

- A need for improved communication between all members of the Multidisciplinary Team who provide the service for HF patients.
10. Recommendations

- Establish a working party to present to the 16 HF teams about working efficiently, utilising all resources, the impact of data collection, highlighting the differences in data collection

- Feed back from NWWG to Cardiac Advisory Board (CAB) and HF teams

- Feed back HF review to Cardiac Advisory Board (CAB) and HF team

- Use CMCSN website for improved communication

- It has been identified that one PCT (Liverpool Community Health) and one Acute Trust (St Helens and Knowsley) are processing data and audit to an excellent standard. This model of data/information could be used to support those HF teams, who feel disempowered, because there is a lack of understanding about their role and their needs, in the provision of care for HF patients.
  - Lorenzo dependency definitions for HF patients could be shared with other Trusts

- The review could help inform the commissioning process, to highlight gaps in service, ensuring key providers are included in the decision making process. To present the review to commissioners in relation to HF, prior to their agreement of Commissioning intentions for 2011

- In relation to the deactivation of ICD’s in the Community:
  - This issue needs to be investigated further, particularly in relation to the potential increasing numbers of ICD’s being inserted as per National Guidelines, which states that a 7% growth, year on year, is required to reach the National Target by 2015.
  - Utilise the role of the BHF Cardiac Physiologist Regional Educational Trainer (Wendy O’Connor) to facilitate training for those not regularly practising and for new practitioners
  - Raise awareness to the community, by attending the HFSN meeting, about the current limitations and constraints within the acute setting, which may impact on the provision of deactivation of an ICD in the Community.

- Develop a simple questionnaire to identify the current provision of Cardiac Rehabilitation in the Community for Heart Failure patients. The development and outcomes could then be addressed by the Network Wide Working Group\textsuperscript{14,15}

- Benchmark the current provision of HF across the Network

\textsuperscript{14} Network Work Programme A2 (Cardiac Rehabilitation ) Action 5
\textsuperscript{15} Appendix 8 Suggested Questionnaire to access this information
A3. HEART FAILURE

GOAL: Improve knowledge and communication to increase the identification of patients with heart failure and inclusion upon practice based registers to allow for optimisation of therapy. Support the Acute and Primary Care Trusts heart failure teams to enable patients with heart failure to receive efficient and effective care delivered through an integrated approach from diagnosis through to end of life stages and palliative care. The project will be delivered in line with World Class Commissioning and the Quality, Innovation, Productivity and Prevention agendas.

Drivers:
- NSF for CHD – standard 11 [2]
- Heart Improvement Team - Priority work programme [4]
- *Heart Failure Rehabilitation links with Cardiac Rehabilitation Cardiac Work Stream (A2)
- Benchmarking and the 18 week Pathway

Action:
1. Facilitate and support the heart failure team to develop a Network wide multidisciplinary heart failure working group to improve the service and identify gaps.
2. Work with commissioners and providers to support the successful implementation and delivery of agreed streamlined pathways across primary and secondary care.
3. Work with commissioners to support identification and appropriate registration and validation of patients with heart failure in primary care.
4. Agree Network guidance and recommendations to streamline access to diagnostics (Echo and BNP) for the identification of patients with suspected or existing heart failure within primary and secondary care.
7. Review options for secondary care databases for patients with heart failure and support implementation of an agreed database across the Network.
8. Support/promote implementation of the Gold Standards Framework, Supportive Care Registers/Care Profiles for End of life Care and the Liverpool Care Pathway for patients with heart failure within primary and secondary care.
9. Assist in the delivery of advanced communications courses for primary and secondary care practitioners for end of life and palliative care.

Timescales
June 2010 - May 2011

Measure of success:
1-9 Development of report to analyse impact / relevance of project on WCC competencies and the QIPP agenda
1. Network wide group established that is representative of all perspectives; Attendance at meetings, actions completed and reported to Cheshire & Merseyside Cardiac Board.
2. Development of resources/information/tools to support commissioners and providers in implementation.
3. PCT validation of heart failure registers.
4-7. Agreed Network wide guidance and recommendations disseminated and tool developed to gauge successful implementation.
8-9. Number of healthcare professionals attending, and evaluation of, conference/courses.
**Appendix 2 Cheshire and Merseyside Cardiac and Stroke Networks Cardiac Work Programme and Delivery Plan (2010 – 2011) A2 Cardiac Rehabilitation**

<table>
<thead>
<tr>
<th>A2. CARDIAC REHABILITATION</th>
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<tr>
<td><strong>GOAL:</strong> Increase access to, equity of provision and uptake of cardiac rehabilitation for all cardiology pathways. Minimise unwarranted variations within and among programmes and between different patient cardiac pathways. Cardiac rehabilitation is integrated into all cardiac care pathways where all patients who can benefit have an assessment of individual needs and ability (menu-driven). The project will be delivered in line with World Class Commissioning and the Quality, Innovation, Productivity and Prevention agendas.</td>
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| Drivers: | NSF for CHD – standards 11 and 12 [2]  
| Heart Improvement Team - Priority work programme [4]  
| BACR – Standards and core components for cardiac rehabilitation [5]  
| NACR – Publication of data/benchmarking [7]  
| BHF – National campaign for cardiac rehabilitation [8]  
| *Heart Failure Rehabilitation links with Heart Failure Cardiac Work Stream (A3)* |

| Action: | 1. Facilitate and support the development of a Network wide multidisciplinary working group to develop and take forward recommendations.  
| 2. Carry out a review of current service configuration and provision for cardiac rehabilitation across the Network.  
| 3. Support implementation of NACR database in all organisations to improve data quality/ submission timelines.  
| 4. Support the development of a Network wide model of service that will support all patients who have an acute cardiac event to access cardiac rehabilitation.  
| 5. Explore expanding routine cardiac rehabilitation to other groups e.g. heart failure (linking with HF work stream).  
| 6. Develop cardiologist clinical leadership for referral to cardiac rehabilitation.  
| 7. Support delivery of educational events for commissioners, practitioners, nursing and medical staff. |

| Measure of success: | 1-7 Development of report to analyse impact / relevance of project on WCC competencies and the QIPP agenda  
| 1. Group membership that is representative of all organisations and appropriate stakeholders; Attendance at meetings, actions completed and reported to Cheshire & Merseyside Cardiac Board.  
| 3. Development of proposed model of services with standardised protocols to support joint agreement, planning and commissioning of services across hospital trusts, GP practice and commissioners.  
| 4. Integration with heart failure work programme; Reported patient referral numbers/types of patients for cardiac rehabilitation.  
| 5. Cardiologist clinical leadership in all organisations across Network.  
| 6. Participation of all sites in NACR database.  
| 7. Number of educational events facilitated by Network Support Team; Number of healthcare professionals attending, and evaluation of, educational events. |

| Timescales | July 2010 – May 2011 |
**Appendix 3 Questionnaire for Heart Failure Nurses re Capturing and Reporting Data**

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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Place of Work</th>
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<tbody>
<tr>
<td>1)</td>
<td>What system do you use for inputting data?</td>
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<tr>
<td>2)</td>
<td>Do you have any problems/issues with inputting data? IF yes, what are they?</td>
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<tr>
<td>3)</td>
<td>Do you have any problems/issues with reports which are generated? If yes, what are they?</td>
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<td>4)</td>
<td>What type of report would you like? What info would you like it to contain?</td>
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<tr>
<td>5)</td>
<td>Do you currently record details on Prescriptions issued by yourself?</td>
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<tr>
<td>6)</td>
<td>Is there a standard proforma for completing these details?</td>
</tr>
<tr>
<td>7)</td>
<td>Please could you provide details, where known, of your IT and Audit Personnel?</td>
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Date
Appendix 4 – CMCSN Scoping Exercise to Acute and Primary Care Trust HF Teams – May 2010

Purpose of Exercise:
To engage with current HF teams and ascertain their level of intervention within their own clinical areas, in relation to HF planning and pathway redesign.

Method:
Each team (x8 across the PCT and x8 across Acute Trusts) were sent a set of 4 questions and asked to return their responses. A total of x7 responses were received from Primary Care Teams and x7 responses received from Acute HF Teams. Unfortunately, no responses were returned before the deadline date, from the Halton & St Helens Team (PCT) and the Countess of Chester Team (Acute Trust).

Emerging Themes:
Staffing levels vary: Out of the PCT Teams, Sefton has the largest team but this covers both North and South Sefton, Knowsley have the second largest, and have just come under new management with the LHCH. Both of these teams also see cardiac conditions other than HF, whereas most of the other PCT teams just tend to see just HF patients. The Acute Teams vary between 1-2 staff in the main. Very few teams have clerical support.

All teams are facing changes within their service provision. Not all teams are being consulted on the new pathways, or if they are, this is often in a limited manner. Previous HF groups have been disbanded in several Trusts, which has halted work progress. Not all teams feel that they are currently being consulted. One team identified real concern that the Commissioners do not engage with them, one team is fearful that they might be included in a round of provider service cuts. One HF Nurse is due to be invited to join her area’s Commissioning Board and she hopes to have more input in service delivery decisions in the future. Primary Care teams still appear to be identifying problems with HF Register validation.

Conclusions:
From this limited exercise it would appear that all teams are undergoing change, but given the high level of HF Nurse expertise across our Network, Teams are demonstrating that those responsible for these service provision changes are not always consulting with the people who tend to be delivering, or initially set up the services. There appears to be an underlying feeling that this aspect must change. Also, the identification of HF patients within the community is still not accurate, as validation of the HF Registers within most areas is still incomplete. It would be helpful if some of the issues raised, could be explored further, in order to establish where communication links could be improved, and how the Network could facilitate this with the Commissioning teams.

It is proposed that local meetings will be arranged with each HF team over the coming weeks in order to gather more opinions on how the teams feel the HF pathway process could be improved, and continue to offer Network support to the HF Nurse teams.

Christine Gardner
Clinical Lead Nurse, CMCSN
May 2010
### Questionnaire for Heart Failure Nurses re Capturing and Reporting Data

**Date:** 04.08.2010  
**Name(s):** Angela Colquehoun, Jenny Leigh, Sally  
**Job Title:** HFNS  
**Place of Work:** Aintree Cardiac Centre

| 1) What system do you use for inputting data? | Trust IT System, which will soon change to Sigma, which will contain the complete pt healthcare record  
Medway to retrieve blood results / investigation results  
AQ data also collected  
CCAD data submitted  
The team have some support  
i) Medway bloods recorded on paper  
ii) AQ data is inputted by a clerk after the team record manually  
iii) CCAD data is inputted by a clerk, after team manually collect on paper |
| 2) Do you have any problems / issues when inputting data? If so, what are they? | At present, the Team have to complete 4 different proformas before they even get to do much with a patient.  
Medway is fine, but there are multiple problems in trying to collect all the data required now. The team do have some clerical support for all the different data required, but there is still a huge amount having to be collected and inputted by Nurses. No-one seems to account for this time and there is criticism that not enough patients are being seen, but they still require the data, and get criticised if it’s not done.  
Not all data can be collected electronically, the AQ data takes up so much time, and there are also the problems in trying to identify the true HF patients. (i.e. Referrals may come from wards, and time is taken up seeing patients, going through notes and then discovering they aren’t HF. There is nowhere to record all this wasted effort, but it detracts from the actual amount of direct HF patient care.) The team feel they should be recording this into a log of some sort, but haven’t the time, and so it is just written manually. For AQ, every patient has to have a discharge proforma recorded, some of those patients may not be HF but the data records that.  
The data may also be possibly skewed as it does not account for the fact that a readmitted patient, may already have had data collected. It only seems to collect data per episode, but doesn’t link to named patients. |
The Team get a report on Patient flows annually from the Medway team, but they do not feel that readmissions are separated enough, as it may be the same patient on a number of occasions. (similar to AQ data) so the team have to manually trawl through the report to clarify. Medication data is recorded, but again, doesn’t differentiate if it is the same patient who was readmitted – this must alter the percentage figures? HF patients can be admitted to many wards, and it takes a long time to find them and ascertain if they are truly HF
This will become more of a problem as some cardiology beds have just been closed, and there will definitely be more outliers - potential for missed quality data.
They can source the Echo list, but patients may have been discharged by the time they find them on the list it can mean patients /data quality can potentially be missed
There may be a coding issue for readmissions (ICD 10 codes v primary diagnosis?)
There is a gap for referrals if the primary diagnosis is not HF, the team have to ask each ward “do you have any HF patients,” relies on the individual nurse having that knowledge to answer correctly else AQ data can be incomplete

| 3) Do you have any problems /issues with reports which are generated? If yes, what are they? | All the above issues and:
- The fact that there is nowhere to record the dependency/complexity of each patient. They get told they aren’t seeing enough patients, but it does not account for the fact that just one patient can take a lot longer to deal with and they have to plan their clinics accordingly, on the face of it, it can look like they have only seen say 4 patients, but one of them may have taken the work of two!
- The reports just say they have seen a new referral, they don’t record the fact that the Team may have had to do repeated in–pt visits to the wards just to sort one patient before discharge. (need to consider new and follow-up visits)
- There is no collection of the actual time it takes to collect all the data, that is not factored into their role and yet it is now a huge part.
- The team feel that there are expectations about what they should be doing, but no-one really understand what it is they actually do and targets are set unrealistically and cannot be achieved.
- Reports do not account for the amount of client linked activity that has to be done to manage a patient correctly and liaise with other services/agencies. (i.e. letter writing, blood analysis, investigation requests, faxing, telephone calls)
- They don’t always get feedback from their data |
| 4) What type of report would you like? | Would like to break down information into more useful sectors to record the above (i.e. |
| What info would you like it to contain? | complexity, readmissions, contacts of new and follow-ups) but scared that this would generate even more work!  
- No-one is collecting data on patients who are supposed to be managed by the Practices but then get readmitted  
- More information on the drugs patients take as it appears skewed  
- Would like to know what are the National expectations / comparative data between teams?..Exactly how many patients should be seen in one day/clinic, and of what complexity, what compares in other parts of the country? Who says what’s good or bad? Who is achieving?  
- Who compares the mortality rates?  
- Who can give constructive performance review if the national standards aren’t known?  
- AQ data is retrospective, not all patients are seen before discharge, therefore is every hospital collecting the same standard, as it really depends on the honesty of each team! Is it a true reflection of quality?  
- Data collection clerks aren’t always clinically trained and information may be left to their interpretation (coding issues?) |
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<tr>
<td>5) Do you currently record details on Prescriptions issued by yourself?</td>
<td>None of the Team currently prescribe, and don’t feel the need to at the moment as there are always Drs about. They would recommend treatment changes and these get done by the Drs.</td>
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<tr>
<td>6) Is there a standard proforma for completing these details?</td>
<td>N/A as they don’t prescribe. A policy would need to be written if they did. Worried that they would then also have to collect even more data!</td>
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| 7) Please would you provide details, where known, of your IT and Audit Personnel | Steve Mangan – CCAD audit data  
Paul Spencer – Medway info  
Steve Lyon – Medway  
Andrea Wakefield – AQ data (not just for Cardiac ) |

Other points:
Team worried about the current political situation and whether the HFNS Band will be altered to cut costs, especially as the data does not always reflect the role requirements.

Questionnaire for Heart Failure Nurses re Capturing and Reporting Data

Date: 24/08/2010
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<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Place of Work</th>
<th>1) What system do you use for inputting data?</th>
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<tr>
<td>Christine Gardner</td>
<td>HF Nurse</td>
<td>Liverpool PCT</td>
<td>Lorenzo - for most work (contacts new and follow-ups; no’s on caseload and allocated staff/caseload; face to face contacts with clients or proxy; telephone contacts with clients or proxy, client linked activity, time taken to perform activity, dependency levels for each pt, appointments, Snowmed activity coding, report/letter writing and storage, patient record sheets, SAP folder pages) Stand alone database for some aspects of clinical effectiveness linked to NICE guidance (diagnosis, PMH, risk factors, before and after drug therapies – target dose or tolerated doses. past cardiac interventions CRT/PPM/ CABG/PCI' Pall care referrals and discharge pathways etc) In last month, we have started using our Electronic diaries for a new coding list v activity which is linked to KPIs for the service spec (i.e. teaching, clinical governance, pt contact, advice offered to others) Personal diaries or sheets (i.e. home visit sheet, clinic attendance sheet, Lorraine (secretary) does a readmission sheet, and collects referrals manually) BHF data quarterly collection returns (for 4 team staff only, also now started to request prescribing data) Snowmed codes Prescribing data is done manually (but can also be retrieved from PACT data)</td>
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<tr>
<td>2) Do you have any problems / issues when inputting data? If so, what are they?</td>
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<td>The amount of places where data now has to be collected, at times of high workload, inputting can be missed, (or the HF nurse may not be able to get to a computer if out of office,) unless it’s also been recorded manually. You never seem to have enough time to do everything. Lorenzo has been improved over the past year, as it develops, most of the PCT now use it in some format, but it has no clinical functionality at present. There is a decision to be taken as to which system the team and PCT, will use in the future this is under consultation. It is becoming part of the role now and appears less of a problem to input on, as we get more familiar with it We rely heavily on our Admin support and if she were to leave (which is looking likely!) we would struggle enormously without this help. It is an appointments / registration system, not a patient management system The system is very time consuming and is not always very user friendly The system frequently “crashes” and won’t allow access, particularly at times of high use for the PCT (i.e. Friday afternoons when every team tries to input their data) Lorenzo can be very slow to open in those buildings where internet connection is difficult It relies on a Smart card, and if this is forgotten, no work can be inputted for that day! Initially data was collected and caused anxiety as it did not seem to reflect activity, some of this</td>
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was down to the fact that the layers of narrative weren’t prescriptive enough, and some of these
issues have been ironed out now. The team have worked closely with IT to try to modify what
we collect.
The team database has never worked properly and we still have not had full data from this, and
as this was the one that was supposed to collect clinical details, it has been a missed
opportunity.
Our service spec data can lead to “rash” comments being made before the data is truly
understood or explained which can be demoralising at times

| 3) Do you have any problems /issues with reports which are generated? If yes, what are they? |
| Initially yes, but this is getting better as we have had input as a team with IT, to suggest how it can be presented. The most recent reports are easier to understand and are broken down for each team member, so performance can be monitored within the team, and is proving that we all work similarly in terms of activity. Not sure that the Senior Managers always appreciate the amount of info that is being collected which is time consuming and can detract from client activity at times. Travel time is not being accounted for at present, and we may need to consider this too.
Can add to the stress of the job, (there’s a pressure to get every contact on and this is not always possible as the role is constantly interrupted and prioritised... worse when computers crash... very frustrating!!! The PCT want the data for reference costing.
Everything also has to be exception reported against if previous activity levels are not achieved for whatever reason, (i.e. holiday / sickness / study).
However, our team is starting to see benefits from all this work, our activity is demonstrating other aspects to care delivery (i.e. to manage a pt at this level, there is also a huge amount of client linked activity which can take a large amount of time)
Our Line Manger keeps an eye on our data monthly and uses this to question the activity/performance which links into our service spec and KPIs
Data collection is evolving constantly which is good, but we need to ensure we aren’t just collecting for collecting’s sake
Comparison between local teams might be good providing we were collecting similar stuff |

| 4) What type of report would you like? What info would you like it to contain? |
| Our reports are starting to look quite meaningful now, so we haven’t really got a lot to complain about at present.
We receive data back every month from the IT team, we can access them at any time and they are helpful. We discuss at team meetings and can all have a say in what is needed/returned.
We are starting to look at complexity and there has been a tool developed which we are about to look at, this might help with considering complexity v dependency v time taken to manage. |
We need to get our stand alone database working better as we’ve had no proper report from this. The first attempt was so poor we rejected it. Back to the drawing board! AQ data will probably start in the community soon too, so we are trying to pre-empt what will be required.

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<th>5) Do you currently record details on Prescriptions issued by yourself?</th>
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<td>Yes, there are four full Nurse Prescribers in the team, one is on Mat leave, one has only just got her Px pad. The other HF Nurse has qualified in prescribing but due to registration problems has not been able to start to prescribe and she has a system to request GP scripts, She keeps a record of this. All scripts are written up in the pt case notes I keep a personal carbon copy of each script issued as well within my own personal file We can receive PACT data upon request from Medicines Management, and this is soon to be standard practice for all Nurse prescribers in the PCT. All Change of Treatments are faxed to the GP on the day of change, and records kept in the pt notes. Of those of us who prescribe, we possibly need to be more diligent accounting for those scripts that we might request from the practice (i.e. for pt convenience, drug issue collection ease/compliance,) We use a Snowmed code everytime we change a treatment, so it will account for this but won’t record which drug is changed (this could be checked manually) The BHF Nurses have to report back quarterly, to BHF now about what drug they prescribe.</td>
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<th>6) Is there a standard proforma for completing these details?</th>
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<td>We have a PCT Non Medical Prescribing Policy and the appendices contain a template to record the start script no, and the end no, and we are obliged to complete this sheet for every script issued. These records are then kept in a personal file. We have a Change of Treatment form which is faxed (as above) on the day of medication change Changes are recorded in our patient notes.</td>
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<th>7)Please would you provide details, where known, of your IT and Audit Personnel</th>
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<tr>
<td>Suzy Smallwood, Lee Hanlon, Gemma ?</td>
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**Questionnaire for Heart Failure Nurses re Capturing and Reporting Data**  
**Date:** 24/08/2010

<table>
<thead>
<tr>
<th>Name</th>
<th>Elaine Gossage</th>
<th>Job Title</th>
<th>HF Team Lead</th>
<th>Place of Work: Knowlsey / LHCH</th>
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1) **What system do you use for inputting data?**

An Excel spreadsheet. Devised in the past using template borrowed from the Cardiac Rehab data. Currently, LHCH are working on producing a new database for the team, which will link into their hospital systems. (ICS) The team try to capture data based on the NACR (National Audit for Cardiac Rehab) and the CCAD data, which only has a few points for HF, they realise they will need more fields. Currently, none of their data is linked to Key Performance Indicators (KPIs) Elaine has arranged a meeting on 24th Sep from a team who work with Papworth Hospital, and she likes this database, and has asked for a demo.

The Excel spreadsheet is cumbersome, but does include a number of fields, including demographics, date of referral, date seen; Home visits; referral date; New patients; those re-referred; NHS No; (which will be being converted to link in with the LHCH Hosp No’s:) Ethnicity; gender; Homeless status; NYHA; Diagnosis (which is not broken down into every category) whether diagnosis is alcohol related; Allocated Nurse; GP; It has only 4 links to limited KPIs of End of Life Care/Palliative Care; Date of diagnosis Method of referral, and whether pt is on GSF, whether pt has a Community Matron; is referral open or closed? Date of discharge; Date of 1st contact; Date of assessment; Care plan; Carer’s assessment offered? Experience survey offered? Rehab (comm. /home) Cardiac Rehab fields: phase 2, 1st call, 2nd call; rehab attendances.

Since joining with LHCH, they no longer have Pharmacy support within the team, or Psychological direct access.

The Admin Staff fill in the first part of the referral demographics, the HF Nurses have to do the rest. LHCH’s new data base may be easier on the eye – more user friendly, as the Excel sheet is unwieldy and off-putting.

The new database should be linked to reference costs and consider face to face contacts Telephone calls are currently collected manually with “stick men ticks”

2) **Do you have any problems / issues when inputting data? If so, what are they?**

Time!

Data collection takes so long and they are a relatively small team. The current system is not user friendly, and relies on the HF nurses having to remember to go back and constantly update their collections. Admin team try to help, but some has to be done by nurses> The Admin girls use a capture sheet and try to complete, but there are often gaps.

Some aspects of data collection and reporting are difficult to decide if they are an Admin role or a HF role? The accuracy of data can often be questioned.
| 3) Do you have any problems/issues with reports which are generated? If yes, what are they? | Yes! Elaine has to do them all at the moment which is time consuming. Would like to see more IT/Audit support to pull the info that’s required, and she is hopeful this will happen with the new team at LHCH. The team don’t use SNOWMED codes, and have no way of collecting clinical effectiveness. Even though things are changing, there is sometimes not enough consultation about what the team actually want. Any reports that are generated are now starting to go to the Commissioners – Elaine is trying to enthuse the team to capture data, so that they can prove what they are doing, and let the Commissioners understand the service better. This has not happened before. Reference cost data requires a lot of inputting, their current systems do not allow for this (which the staff did not fully appreciate the reasons for collecting initially.) and so the reports did not always reflect activity. |
| 4) What type of report would you like? What info would you like it to contain? | Activity of the team, and the effort it takes to manage a HF patient. KPIs based on the Service Spec Patient Experience survey does not always seem to reflect correctly. Currently, no way of recording dependency or complexity of patient management. - Discussed use of Snowmed codes, which would support data collection around HF Nurse treatments but would need to be included from now on the new database - Liverpool’s codes will be emailed over tomorrow |
| 5) Do you currently record details on Prescriptions issued by yourself? | Within the team, there are a no of Nurse Prescribers, Elaine, Marj, Sarah, (and Joanne, but she is due to leave shortly) and two new members who are awaiting their pads, Sharon, and Linda Julie and Debs prescribe within the Cardiac rehab Team They all follow the PCT Policy for prescribing, and record within the patient record. Marj follows my suggestion for keeping her own record of each script |
| 6) Is there a standard proforma for completing these details? | No |
| 7) Please would you provide details, where known, of your IT and Audit Personnel | Kieran Wright and Matthew Jackson are the members of the IT staff at LHCH who are designing the new database. The Audit Lead is Aasiya Moreea The teams are briefed to work through Stroke, Cardiac rehab, and then will be getting around to Heart Failure |
1) What system do you use for inputting data?

Stand alone data base made some years ago, not connected to any other system
CCAD Rehab data is also collected by part of the team
Team apparently due to start to use Lorenzo system in September, but they have still to receive any
training, they have not been issued with Smart Cards/ passwords/usernames and have not had opportunity
to devise data requirements. Currently don’t know anything about the system’s uses or functionality. Don’t
currently use Snowmed codes. The system is not available as yet. Do have their own computers when it
does arrive.

2) Do you have any problems / issues when inputting data? If so, what are they?

Their current data base is a basic system to record essentially the demographics and not much else. It is
inadequate for their current needs and does not reflect their workload/ caseload.
The secretary does help, but time is an issue as they have a large caseload with no service spec to set
target caseload numbers.
The team is large, and they have just one secretary over 2 sites, with 16 nurses.
They see patients with all types of HF and there is no provision to record this apart from new and follow-up
referrals, NYHA classifications which do not always reflect the patient at the end of treatment, or suggest
the complexity of the patient (i.e. a NYHA 11 may take up more time than a NYHA 111 on occasion, but this
is not captured)
The switch over to Lorenzo will be a very difficult time, as Lorenzo is very time consuming and requires a
great deal of organisation of workloads and access to the system in a variety of settings. It will also require a
dedicated reporting team to return the info in a way which is acceptable to the HF team
The GPwSI they work with does not always have neat handwriting, his reports were frequently returned
requesting interpretation, and it has been difficult to get him to type his reports. They do not feel he would
use Lorenzo so data may be missed, or have to be inputted by someone else... who?

3) Do you have any problems /issues with reports which are generated? If yes, what are they?

Current decisions taken about what data is collected is made by the Executive Committee, and the team do
not feel they have a lot of input into what is decided, and therefore do not feel that it reflects what they do.
The service direction is being decided by a Manager, who is not a clinician, and this means some clinical
issues aren’t considered.
There is a constant threat that the service may be decommissioned because the data collected is not
meeting targets, but the targets are not meaningful in light of the caseload or workload.
They are monitored on the numbers of referrals, when there is no cap on the caseload and their workload is
large and does not reflect the complexity of the type of patients they are required to see.
They currently have a huge percentage of housebound patients and clinic attendances are few.
The reports do not reflect the average working day and the Team constantly have to complete work at home
during an evening, in order to be prepared for the next working day.
There is an issue over their current dictation service which is the main way they can generate GP reports.
4) What type of report would you like? What info would you like it to contain?

At the moment, they only can collect data on:
   i) Numbers of referrals
   ii) Admission avoidance (partially, as they don’t all record all prescribing changes which might lead to admission avoidance)
   iii) Just started urgent intervention logs
   iv) Can record some changes to prescriptions but not all captured
The team are willing to see what Lorenzo can offer as they know from Liverpool PCT that their team are now receiving some useful info back.

5) Do you currently record details on Prescriptions issued by yourself?

Only recorded in patient notes.
Prescribing Policy is just that of a non-medical prescriber, and they do not record personal data, as this is returned via the PACT data if requested at 3/12 intervals
As with most teams, data is centred around use of evidenced based HF therapies on ACEi/ARB/BBs when most interventions amount to changes in diuretics. The implications for this are not captured fully
They are also aware that they do not always initiate / prescribe a script, rather instruct a Practice to alter a dose, and this information is not captured by Pact data or recorded as an intervention

6) Is there a standard proforma for completing these details?

Only adhering to the Trust Policy on Non –medical prescribing, they would not record/ keep copies of each script written, also bound by NMC Code for Record keeping.
Local Chemists keep a close eye on Nurse prescribers, and are quick to inform them if any errors are found, both Nurses currently had issues outstanding with a prescription, where minor details had been missed off, and the chemist is waiting for them to go and complete the script formally. (in both instances, the issue was highlighted over the ‘phone and no patient delay has materialised)

7) Please would you provide details, where known, of your IT and Audit Personnel

Unsure of their own Trust IT staff’s names
Ian Grivosti from Liverpool, is currently leading / liaising with them over the forthcoming Lorenzo switch
Cardiac Rehab data gets returned to the CCAD office via the Trust IT team.

Other comments:

The team do not feel that their current data collections truly reflect what they are doing, and don’t capture what they are having to do. They feel their workload is too vast in comparison to the complexity of patients they deal with, but have no means of demonstrating this with current data collections.
They would like to see a copy of the Liverpool Community HF Team’s service spec.
1) What system do you use for inputting data?

Access database – AQ data form
All documents scanned in by Audit team personnel once completed.
Info collected on all Primary HF diagnoses, HF secondary to other causes,
demographics/education/drugs/treatments/investigations etc
Simon Thornton also keeps his own database so he can keep track of all his patients, Pam
does not use this.
However, data inputted by others within the hospital also has to be considered:
Hospital PAS system
IPM system
The team have to check TOMCAT system regularly for investigation reports and to see if
investigations are booked in
Have to look at ICE system for results and investigations
The team also receive a list from audit dept (they call it the “Gibbs list” after the guy who usually
sends it!) about every pt who is admitted to the hospital who has either a primary or secondary
diagnosis of HF, and they have to trawl through this to ensure they haven’t missed anyone.
They also receive an Echo list from the Cardio Respiratory Dept which they will also check and
cross reference

2) Do you have any problems / issues when inputting data? If so, what are they?

No, audit team have to do the inputting
However, the team have realised that a lot of their workload is spent trying to “track” patients
and decided if HF diagnosis is definite. None of workload is recorded if a diagnosis is refuted.
The team spend a lot of time, per day doing this.
They feel that as BNP is not being used in the hospital, early diagnoses can be misinterpreted,
especially on pts who may not be on a Cardiology ward. – only half the patients within the
hospital who may have HF diagnosis ever get to a Cardiology ward.
The team have noticed a difference of management for pts on a Cardiology ward as opposed to
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<tr>
<td>a general outlier ward, and their role is different on those wards, as they need to spend time prompting evidenced based treatments/suggesting investigations etc. This related client linked activity is not being recorded, but is vital to the management of patients, and the accuracy of the hospital coding systems.</td>
<td></td>
</tr>
</tbody>
</table>
| 3) Do you have any problems /issues with reports which are generated? If yes, what are they? | Yes, mostly with the AQ data – with missing Audit forms! The team had a problem with sending their AQ data forms which were not always processed, the audit team said they had not received them. The team realised several weeks down the line that data was missing when their figures did not appear realistic. Pam has now asked to receive a “read receipt” for each AQ form sent, and this has improved the situation. The AQ form can be misinterpreted by clerks, you have to check the box that says whether pt has a low ejection fraction, which then allows the evidenced based therapies to be completed. Managers only appear interested in the AQ data.  
- The team don’t get anything else returned to them regarding their performance. They feel they can produce data round the numbers of pts they have seen with HF, and the numbers actually referred to them, but no Manager appears interested in the discrepancy, and they are only therefore judged on actual confirmed HF, and this omits all the other work they have to do to refute the diagnosis.  
- They could possibly ask the Corporate Depts to produce this info (via coding lists), but as no-one appears interested, they are unsure if that effort would be worth doing?  
- This time issue is becoming a big problem for their workload, and yet the hospital are not capturing any of it. |
| 4) What type of report would you like? What info would you like it to contain? | Would like some ability to record their client linked activity, and also the time taken to establish the correct diagnosis, compared to those in whom it is refuted. They are not currently collecting info on dependency/complexity of pts. And feel their workload should be able to reflect this Clinic slots allow for 30minutes to see each pt, but it doesn’t reflect Pt dependency or whether the pt is new of follow-up, and the subsequent needs of that pt. (they are recording the nos’ of new and follow-up) They always run over their allotted times, and often squeeze pts in who may not be reflected in their figures, because the system only allows recording of the 8 slots. |
| 5) Do you currently record details on Prescriptions issued by yourself? | Only Pam is a prescriber at present, Simon is due to complete the course shortly. Pam prescribes for the titrations, she only records in the hospital case notes, and does not keep her own records. She tries to send as many of the LVSD pts out to the community team, but is left with a caseload for the non-LVSD pts. She has now realised (today!) she is not collecting info on drug changes which influence... |
hospital admissions (i.e diuretic changes) AQ only concentrates on the ACE/BB etc combos. And yet diuretic changes make the difference. As she sees lots of pt who cannot be referred to the Community HF team (i.e Valvular/diastolics) she is not able to demonstrate her management on these patients at all, and yet these are the ones she will be changing, as the LVSD pts will come out to the community. The problem with Nebivolol prescribing, means that they see these patients who are prescribed this drug as the Community team are not allowed to prescribe (due to the SPC on the drug and PCT decision) There is no record of how many pts this involves. No treatment changes are being recorded (i.e Snowmed codes not being used.)

| 6) Is there a standard proforma for completing these details? | Simon is still using Clinical Management Plans and PGDs until he can formally prescribe upon completion of his prescribing course. Pam prescribes but does not keep any record of her own prescribing actions, other than what she records in the patient case note and formal GP summary letters. If she does not prescribe the drug at the consultation, for whatever reason, (and whenever Simon needs to request a change of meds from the GP) – they will use the Hospital standard proforma for GP requests. This is carbon copied, and the blue copy is retained within the pt case note – again, there is no formal collection of data around drug changes, and the case notes would have to be pulled if there were any queries over drug changes.

The RULH now has a new agreement/system whereby all Nurse prescribed Pt drugs / changed prescriptions have to be forwarded to the Lloyds Pharmacy within the grounds of the hospital, for dispensing – this means that Pam could potentially check her prescribing habits via this system if needed, but it would be time consuming to pull every script info. |

| 7) Please would you provide details, where known, of your IT and Audit Personnel | 1) Audit Team for AQ data: Bernice Crawshaw is the Lead; the people who tend to do most of the daily liaison with the HF team are Kiki Doran and Emma Allcock.
2) IT Team: contact the Corporate Information Team within the hospital. |
| 1) What system do you use for inputting data? | St Helens: Stand alone data base system, devised by the team and data pulled by the Administrative support, (Sandra and Julie) The data was initially devised using what had been asked for from the Key Performance Indicators (KPIs) Halton: similar situation, data is based on KPIs, but their admin support is currently under review. They can pull data monthly, and they will have an annual report. Most of their data base is on spreadsheets, and so the report is hard to understand. |
| 2) Do you have any problems / issues when inputting data? If so, what are they? | Time! Both teams struggle to record data as the systems are not that comprehensive. Both teams feel their current data collections are based on old KPIs, which they don’t think reflects their quality of the service provided. Neither team have a proper set service spec, however, the Commissioners are starting to ask for more quality data which is evidenced based. The current systems won’t allow them to do this yet. Some data could be collected manually, but there would be no-one to pull it off, and work it out into meaningful reports The teams are asked to see a broad range of diagnosed pts, which makes collection of data hard, (as there is no evidence based treatment for some pt groups i.e. preserved systolic function/ valvular/ right sided HF) and yet they are expected to deliver data on all these patients. St Helens received extra funding for staff to see some patient groups (diastolic failure) Halton didn’t, and their team has been stretched due to absence through sickness, and lack of admin support. The teams have no idea what is expected of them on how to consider “active patients” and this is currently being looked at by Wendy Burton, and should lead to further discussion in the future. St Helens: will collect data on: No’s of referrals, new and follow-ups; demographics; No’s on ACE, Beta blockers, Spiro, Clinic attendances, Home visits, altered meds, admission avoidance through meds, they will soon be trying to capture dependency levels (high, medium, low) Time from referral to initial contact. They do not feel they have any way of reporting non clinical activity (dictation, typing, phone calls to others, time taken to check blood results, travel) all of which take up time and are linked to client activity. |
Halton: Are now starting to link activity to patient contact, and establishing capacity, but this has never been targeted before. Their main problem is the Admin support which is not as good as St Helens’, although the Admin role is about to be increased for Halton shortly. Neither team has targets, but the expectation to deliver on all aspects is there. Both teams can link into the PCT central server, but none of their info is held there.

<p>| 3) Do you have any problems/issues with reports which are generated? If yes, what are they? | YES! Biggest issue is they don’t get reports done or returned! As Both teams’ info is mainly on spreadsheets, the figures are not easy to interpret; there is no narrative with them. Halton’s admin did not know how to input the formulae to get decent figures out. St Helens went through a “Lean Project review” and realised they were having to input onto 5 different databases, none of which were linked. Neither team feel their data is currently reflecting their effectiveness or quality |
| 4) What type of report would you like? What info would you like it to contain? | Neither team had much time to consider this as they feel their existing data is so far behind what it should be, and does not demonstrate what they all do. Halton: currently only feel their data reflects basic equality and diversity, consent and patient info which is important, but not the whole picture. Their reports follow NICE Guidance and how that might be achieved. They are not sure that the data returned is truly validated though, due to the different client groups involved... it’s all linked together, and as above, (not all treatment is evidenced based for diastolics etc) and should be separated. St Helens: As with Halton, but feel they should also be collecting more around their clinical interventions and how this impacts on admission avoidance. They are also looking at how records are shared with others. Consent is a big issue for them and they have rejected one that was suggested by the PCT, which was so long winded and took ages to complete, that they have now devised one that the patients are given/sent and the patients complete their own forms and agree that they understand / consent to taking part in the service |
| 5) Do you currently record details on Prescriptions issued by yourself? | St Helens: Only Amanda is a Nurse Prescriber. She had no set policy to follow, and so is currently using a version of the Liverpool PCT Policy appendices (that I sent her some time ago) for her own records. She records in the patient notes as well, and includes the prescription number in the casenotes. (discussed using a carbon copy book like I do, and she feels this would be useful) The PCT return Pact data, but there is no other data collection for prescriptions issued There is no data collected on the number of scripts requested via GPs Halton: There is no-one currently prescribing in Halton. There is no up to date Policy for Prescribing in Halton, so Paula will not use her qualification |</p>
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<th>Question</th>
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<tr>
<td>until this is in place. GP requests for change of medication would be sent.</td>
<td>N.B Halton are not allowed to prescribe Nebivolol St Helens do not get a lot of patients on this drug, but have not noticed any problems so far.</td>
</tr>
<tr>
<td>6) Is there a standard proforma for completing these details?</td>
<td>No, for both teams. Amanda has devised her own.</td>
</tr>
<tr>
<td>7) Please provide details, where known, of your IT and Audit Personnel</td>
<td>The IT Business Intelligent Unit - Simon Booker Sandra (?Griffiths?) and Julie Mather are the Admin support for the St Helens Team</td>
</tr>
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</table>
Questionnaire for Heart Failure Nurses re Capturing and Reporting Data

Date: 26/08/2010

Name: Carole Roscoe & Angela Jones  
Job Title: HFNS  
Place of Work: Whiston Hospital

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tr>
<td>1) What system do you use for inputting data?</td>
<td>The team use a stand alone database, Excel spreadsheet, which they have devised themselves. It has been revised over the years, and collects info on patient demographics, referrals, hospital number, follow-ups - clinic reviews or community reviews, GP, LV function. All the data can be pulled upon request. They also collect CCAD data, and info for the National database.</td>
</tr>
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</table>
| 2) Do you have any problems / issues when inputting data? If so, what are they? | Information entered onto the systems is as comprehensive as they can get it, but a problem was identified around the collection of data when the Primary diagnosis was not heart failure, as they pulled info on every patient seen, whilst National data only wanted Primary HF diagnoses. They have worked closely with the Audit Clerks to try and improve coding and inputting. As there are only two of them in the team, there is still a small element of retrospective inputting. They have tried to be more structured in their daily routines in order to capture data more easily:  
- Every night, time is taken to collect the day’s Echo reports, which forms the basis of the next day’s work list.  
- Work can then be prioritised  
- They are still looking at patients who have confirmed LVSD, but also those who may have possible HF. Those patients, who are excluded by diagnosis, are now entered onto the data base every night, and accounted for.  
- The Trust is starting to ask for info on those with preserved LV function, who are being treated as HF.  
- They have devised a pathway to isolate these from the normal LVSD pts. The team collect the required AQ data (were the first team in our Network to start) However, the team feel that their timed activity, trawling the wards, establishing the diagnosis etc, is not logged on any system, as part of routine data collection. This is a gap. The AQ programme has improved the care HF pts receive. The aim is for outliers to be automatically triaged and assessed (by a specialist team) and moved to a Cardiology ward for |
management if appropriate, where in the past, they might have been missed. Other Consultants are now much more ready to refer directly to the team, whereas before, there might have been a huge delay in appropriate treatments /Assessments. In order to do this, the team often have to join in on Ward rounds and are “visible” on the wards.

The team were concerned that they were definitely following NICE’s recommendations by ensuring that every LVSD pt was seen and assessed by a Consultant/"Specialist Assessment”. This led to them re-designing their pathway to ensure that this happened, and allowed them to “let go” of some pts who could be seen within the Community by the Community HF team, rather than bringing pts to a hospital clinic. This is on the proviso that they have all had an assessment and management plan formulated first. The team feel this has helped validate their data.

They also feel this has helped communication with community teams, who know to refer in for this assessment, knowing that Pts will see a Consultant. It means that the HFNS always work alongside a Consultant. (different to most of our teams across the patch) Currently there is no provision for the Housebound patients to receive this service, and the team feel this may be an area they need to consider in the future, (or at least for the Community teams to receive direct management support from the Consultant in these situations)

3) Do you have any problems /issues with reports which are generated? If yes, what are they?

Initially “yes” but they have worked on several presenting issues: They still have to produce reports for the National Team, and the AQ data is supplied to the Trust’s AQ Premiere Lead.

They can produce monthly info, but this is not yet being requested by the Trust, they do continue to collect it however. It is there if anyone decides they want it!

Some of their data still involves a manual trawl to retrieve, which is time consuming.

The team’s Excel Spreadsheets can now generate better info. They retain control over their own database and therefore know that the info they input is correct.

The team also have support from IT Audit in-putters

They have revamped them to make them more meaningful on a daily basis, by way of utilising colour coding to prioritise workloads.

They have useful info on each area of the Network from which they will see patients. (St Helens, Halton, Knowsley, and Liverpool) they can see who are new of follow-ups.

As noted above, there has been a lot of work with the Coding Teams to ensure clear criteria for use of ICD 10 codes, and the team feel this has helped to generate more validated diagnostic codes.
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<tr>
<td>4) What type of report would you like? What info would you like it to contain?</td>
<td>Their database does not really collect info on their time/activity. They do not collect info on client linked activity, the time it takes spent on wards, the support of other staff, attending ward rounds and suggestions for treatment to other cohorts of staff. There are therefore no benchmarks/standards to attain or strive for. This might be useful in the future.</td>
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<tr>
<td>5) Do you currently record details on Prescriptions issued by yourself?</td>
<td>Neither HFNS are currently Nurse prescribers. They do not feel it is an absolute necessity in the hospital setting providing the Medical Staff are willing to follow their suggestions for treatments, which are based on NICE Guidance anyway. Recommended treatment plans are documented in the case sheets. The team do use reflective practice to debrief on cases/management plans. The Team will also do case reviews of patients who get re-admitted and will consider if therapy, (or lack of) was a possible cause of readmission.</td>
</tr>
<tr>
<td>6) Is there a standard proforma for completing these details?</td>
<td>No, just usual documentation within the patient record.</td>
</tr>
<tr>
<td>7) Please would you provide details, where known, of your IT and Audit Personnel</td>
<td>The Trust Audit Lead Office; Samantha Doderidge – deals with all Cardiology Audits, Minap Data, AQ data, and CCAD data collections.</td>
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### Appendix 5b – Questionnaire – Results – Information gathered by Anne Porter

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<tr>
<th>Countess of Chester (Acute) Alison Bethel</th>
<th>Western Cheshire PCT Sarah Ellison, Diana Astbury and Diane Taylor</th>
<th>Liverpool Heart and Chest (Acute) Lorraine English</th>
<th>Warrington PCT Sandra Dunne</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1) What system do you use for inputting data?</strong></td>
<td>AQ through internet onto premier. Limited data on excel. Currently on Meditec – onto Minap</td>
<td>Oracle + Word doc for Clinical Letters</td>
<td>In Hospital Database – audit print off the data, then put onto another database – this then complies with CCAD and AQ – Looking to get a hand held device.</td>
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<td>PAS – quantitative</td>
<td>Joanne inputs into NACR – waste of time</td>
<td></td>
<td></td>
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<tr>
<td><strong>2) Do you have any problems/issues with inputting data? IF yes, what are they?</strong></td>
<td>AQ IS 5/12 out of date. From next month will do CCAD through Lotus Notes</td>
<td>Only been entering this data for 6/12. quite new. Enter their own info, but backlog is done by restricted admin support</td>
<td>Time consuming</td>
</tr>
<tr>
<td>AQ IS 5/12 out of date. From next month will do CCAD through Lotus Notes</td>
<td></td>
<td></td>
<td>No. Easy to input onto PAS – Can do clinic letters also</td>
</tr>
<tr>
<td><strong>3) Do you have any problems/issues with reports which are generated? If yes, what are they?</strong></td>
<td>Reflect IP workload, not OP</td>
<td>Basic table of activity on entire caseload. Nos referred, contact detail. Doesn’t take into account time spent indirectly</td>
<td>None of the databases can demonstrate patients picked up in OPD because, they are referred by the consultant – only one episode allowed at OPD</td>
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<td>The reports are quantitative and are sent to the commissioners – limited info, but does show trends of attendance at clinics etc</td>
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<td><strong>4) What type of report would you like? What info would you like it to contain?</strong></td>
<td>Record of patients discharged – that their care is optimised</td>
<td>On what you actually do with the pts. Would also like one standard letter</td>
<td>One which reflects the length of time spent with the pt – dealing with other services etc and the number of occasions for each pt including telephone contact</td>
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<td>When palliative support received; when admission/readmissions prevented; number of patients on the active register and the %seen within 10 days</td>
</tr>
<tr>
<td><strong>5) Do you currently record details on Prescriptions issued by yourself?</strong></td>
<td>Not currently a prescriber but recommends to GP what to do – copy in notes and with pharmacy</td>
<td>All are prescribers – don’t keep a record, but PCT keeps one of new prescriptions – frequently suggest changes without having to prescribe new prescription</td>
<td>Waiting to qualify. Would be useful if Standard profile available to complete</td>
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<td>Just provisionally passed – waiting for conformation- Rest of her staff are band 6. so hasn’t kept a record yet but knows she has to keep her competency up to date</td>
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<tr>
<td>Location</td>
<td>Contact Person(s)</td>
<td>System/Process Details</td>
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</table>
| Countess of Chester (Acute) | Alison Bethel | N/A
| Western Cheshire PCT Sarah Ellison, Diana Astbury and Diane Taylor | | Think it could be added to Oracle
| Liverpool Heart and Chest (Acute) Lorraine English | | See above
| Warrington PCT Sandra Dunne | | NO

6) Is there a standard proforma for completing these details?

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<th>Location</th>
<th>Response</th>
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| Warrington PCT | Remote access to the helpdesk. No link between NACR and PAS

7) Please could you provide details, where known, of your IT and Audit Personnel?

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<tr>
<th>Location</th>
<th>IT and Audit Personnel</th>
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</table>
| Southport and Ormskirk (Acute) | Keith Geaves – head of Info dept. Audit – Rosemary Tate Neil Griffiths for Oracle; Nancy Moss –Audit. Brendan Burke – 1829 Building. Same site as COCH (PCT) 01244650300
| St Catherine’s Hospital – Wirral Community | Audit- Paul Arnold and Ian Whittle 600 1418 Kieran in IT.
| Wirral University Teaching Hospitals – Arrowe Park Vikki Ludgate | |
| Southport and Ormskirk PCT | Neil Griffiths for Oracle; Nancy Moss –Audit. Brendan Burke – 1829 Building. Same site as COCH (PCT) 01244650300
| St Catherine’s Hospital – Wirral Community Barbar | Audit- Paul Arnold and Ian Whittle 600 1418 Kieran in IT.
| Wirral University Teaching Hospitals – Arrowe Park Vikki Ludgate | |
| Warrington PCT | Sandra Dunne

1) What system do you use for inputting data?

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<th>Location</th>
<th>System/Process Details</th>
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</table>
| Southport and Ormskirk (Acute) | Has own excel spreadsheet for In Patients. AQ is inputted by Audit and she is waiting for an update of AQ and CCAD
| Southport and Ormskirk PCT | Has own excel spreadsheet. Not on Lorenzo yet – in the pipeline Nurses do their own monitoring – now completing dependency
| St Catherine’s Hospital – Wirral Community | Don’t enter National data. Keep activity numbers. pts seen in clinic, home visits etc Sec enters the data. Use Microsoft Access
| Wirral University Teaching Hospitals – Arrowe Park Vikki Ludgate | Only just started entering CCAD in June. No admin. Spends ½ day doing AQ but Vikki doesn’t enter the info. OP clinics are booked onto PCIS – Patient Care Info System. Ward Visits and Telephone calls – keeps own record
| Warrington PCT | AQ; Write in the medical notes; clinical data goes onto Meditec; referrals to community nurses

2) Do you have any problems/issues with inputting data? IF yes, what are they?

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<thead>
<tr>
<th>Location</th>
<th>Issues/Problems</th>
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| Southport and Ormskirk (Acute) | Issues relating to the initial coding of patients – discharge letter and referral are wrong, plus Consultants won’t agree on the time of day
| Southport and Ormskirk PCT | Secretary inputs data
| St Catherine’s Hospital – Wirral Community | Secretary does it. Medication not inputted
| Wirral University Teaching Hospitals – Arrowe Park Vikki Ludgate | No probs inputting – the thing which takes the most time is completing the paperwork.
| Warrington PCT | AQ inputted by somebody else; duplication of data inputted; no admin support; not inputting National Data because no admin support or time
<table>
<thead>
<tr>
<th>Question</th>
<th>Southport and Ormskirk (Acute) Barbara Flowers</th>
<th>Southport and Ormskirk PCT Sharon Forrester</th>
<th>St Catherine’s Hospital – Wirral Community Barbara Stephens</th>
<th>Wirral University Teaching Hospitals – Arrowe Park Vikki Ludgate</th>
<th>Warrington Hospitals – (Acute) Ann Cottam and Kirsty Morgan</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Do you have any problems/issues with reports which are generated? If yes, what are they?</td>
<td>Annual report from IT only consists of numbers</td>
<td>Main issue – doesn’t reflect what she does</td>
<td>Activity – not clinical – is reported – not a complete report- but the info required by the commissioners is there</td>
<td>Gets Activity from PCIS. No reports from CCAD yet. Gets AQ 5/12 behind.</td>
<td>Get feedback from AQ but don’t get any other reports</td>
</tr>
<tr>
<td>4) What type of report would you like? What info would you like it to contain?</td>
<td>Accurate reflection of the diagnosis of heart failure admissions and discharges, by month</td>
<td>Doesn’t need the numbers. But does want what she actually does for the pt, prevention of readmission – where would the pt be without the nurse?</td>
<td>2 aspects – need to justify the nos seen – have it linked in with GP registers; readmission rates; more clinical info</td>
<td>Ratio of new to follow up in clinic, maximum tolerated drug regime, ward visits and telephone calls etc</td>
<td>Type of Heart Failure; Readmission and the time between – dates; which medication prescribed in line with NICE guidance</td>
</tr>
<tr>
<td>5) Do you currently record details on Prescriptions issued by yourself?</td>
<td>Does prescribe but doesn’t keep a record</td>
<td>Does prescribe but doesn’t keep a record, but does document it to the GP – would keep a record if a standard proforma</td>
<td>All prescribe, but it is mainly faxing recommendations to the GP. Don’t keep records</td>
<td>Is a prescriber – doesn’t generally generate prescriptions, but faxes recommendations to the GP – rare that there is ever a problem.</td>
<td>Both are prescribers but not prescribing in current post – just working with the cardiologists and making recommendations to the GP’s</td>
</tr>
<tr>
<td>6) Is there a standard proforma for completing these details?</td>
<td>No</td>
<td>No</td>
<td>No – feel it may be timer wasting</td>
<td>No reason to record. All goes through Drugs and therapeutics Hospital Proforma on a P formulary. Wouldn’t want another sheet to complete</td>
<td>In previous post worked to a formulary – prescriptions can be tracked in the PCT</td>
</tr>
<tr>
<td>7) Please could you provide details, where known, of your IT and Audit Personnel?</td>
<td>Roger Lunt AQ audit Carla – Clinical audit No contact for IT</td>
<td>Don’t liaise with audit IT from CPCT Team</td>
<td>IT Helpdesk – Lee Wainwright for the whole of the Wirral PCT</td>
<td>Audit – Elaine Scott, was involved with CCAD. Just done a CRT Audit - ? Melanie Maxwell</td>
<td>Nobody identified to them – not been welcomed</td>
</tr>
</tbody>
</table>

NB – It has been noted that the questionnaires have been completed in more detail by Christine Gardner, than by Anne Porter. This is a reflection of both their knowledge and their roles in relation to the outcome of this document
Appendix 6 – Snowmed Codes – these are used by the HF Nurse Specialists

CCTRE- General Treatment. 7922000 (F/U Including titrations, or changes in treatment plan)
CCTRE-Ongoing review 395101001 (F/U- no meds changed)
CCTRE-Clinical Investigations 386053000 (F/U- Bloods arranged/ other investigations requested or followed up.)
CCAS-General treatment. 310813001(New pt-first assessment)
Appendix 7 Dependency Definitions for Lorenzo for HF patients

Proposal:

**Low risk HF patient: Definition**

Probable > 90 days post discharge, or possible new referral with no previous admissions
Confirmed LVSD / HF
- **Symptoms are currently stable**
  No changes to daily weight
  No increase in oedema
  No changes to normal breathing status / no PND
  Exercise tolerance stable
  NYHA 1 – 11

- **Clinical observations: stable**
  i.e. Controlled HR 60-80bpm
  Controlled target blood pressure
  Tolerating maximum doses or target doses of optimal therapies

**Medium Risk patient: Definition**

Probable discharge </> 30-90 days, or having been seen for some time
Confirmed LVSD / HF
- **Apparent changes in existing symptoms or need for observation**
  Increasing weight gain / signs of fluid retention
  Increasing symptoms of breathlessness on exertion
  Possible PND episodes
  Changes to NYHA classification from 1-111

- **Clinical observations changing: more unsettled**
  i.e. increasing or decreasing HR
  Changes to high, or symptomatic low blood pressure
  Newly identified arrhythmias
  12/12 End of life Care pathway identified

**High Risk patient: Definition**

Newly presenting, or evidence of decompensation from previously stable situation
Confirmed LVSD / HF
Acute episode of HF decompensation
- **Worsening symptoms from previous condition, patient very unstable**
  Experiencing PND
  Sudden weight gain ( >2kg / 2 days)
  Increasing breathlessness at rest
  Reduced exercise tolerance
  Changes to NYHA classification 111-1V

- **Changes to clinical observations: unstable/ brittle patient**
  i.e. increased / decreased HR
  Uncontrolled high, or symptomatically low blood pressure
  Identified new arrhythmias
  Changes to clinical parameters i.e. bloods abnormal and unstable
  Palliative care needs
## Appendix 8 Suggested Questionnaire to access information about the provision of Cardiac Rehabilitation for Heart Failure Patients

Questionnaire to establish the provision of Cardiac Rehabilitation for patients with Heart Failure

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Place of Work</th>
<th>Acute/Community</th>
<th>Date</th>
</tr>
</thead>
</table>

1) Do you provide CR for patients with Heart Failure?  

2) If no, please state the reasons why  

3) If yes, are there any restrictions and if so, what are they?  

4) Which catchment area do you cover?  

Any other comments you would like to add  

Thank you in anticipation for your cooperation