Wales Quality Requirements in support of

The National Service Framework for Cardiac Disease

September 2009
Introduction

1. These Quality Requirements (QRs) have been developed to support implementation of the updated National Service Framework (NSF) for Cardiac Disease for Wales. They can be used by the new LHBs in Wales and supersede any previous version. There are no significant content differences between these and the interim Quality Requirements other than the inclusion of QRs for Standard 7, “Managing the care of adults with Congenital Heart Disease”; the Quality Requirements have however been renumbered and reordered.

2. The Quality Requirements support Standards 1 -7 and the “Cross-Cutting Interventions” in the updated NSF for Cardiac Disease. Based on the updated NSF they therefore reflect its scope, the content of the Standards, and the “Cross-Cutting Interventions”. Like the updated NSF, the Quality Requirements support the principles set out in Designed for Life and should be reviewed, at the latest, by 2015.

3. National Service Frameworks can be interpreted in different ways and may not always be implemented in full. The Quality Requirements clarify the standard of service that is expected throughout Wales by 2015. They help to provide the answer to the question: “How will I know that each service meets the quality standards set out in the NSF?” The Quality Requirements are suitable for use in self-assessment or peer review although there is, as yet, no agreement that peer review visits will take place.

4. The Groups which updated the NSF and developed these Quality Requirements tried to find the balance between clear, unambiguous requirements and reasonable flexibility and responsiveness to local circumstances and settings. The groups also tried to avoid duplication with the other review systems. In particular, areas already covered by JRCALC guidelines or the Quality and Outcomes Framework (QOF) for general practice are not repeated here. Because areas covered by the QOF are not repeated, these Quality Requirements may appear to underestimate the contribution of primary care to the prevention and treatment of patients at risk of or with established cardiac disease. The updated NSF reflects the full contribution that is made by Primary Care.

5. The NSF for Cardiac Disease describes the objectives which these Quality Requirements are supporting and should be consulted if there are any queries over the interpretation of the Quality Requirements. The patient pathway is structured in the way described in the NSF. In particular, acute hospitals may provide:

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1 Welsh Assembly Government, 2009, National Service Framework for Cardiac Disease, WAG, Cardiff
3 Membership of the Development Groups is given in Appendix 1 to the NSF for Cardiac Disease
• Immediate treatment only (ITO)
• District general hospital services (DGH)
• District general hospitals with enhanced cardiac services (EDGH) or
• Tertiary cardiac services (TCS)

Tertiary cardiac services may also provide secondary care cardiac services to their local population.
The summary of the proposed characteristics of acute hospital services can be found in the NSF (See Box 5 page 38)

6. The Quality Requirements have been mapped to the overarching healthcare standards set out in the Healthcare Standards for Wales⁶.

7. Responsibilities:
Cardiac Networks bring together users and providers of services for people at risk of cardiac disease. The Networks focus on improvements that require a collaborative approach. These Quality Requirements require action by the constituent parts of the Networks working locally, for which they retain their individual accountabilities. They also require action by the constituent parts of the Networks acting collectively, for which responsibility is placed on the Cardiac Network Boards.

8. Definitions: A glossary and full set of abbreviations is given in the updated NSF. Appendix 1 gives definitions which are used throughout the Quality Requirements and abbreviations.

9. Document control: All guidelines, policies and procedures should comply with reasonable document control standards (date, version, numbers and review dates), and should have been reviewed with reasonable frequency.

10. The NSF for Cardiac Disease includes acknowledgements of the contribution of many people, in particular, members of the Development Groups. These acknowledgements also apply to these Quality Requirements.

Structure of the Quality Requirements
In this WORD document the following items are recorded for each Quality Requirement:

Column 1: New Reference number
This number is unique to these Quality Requirements and is used for all cross-referencing with the Quality Requirements.
(NB The reference numbers supersede those in the interim version)

Column 2: Short Title
These give the reader an overview of the content of the Quality Requirement and are self-explanatory.

**Healthcare Standard**
The relevant Health Care Standards have been mapped to the QR and the HCS number included in this column. (e.g. HcS 9)

**Weight**
Failure to comply with some QRs carries more risk than others. A multidisciplinary group has ascribed risk scores using the ‘Making it Work’ approach. This approach calculates consequence and likelihood score which are then multiplied to give an overall risk score. The consequence score is derived by considering whether non-compliance with a QR would constitute an insignificant (1), a minor (2), a moderate (3), a major (4), or a catastrophic risk (5). Consequence modifiers were added (+1) for a service important to the whole Trust/more than a single ward or department, (+2) for a service critical to the whole Trust/more than the whole Trust. The likelihood score is the likelihood of the adverse consequences, not the frequency of the activity. The score for likelihood is: Rare(1), Unlikely (2), Possible (3), Likely(4), Almost certain (5). This work is in its early stages and the weights require further validation, however scores are included here as an initial guide to risk for those completing the self assessment (e.g. W8). The Excel QR spread sheet includes detail on the composition of the scores themselves and the domain of risk.

Column 3: Quality requirement
This describes the standard that new Local Health Boards, District General Hospitals, District General Hospitals with enhanced cardiac services, Tertiary Cardiac Services, Health Commission Wales (HCW) and Cardiac Networks are expected to meet. It is recognised that the responsibilities of HCW will be changing and the QR responsibilities will change accordingly.

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7 HealthCare Standards Unit, Keele University, 2004, *Making it Work: Guidance for Risk Managers on Designing and Using a Risk Matrix*, Keele University
**Column 4: Demonstration of Compliance**
This describes how organisations may show that they are meeting the Quality Requirement. This is not prescriptive. Organisations may have other ways of showing that they meet the requirement.

*Notes*
The notes give more detail about either the interpretation or the applicability of the Quality Requirement.

**Column 5: Service**
This identifies the service area which will have responsibility for meeting the Quality Requirement. This section has been revised to accommodate the organisational changes in NHS Wales but may require updating over time.

- Health Promotion
- Primary Care Support
- Ambulance Services
- Acute Hospital Services
  - Acute hospitals providing immediate treatment only (ITO)
  - Acute hospitals providing cardiac services
    - District General Hospitals (DGH)
    - District General Hospitals with enhanced cardiac services (EDGH)
    - Tertiary Cardiac Services (TCS)
    - Tertiary Cardiac Services including adult congenital heart disease specialist team (TCS (A))
- Community based Local Heart Failure Teams (LHFT)
  [Where local heart failure services are provided by acute hospitals, the relevant Quality Requirements are included within those for acute hospitals providing cardiac services.]
- Cardiac Rehabilitation Teams
- Planning and Funding
- Cardiac Networks

**Column 6: Compliance**
Compliance with a QR is either yes or no. A non/applicable column has been included to help users identify which QRs are relevant to their service; a comments section for their use has also been included.
Self Assessment against the Quality Requirements

The Quality Requirements are intended to improve the quality of cardiac services in Wales; they have been developed to help and support clinicians and managers to assess their services and plan accordingly.

Local Health Boards in Wales are required by the Welsh Assembly Government to use the Quality Requirements to inform baseline assessments which will in turn inform the Local Delivery Plans to be submitted to Dr Phil Thomas as the Lead Cardiac Clinician for Wales by March 2010. This WORD version is accompanied by an Excel spreadsheet which will allow searching as required. A web-based QR directory is planned for October 2009.

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8 Welsh Assembly Government, July 2009, Ministerial Letter EH/ML/0019/09
<table>
<thead>
<tr>
<th>New Ref. No.</th>
<th>Short Title and Healthcare Standard and weight (W)</th>
<th>Quality Requirement</th>
<th>Demonstration of compliance Notes</th>
<th>Service</th>
<th>Compliance</th>
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<td>Y N N/A</td>
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<tr>
<td>1</td>
<td>Support for smoke free policies (HcS 29, 30) W8</td>
<td>Local Health Boards should provide support for local organisations and employers in implementing smoke-free policies.</td>
<td>Details of support available.</td>
<td>(LHB) Health Promotion</td>
<td></td>
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<tr>
<td>2</td>
<td>Smoking prevention programmes (HcS 29, 31) W8</td>
<td>Local Health Boards should work with their Health, Social Care and Well-Being Partnership and Children and Young People Partnership to implement a smoking prevention programme for children.</td>
<td>Details of local smoking prevention programme for children, including progress with implementation. 1 This programme should cover all aspects of the national smoking prevention programme and may include other local initiatives.</td>
<td>(LHB) Health Promotion</td>
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<td>3</td>
<td>Nutrition and physical activity programmes (HcS 9) W6</td>
<td>Local Health Boards should work with their Health, Social Care and Well-Being Partnership to implement a local nutrition and physical activity programme. This programme should include an exercise referral scheme.</td>
<td>Details of local nutrition and physical activity programme and exercise referral scheme, including progress with implementation. 1 This programme should include consideration of food cooperatives.</td>
<td>(LHB) Health Promotion</td>
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<td>4</td>
<td>Healthy Schools Network (HcS 31) W3</td>
<td>Local Health Boards should work with their Local Authority, NPHS, Health, Social Care and Well-Being Partnership and Children and Young People Partnership to increase the number of schools participating in the Welsh Network of Healthy School Schemes.</td>
<td>Programme to increase participation in Welsh Network of Healthy School Schemes, including progress with implementation and progression through phases of the Scheme.</td>
<td>(LHB) Health Promotion</td>
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<td>5</td>
<td>Primary care opportunistic advice training (HcS 22, 31) W6</td>
<td>Local Health Boards working with NPHS should provide support materials and training for primary health care workers providing brief opportunistic advice on: a) Smoking cessation b) Nutrition, physical activity and weight management</td>
<td>Examples of support materials and training provided. 1 Guidelines should be based on network-agreed guidance.</td>
<td>(LHB) Primary Care Support</td>
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</table>
|   | Primary care clinical guidelines (HcS 11, 28) W6 | Local Health Boards should have agreed and distributed guidelines for general practice covering the management of patients at high risk or with established CHD, including:  
  a) Anti-platelet therapy  
  b) Lipid reduction therapy  
  c) Control of hypertension | Agreed guidelines and details of distribution (LHB) Primary Care Support |
|---|---|---|---|
|   | Primary care referral guidelines (HcS 28, 29) W12 | Local Health Boards should have agreed and distributed guidelines for general practice covering:  
  a) Referral to smoking cessation services.  
  b) Referral guidelines for investigations available to general practice (for example, exercise tolerance test, echocardiography, other forms of functional assessment)  
  c) Referral to rapid access chest pain assessment service  
  d) Referral to the diagnostic heart failure clinic  
  e) Indications for seeking advice from the Local Heart Failure Team  
  f) Referral to the Local Heart Failure Team  
  g) Referral to rapid access arrhythmia services  
  h) Referral for assessment by a consultant cardiologist  
  i) Referral for assessment by a heart rhythm specialist  
  j) Referral to cardiac rehabilitation services. | Agreed guidelines and details of distribution (LHB) Primary Care Support |
|   | Primary care patient information (HcS 6) W6 | Local Health Boards should ensure that information for patients at high risk of developing cardiovascular disease or with established CHD or heart rhythm disorders is available within local general practices, covering at least:  
  a) Support for smoking cessation and programmes on diet, physical activity and weight control  
  b) Treatment regimes for patients at high risk of cardiovascular disease or with established CHD  
  c) Management of symptoms of angina  
  d) Management and monitoring of heart failure  
  e) Management of arrhythmias  
  f) Recognition of symptoms of acute MI and actions to take  
  g) Access to basic life support training  
  h) Sources of further information and advice, including support groups. | Examples of information for patients and carers covering all aspects of this QR. (LHB) Primary Care Support |

1. Guidelines should be based on network-agreed guidance.
2. All guidelines should have been agreed with the main services to which general practices within the LHB refer patients.
3. Guidelines for investigations and for referral to a consultant cardiologist should take into account the needs of all patients with CHD and arrhythmias covered by the updated NSF.
4. Referral guidelines should include families following a cardiac arrest in a relative aged less than 40 years.

1. Local Health Boards may wish to work with other LHBs through their Cardiac Network in order to achieve this QR.
2. Information for patients with different conditions may be produced separately.
|   | Primary care angina guidelines (HcS 12, 28) W12 | Local Health Boards should have agreed and distributed guidelines for general practice on the diagnosis and management of angina. | Agreed guidelines Details of distribution  
1 Guidance should be based on network-agreed guidance and agreed with representatives of local practices and DGH/s to which patients are usually referred. | (LHB) Primary Care Support |
|---|---|---|---|---|
| 10 | Primary care acute MI guidelines (HcS 2, 3, 12) W12 | Local Health Boards should have agreed and distributed guidelines for general practices and out of hours centres on dealing with calls about a patient who may be having an acute myocardial infarction. These guidelines should cover:  
a) Assessing the symptoms and signs and determining priority  
b) Calling an ambulance  
c) Advising the caller until the ambulance or other trained help arrives including, if necessary, advice on cardiopulmonary resuscitation  
Guidance should also have been agreed with the ambulance service. | Agreed guidelines Details of distribution  
1 Guidance should be based on network-agreed guidance and agreed with representatives of local practices and DGH/s to which patients are usually referred.  
2 Guidance should also have been agreed with the ambulance service. | (LHB) Primary Care Support |
| 11 | Primary care ACS management guidelines (HcS 12, 28) W12 | Local Health Boards should have agreed and distributed guidelines on the initial management of acute coronary syndromes to general practices, minor injuries units and community hospitals based within the LHB area. | Agreed guidelines Details of distribution  
1 Guidance should be based on network-agreed guidance and agreed with representatives of local practices and DGH/s to which patients are usually referred. | (LHB) Primary Care Support |
| 12 | Primary care heart failure guidelines (HcS 12, 28) W12 | Local Health Boards should have agreed and distributed guidelines on  
a) Primary care aspects of guidelines for the management of patients with heart failure.  
b) Primary care aspects of guidelines for monitoring patients with heart failure.  
c) Primary care management of acute exacerbations of heart failure and the indications for urgent / emergency referral.  
d) Referral of patients with heart failure for rehabilitation and specialist palliative care.  
Guidance should be based on network-agreed guidance and agreed with representatives of local practices, the ambulance service and LHFT/s to which patients are usually referred. | Agreed guidelines Details of distribution  
1 Guidance should be based on network-agreed guidance and agreed with representatives of local practices, the ambulance service and LHFT/s to which patients are usually referred. | (LHB) Primary Care Support |
| 13 | Primary care arrhythmia guidelines (HcS 12, 28) W12 | Local Health Boards should have agreed and distributed guidelines for general practice on the diagnosis and management of arrhythmias. These guidelines should include giving the patient a copy of any ECG taken during typical symptoms. | Agreed guidelines Details of distribution

1. Guidance should be based on network-agreed guidance and agreed with representatives of local practices and DGH/s to which patients are usually referred. |

(LHB) Primary Care Support |}

| 14 | Staff training programmes 1 (HcS 22) W6 | The Local Health Board should cooperate with other organisations within the Cardiac Network to ensure a programme of training and awareness is run for general medical practices (QR182). | Details of training and awareness programme/s.

1. This programme may be part of a general training and education programme for primary care. |

(LHB) Primary Care Support |}

| 15 | Ambulance service community response programme (HcS 12, 24) W5 | A national programme of community involvement in cardio-pulmonary resuscitation should be delivered, including:

a) Local public awareness initiatives about acute MI symptoms and action to take
b) Community access to defibrillators
c) First responder schemes | Details of local programme and examples of implementation

1. Local public awareness work should complement the work of the Wales Centre for Health. |

Ambulance services |}

| 16 | Ambulance thrombolysis (HcS 12, 28) W15 | Agreed clinical guidelines should be in use covering ECG interpretation and administration of thrombolysis. | Network-agreed clinical guidelines.

1. ECG interpretation may be by trained ambulance staff or by transmission for interpretation elsewhere.

2. These guidelines should specify the circumstances under which pre-hospital thrombolysis will be administered and the level of pre-hospital thrombolysis that the ambulance service should be achieving. |

Ambulance services |
|   | Ambulance ACS management (HcS 12, 27, 28) W9 | Agreed clinical guidelines should be in use covering the hospitals to which patients with suspected acute coronary syndromes should be taken. These guidelines should identify:  
   a) Which patients should be transported directly to the nearest DGH, a DGH with enhanced cardiac services and to tertiary cardiac services.  
   b) The management of the patient during the journey.  
   c) Liaison with the admitting team in the hospital to which the patient is being taken. | Network-agreed clinical guidelines. | Ambulance services |
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|   | Ambulance arrhythmia management (HcS 12, 28) W9 | Agreed clinical guidelines should be in use covering the assessment and initial management of patients in whom arrhythmia is suspected. These guidelines should include:  
   a) Recording an ECG and ensuring a copy goes with the patient on arrival at hospital  
   b) Ensuring any rhythm information stored in AEDs is readily available. | Network-agreed clinical guidelines  
1. If Automatic External Defibrillator (AED) rhythm information cannot be made immediately available then a system for making the trace available subsequently should be in use. | Ambulance services |
| 18 | | | |
|   | Ambulance hospital by-pass (HcS 2, 3) W6 | An agreed protocol should identify:  
   a) Which hospitals provide immediate treatment only and should be by-passed by ambulances carrying emergency patients with possible coronary heart disease and arrhythmia related conditions  
   b) Where within each DGH, EDGH or tertiary cardiac service patients, including patients resuscitated following a cardiac arrest outside hospital, should be taken in order to have immediate access to assessment and treatment. | Network-agreed protocol and updating arrangements  
1. This QR is linked with QR162 | Ambulance services |
| 19 | | | |
| 20 | Ambulance transfers (HcS 12) W12 | Arrangements should be agreed covering:  
   a) Transfer of patients from hospitals providing immediate treatment only to hospitals providing cardiac services  
   b) Transfer of patients from DGHs to hospitals with enhanced cardiac services  
   c) Transfer of patients from DGHs / EDGHs to tertiary cardiac services.  
   d) Transport of patients needing primary PCI (when service available)  
   d) Transfer of patients from tertiary cardiac services to DGHs / EDGHs.  
   e) Completion of the patient care record and ensuring a copy remains with the patient following transfer. | Network-agreed arrangements  
   1 These arrangements should specify what hospital staff need to say in order to ensure an appropriate response from ambulance staff.  
   2 Completion of the patient care record is required for collection of the full MINAP dataset. | Ambulance services |
| 21 | Staff training programmes 2 (HcS 22) W6 | The ambulance service should contribute to and participate in relevant staff training and awareness programmes (QRs 182 to 184). | Details of training and awareness programme/s. | Ambulance services |
| 22 | ACS initial management (hospitals providing immediate treatment only) (HcS 12, 28) W4 | Clinical guidelines should be in use covering the assessment and initial management of patients with acute coronary syndromes, including:  
   a) Resuscitation and stabilisation  
   b) Relief of pain and breathlessness  
   c) Appropriate diagnostic tests  
   d) Administration of thrombolyis  
   e) Early in-hospital care  
   f) Transfer of patients to a hospital providing cardiac services | Network-agreed clinical guidelines.  
   1 This QR is linked to QRs 19 and 20 in relation to ambulance transfers to a hospital providing cardiac services.  
   2 These guidelines should specify which patients should be transferred to a hospital providing cardiac services. | Acute hospitals - immediate treatment only |
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<td>23</td>
<td><strong>Arrhythmia initial management</strong> (hospitals providing immediate treatment only) (HcS 12, 28) W4</td>
<td>Clinical guidelines should be in use covering the assessment and initial management of patients with arrhythmias, including those patients already fitted with an Implantable Cardioverter Defibrillator (ICD).</td>
<td>Network-agreed clinical guidelines. 1 This QR is linked to QRs 19 and 20 in relation to ambulance transfers to a hospital providing cardiac services. 2 These guidelines should specify which patients should be transferred to a hospital providing cardiac services. 3 The guidelines should include recording an ECG for any patient with suspected arrhythmia and ensuring a copy goes with any patient transferred to a hospital providing cardiac services.</td>
<td>Acute hospitals - immediate treatment only</td>
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<td>24a</td>
<td><strong>Clinical leadership - cardiologist</strong> (DGH, EDGH, TCS) (HcS 6, 12, 22, 28) W9</td>
<td>A nominated lead consultant cardiologist should be responsible, with the lead nurse (QR24b), for: a) Protocols covering the assessment and management of patients with acute cardiac disease. b) Ensuring appropriate training, data collection and audit takes place as expected by these Quality Requirements c) Ensuring information and support is offered to patients and carers as expected by these Quality Requirements d) Oversight of adherence to clinical and referral guidelines and protocols. e) Monitoring and developing the effective liaison and communication with the other acute hospital services, Local Health Board/s, general practices, Local Heart Failure Team/s (if applicable) and Cardiac Rehabilitation Team/s with which the hospital is linked.</td>
<td>Name of nominated lead consultant cardiologist. 1 The other acute hospital services, Local Heart Failure Team/s (if applicable) and Cardiac Rehabilitation Team/s with which the hospital is linked are as agreed by the Cardiac Network (QR162, 163, 164).</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
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<td>Clinical leadership - nursing (DGH, EDGH, TCS) (HcS 6, 12, 22, 28) W12</td>
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| 24b | A nominated lead nurse should be responsible, with the lead consultant (QR24a), for:  
  a) Protocols covering the assessment and management of patients with acute cardiac disease.  
  b) Ensuring appropriate training, data collection and audit takes place as expected by these Quality Requirements  
  c) Ensuring information and support is offered to patients and carers as expected by these Quality Requirements  
  d) Oversight of adherence to clinical and referral guidelines and protocols.  
  e) Monitoring and developing the effective liaison and communication with the other acute hospital services, Local Health Board/s, general practices, Local Heart Failure Team/s (if applicable) and Cardiac Rehabilitation Team/s with which the hospital is linked.  
  Name of nominated lead nurse.  
  1 The other acute hospital services, Local Heart Failure Team/s (if applicable) and Cardiac Rehabilitation Team/s with which the hospital is linked are as agreed by the Cardiac Network (QR162, 163, 164). <DGH>, <EDGH>, <TCS>, <TCS(A)> |

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<th>Cardiologist availability (DGH) (HcS 2, 11) W12</th>
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| 25 | A consultant cardiologist should be available during ‘normal working hours’. Out of hours, if a consultant cardiologist is not on call, there should be agreed arrangements for a consultant cardiologist to be available to review results and give specialist advice to the consultant who is taking clinical responsibility for the patient.  
  Details of arrangements, including agreed clinical criteria for seeking the advice of the ‘out of hours’ consultant cardiologist.  
  In all QRs, ‘available’ means ‘available to see patients’. <DGH> |

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<tr>
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<th>Cardiac clinical physiologist (DGH) (HcS 2, 11) W9</th>
</tr>
</thead>
</table>
| 26 | A cardiac clinical physiologist should be available during normal working hours.  
  Details of arrangements <DGH> |
| 27a | LHFT clinical leadership – cardiologist (HcS 11, 22, 24) W6 | The Local Heart Failure Team should have a nominated lead cardiologist for heart failure responsible, with the lead nurse (QR27b), for:  
1. Leadership of the Local Heart Failure Team  
2. Ensuring Quality Requirements relating to the work of the Local Heart Failure Team are met.  
3. Development of services for patients with heart failure across the area served by the team.  
4. Coordination of the care of patients with heart failure across the area served by the team.  
5. Liaison with primary care, acute cardiac services and Cardiac Rehabilitation Teams serving the local population in relation to care of patients with heart failure.  
6. Liaison with the Tertiary Heart Failure Team to which patients with complex needs that cannot be managed locally are usually referred. | Names of lead consultant.  
1. For community-based or DGH LHFTs, the nominated lead may be a consultant physician with a special interest in heart failure.  
2. The lead cardiologist should be a core member of the LHFT. | <LHFT>,<DGH>,<EDGH> |
| 27b | LHFT clinical leadership - heart failure nursing (HcS 11, 22, 24) W6 | The Local Heart Failure Team should have a nominated lead nurse responsible, with the lead consultant (QR27a), for:  
1. Leadership of the Local Heart Failure Team  
2. Ensuring Quality Requirements relating to the work of the Local Heart Failure Team are met.  
3. Development of services for patients with heart failure across the area served by the team.  
4. Coordination of the care of patients with heart failure across the area served by the team.  
5. Liaison with primary care, acute cardiac services and Cardiac Rehabilitation Teams serving the local population in relation to care of patients with heart failure.  
6. Liaison with the Tertiary Heart Failure Team to which patients with complex needs that cannot be managed locally are usually referred. | Name of lead nurse.  
1. For community-based or DGH LHFTs, the nominated lead may be a consultant physician with a special interest in heart failure.  
2. The lead nurse should be a core member of the LHFT. | <LHFT>,<DGH>,<EDGH> |
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<th>LHFT membership - nursing / allied health professionals (HcS 24) W9</th>
<th>In addition to the lead nurse (QR27b), other heart failure specialist nurses and/or allied health professionals specialising in the care of patients with heart failure should be available as appropriate for the number of patients cared for by the LHFT.</th>
<th>Names of Local Heart Failure Team members. 1 Members of the team may spend only part of their time working with patients with heart failure, although the lead heart failure specialist nurse is likely to be a full-time responsibility. 2 Core members of the team should have at least one session per week specified for care of patients with heart failure. 3 All team members should have the competences needed for their role. The Skills for Health National Workforce Competences may be helpful in designing role profiles and developing and reviewing competence. 4 For community-based or DGH LHFTs, the consultant role on the team may be taken by an associate specialist or GP with a special interest, working under the direction of a consultant. 5 Members of the team may be employed by different healthcare organisations within the area served by the local team. 6 The team may choose to identify additional members. 7 When available, guidance on staffing levels appropriate for different numbers of patients should be used to determine compliance with this QR.</th>
<th>&lt;LHFT&gt;,&lt;DGH&gt;,&lt;EDGH&gt;</th>
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<tr>
<td>28b</td>
<td>LHFT membership - clinical physiologist (HcS 24) W8</td>
<td>A clinical physiologist/s with expertise in cardiac and respiratory physiology should be a core member of the Local Heart Failure Team.</td>
<td>Names of Local Heart Failure Team members. As QR 28a</td>
<td>&lt;LHFT&gt;,&lt;DGH&gt;,&lt;EDGH&gt;</td>
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<td><strong>28c</strong></td>
<td>LHFT membership – pharmacist (HcS 24) W3</td>
<td>A pharmacist should be a core member of the Local Heart Failure Team.</td>
<td>Names of Local Heart Failure Team members. As QR 28a</td>
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<td><strong>28d</strong></td>
<td>LHFT membership - administrative support (HcS 24) W4</td>
<td>A secretary / administrator / team coordinator should be a core member of the Local Heart Failure Team.</td>
<td>Names of Local Heart Failure Team members. As QR 28a</td>
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<td><strong>29</strong></td>
<td>LHFT cover arrangements (HcS 24) W6</td>
<td>The cover arrangements for each core member of the Local Heart Failure Team should be identified.</td>
<td>Details of cover arrangements. 1 These arrangements should ensure that, during periods of leave, the service to patients with heart failure does not deteriorate significantly and the individual’s role within the team is covered.</td>
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<tr>
<td><strong>30a</strong></td>
<td>EDGH staffing - cardiology (HcS 11, 24) W15</td>
<td>A consultant cardiologist should be available at all times.</td>
<td>Details of staff available.</td>
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<td><strong>30b</strong></td>
<td>EDGH staffing - cardiac clinical physiologist (HcS 11, 24) W15</td>
<td>A cardiac clinical physiologist should be available at all times.</td>
<td>Details of staff available.</td>
<td></td>
</tr>
<tr>
<td><strong>30c</strong></td>
<td>EDGH staffing - heart rhythm specialist (HcS 11, 24) W6</td>
<td>A heart rhythm specialist should be available during normal working hours.</td>
<td>Details of staff available.</td>
<td></td>
</tr>
<tr>
<td>30d</td>
<td>EDGH staffing - arrhythmia specialist nurse (HcS 11, 24) W3</td>
<td>An arrhythmia specialist nurse should be available during normal working hours.</td>
<td>Details of staff available.</td>
<td>&lt;EDGH&gt;</td>
</tr>
<tr>
<td>30e</td>
<td>EDGH staffing - adult congenital heart disease (HcS 11, 24) W6</td>
<td>A consultant cardiologist with an interest in the care of adults with congenital heart disease should be available during normal working hours.</td>
<td>Details of staff available.</td>
<td>&lt;EDGH&gt;</td>
</tr>
<tr>
<td>30f</td>
<td>EDGH staffing - echocardiography for adults with congenital heart disease (HcS 11, 24) W8</td>
<td>A member of staff with competence in echocardiography of adults with congenital heart disease should be available.</td>
<td>Details of staff available.</td>
<td>&lt;EDGH&gt;</td>
</tr>
<tr>
<td>31a</td>
<td>TCS staffing – cardiology (HcS 11, 24) W25</td>
<td>A consultant cardiologist should be available at all times.</td>
<td>Details of arrangements</td>
<td>&lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>31b</td>
<td>TCS staffing - cardiac surgery (HcS 11, 24) W20</td>
<td>A consultant cardiac surgeon should be available at all times. One cardiac surgeon should be a core member of the Tertiary Heart Failure Team.</td>
<td>Details of arrangements. Name of THFT member.</td>
<td>&lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
</tbody>
</table>
| 31c | TCS staffing - cardiac clinical physiologist (HcS 11, 24) W20 | A cardiac clinical physiologist should be available at all times. One cardiac physiologist should be a core member of the Tertiary Heart Failure Team. | Details of arrangements. Name of THFT member.  
1 An ‘on call’ based system is not appropriate if a 24 hour primary PCI service is provided. | <TCS>, <TCS(A)> |
| 31d | TCS staffing - cardiac interventionist (HcS 11, 24) W25 | A cardiac interventionist should be available during normal working hours. If a primary PCI service is provided, a consultant cardiac interventionist should be available at all times. One cardiac interventionist should be a core member of the Tertiary Heart Failure Team. | Details of arrangements. Name of THFT member.  
1 An ‘on call’ based system is not appropriate if a 24 hour primary PCI service is provided. | <TCS>, <TCS(A)> |
| 32a | TCS THFT clinical leadership – cardiologist (HcS 11, 22, 24) W9 | The nominated lead consultant cardiologist (QR24a) should be supported by a nominated cardiologist responsible, with the lead heart failure specialist nurse (QR32b), for aspects of QR24a relating to heart failure services and specific responsibility for: 
a) Leadership of the Tertiary Heart Failure Team  
b) Ensuring Quality Requirements relating to the work of the Tertiary Heart Failure Team are met.  
c) Development of services for patients with heart failure across the area served by the team.  
d) Coordination of the care of patients with heart failure across the area served by the team.  
e) Liaison with primary care, acute cardiac services and Cardiac Rehabilitation Teams serving the local population in relation to care of patients with heart failure.  
f) Liaison with referring Local Heart Failure Teams. | Name of lead consultant.  
1 The lead cardiologist should be a core member of the THFT. | <TCS>, <TCS(A)> |
<table>
<thead>
<tr>
<th>32b</th>
<th>TCS THFT clinical leadership - heart failure nursing (HcS 11, 22, 24) W6</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>The nominated lead nurse (QR24b) should be supported by a lead nurse responsible, with the lead consultant (QR32a), for aspects of QR24b relating to heart failure services and for:</td>
</tr>
<tr>
<td></td>
<td>a) Leadership of the Tertiary Heart Failure Team</td>
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<td></td>
<td>b) Ensuring Quality Requirements relating to the work of the Tertiary Heart Failure Team are met.</td>
</tr>
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<td></td>
<td>c) Development of services for patients with heart failure across the area served by the team.</td>
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<tr>
<td></td>
<td>d) Coordination of the care of patients with heart failure across the area served by the team.</td>
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<tr>
<td></td>
<td>e) Liaison with primary care, acute cardiac services and Cardiac Rehabilitation Teams serving the local population in relation to care of patients with heart failure.</td>
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<tr>
<td></td>
<td>f) Liaison with referring Local Heart Failure Teams.</td>
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<tr>
<td></td>
<td>Name of lead heart failure specialist nurse.</td>
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<td></td>
<td>1 The lead nurse should be a core member of the THFT.</td>
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<tr>
<th>33a</th>
<th>TCS THFT membership - nursing / allied health professionals (HcS 24) W9</th>
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<td>In addition to the lead nurse (QR27b), other heart failure specialist nurses and/or allied health professionals specialising in the care of patients with heart failure should be available as appropriate for the number of patients cared for by the THFT.</td>
</tr>
<tr>
<td></td>
<td>Names of Tertiary Heart Failure Team members.</td>
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<tr>
<td></td>
<td>1 Members of the team may spend only part of their time working with patients with heart failure.</td>
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<td>2 Core members of the team should have at least one session per week specified for care of patients with heart failure.</td>
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<td>3 All team members should have the competences needed for their role. The Skills for Health National Workforce Competences may be helpful in designing role profiles and developing and reviewing competence.</td>
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<td>4 The THFT may choose to identify additional members.</td>
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<td>5 When available, guidance on staffing levels appropriate for different numbers of patients should be used to determine compliance with this QR.</td>
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<td>&lt;TCS&gt;, &lt;TCS(A)&gt;</td>
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|      | <TCS>, <TCS(A)> |
| 33b | TCS THFT membership – pharmacist (HcS 24) W3 | A pharmacist should be a core member of the Tertiary Heart Failure Team. | Names of Local Heart Failure Team members. As QR 33a | <TCS>, <TCS(A)> |
| 33c | TCS THFT membership - administrative support (HcS 24) W4 | A secretary / administrator / team coordinator should be a core member of the Tertiary Heart Failure Team. | Names of Local Heart Failure Team members. As QR 33a | <TCS>, <TCS(A)> |
| 34 | TCS THFT cover arrangements (HcS 24) W6 | The cover arrangements for each member of the tertiary heart failure team should be identified. | Details of cover arrangements.  
1 These arrangements should ensure that, during periods of leave, the service to patients with heart failure does not deteriorate significantly and the individual’s role within the team is covered. | <TCS>, <TCS(A)> |
<p>| 35a | Clinical leadership - heart rhythm specialist (EDGH, TCS) (HcS 11, 24) W9 | The nominated lead consultant cardiologist (QR24a) should be supported by a nominated heart rhythm specialist responsible, with the lead nurse (QR35b) for aspects of QR24a relating to arrhythmia services. | Names of lead heart rhythm specialist. | &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt; |
| 35b | Clinical leadership - arrhythmia nurse (EDGH, TCS) (HcS 11, 24) W6 | The nominated lead nurse (QR24b) should be supported by a nominated nurse responsible, with the lead heart rhythm specialist, for aspects of QR24b relating to arrhythmia services. | Names of nurse providing leadership for arrhythmia services. | &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt; |</p>
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<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
<th>Arrangements</th>
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<tbody>
<tr>
<td>36a</td>
<td>TCS arrhythmia staffing – electrophysiologist (HcS 11, 24) W20</td>
<td>An electrophysiologist should be available during normal working hours.</td>
<td>Details of staff available.</td>
</tr>
<tr>
<td>36b</td>
<td>TCS arrhythmia staffing - arrhythmia specialist nurse W6</td>
<td>An arrhythmia specialist nurse should be available during normal working hours.</td>
<td>Details of staff available.</td>
</tr>
<tr>
<td>36c</td>
<td>TCS arrhythmia staffing - cardiac physiologist (HcS 11, 24) W20</td>
<td>A cardiac clinical physiologist with competences in complex device therapy and interventional electrophysiology should be available during normal working hours.</td>
<td>Details of staff available.</td>
</tr>
<tr>
<td>37</td>
<td>TCS (Adult Congenital Heart Disease) clinical leadership (HcS 11, 24) W12</td>
<td>The nominated lead consultant cardiologist (QR24a) should be supported by a nominated consultant with responsibility for aspects of QR24a relating to services for adults with congenital heart disease.</td>
<td>Names of consultant providing leadership for Adult Congenital Heart Disease Service</td>
</tr>
<tr>
<td>38</td>
<td>TCS (Adult Congenital Heart Disease) advice available (HcS 11, 22) W9</td>
<td>Specialist medical advice on the care of adults with congenital heart disease should be available at all times.</td>
<td>Details of arrangements</td>
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1 Collaboration between tertiary cardiac services caring for adults with congenital heart disease will be needed to achieve this QR.
2 Availability to see patients is not expected by this QR.
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<tr>
<th></th>
<th>TCS (Adult Congenital Heart Disease) staffing – cardiology (HcS 11, 24) W16</th>
<th>A consultant cardiologist specialising in the care of adults with congenital heart disease (adult congenital cardiologist) should be available during normal working hours.</th>
<th>Details of staff available 1 The competences expected for an ‘adult congenital cardiologist’ are set out in the Type 1 advanced curriculum for adults with congenital heart disease of the Joint Royal Colleges Postgraduate Training Board (2007).</th>
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<tbody>
<tr>
<td>39a</td>
<td>TCS (Adult Congenital Heart Disease) staffing - specialist nurse (HcS 11, 24) W8</td>
<td>An adult congenital heart disease specialist nurse should be available during normal working hours.</td>
<td>Details of staff available 1 The competences for an adult congenital heart disease specialist nurse are described in DH(2006) Adult Congenital Heart Disease: A commissioning guide for services for young people and Grown Ups with Congenital Heart Disease.</td>
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<tr>
<td>39b</td>
<td>TCS (Adult Congenital Heart Disease) staffing - transition nurse (HcS 11, 24) W10</td>
<td>A transition specialist nurse for young people with congenital heart disease should be available during normal working hours.</td>
<td>Details of staff available</td>
<td></td>
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<tr>
<td>39c</td>
<td>TCS (Adult Congenital Heart Disease) staffing - cardiac interventionist (HcS 11, 24) W9</td>
<td>A cardiac interventionist with training and expertise in the range of interventional procedures undertaken for adults with congenital heart disease (QR125) should be available during normal working hours.</td>
<td>Details of staff available</td>
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<td>39d</td>
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<tr>
<td>39e</td>
<td>TCS (Adult Congenital Heart Disease) staffing – arrhythmias (HcS 11, 24) W12</td>
<td>Staff with training and expertise in managing complex arrhythmia and device problems in adults with congenital heart disease should be available during normal working hours.</td>
<td>Details of staff available</td>
<td>&lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>40</td>
<td>CCU and cardiac ward (DGH, EDGH, TCS) (HcS 4) W20</td>
<td>The following facilities should be available: a) Cardiac Care Unit (Level 2 critical care) b) Cardiac Ward (Level 1 critical care)</td>
<td>Facilities available</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>41</td>
<td>CCU and ward nurse staffing (DGH, EDGH, TCS) (HcS 24) W20</td>
<td>Staffing of the Cardiac Care Unit and Cardiac Ward should be, at least: a) 3.5 WTE nurses per bed (on the Cardiac Care Unit: Level 2 critical care) b) Appropriate number of registered practitioners dependent upon nurse-patient dependency ratio (on the Cardiac Ward: Level 1 critical care).</td>
<td>Staffing details and rotas of usual staffing.</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
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<td>1 ‘Nurse’ is taken to include any member of staff assessed as having the competences to provide acute cardiac care.</td>
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<tr>
<td>42</td>
<td>CCU lead nurse (DGH, EDGH, TCS) (HcS 21, 22) W12</td>
<td>The nurse in charge of the Cardiac Care Unit and Cardiac Ward should have undertaken recognised post-registration training in cardiac nursing.</td>
<td>Details of training undertaken</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>43</td>
<td>Diagnostic services 24 hours (DGH) (HcS 2, 3) W20</td>
<td>The following diagnostic services should be available at all times: a) Bedside monitoring b) Blood analysis c) Resting 12 lead ECG d) Basic radiological imaging e) CT scanning</td>
<td>Details of services available</td>
<td>&lt;DGH&gt;</td>
</tr>
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</table>
|   | Diagnostic services normal working hours (DGH) (HcS 2, 3) W6 | The following diagnostic services should be available during normal working hours:  
|   |   | a) Exercise testing  
|   |   | b) Ambulatory ECG and blood pressure monitoring  
|   |   | c) Prolonged patient activated monitoring  
|   |   | d) Tilt table testing  
|   |   | e) Lung function testing  
|   |   | f) Long term oxygen therapy assessment  
|   |   | g) Echocardiography assessment  
|   | Details of services available |  
|   | 1 24 hour diagnostic services are also available during normal working hours |   

|   | Diagnostic services normal working hours (EDGH) (HcS 2, 3) W20 | The following diagnostic services should be available at all times:  
|   |   | a) Bedside monitoring  
|   |   | b) Blood analysis  
|   |   | c) Resting 12 lead ECG  
|   |   | d) Basic radiological imaging  
|   |   | e) CT scanning  
|   |   | f) Echocardiography assessment  
|   |   | g) Trans-oesophageal echocardiography  
|   | Details of services available |  

|   | Diagnostic services normal working hours (EDGH) (HcS 2, 3) W9 | The following diagnostic services should be available during normal working hours:  
|   |   | a) Exercise testing  
|   |   | b) Ambulatory ECG and blood pressure monitoring  
|   |   | c) Prolonged patient activated monitoring  
|   |   | d) Tilt table testing  
|   |   | e) Lung function testing  
|   |   | f) Long term oxygen therapy assessment  
|   |   | g) Stress echocardiography  
|   |   | h) Cardio-pulmonary exercise testing  
|   |   | i) Electrophysiological studies  
|   |   | j) Nuclear imaging  
|   |   | k) coronary angiography  
|   | Details of services available |  
|   | 1 24 hour diagnostic services are also available during normal working hours |   

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| **47** | **Diagnostic services 24 hours (TCS)** (HcS 2, 3) W20 | The following diagnostic services should be available at all times:  
a) Bedside monitoring  
b) Blood analysis  
c) Resting 12 lead ECG  
d) Basic radiological imaging  
e) CT scanning  
f) Echocardiography assessment  
g) Trans-oesophageal echocardiography  
h) Coronary angiography | Details of services available | <TCS>, <TCS(A)> |
| **48** | **Diagnostic services normal working hours (TCS)** (HcS 2, 3) W9 | The following diagnostic services should be available during normal working hours:  
a) Exercise testing  
b) Ambulatory ECG and blood pressure monitoring  
c) Prolonged patient activated monitoring  
d) Tilt table testing  
e) Lung function testing  
f) Long term oxygen therapy assessment  
g) Stress echocardiography  
h) Cardio-pulmonary exercise testing  
i) Electrophysiological studies  
j) Nuclear imaging | Details of services available | 1 24 hour diagnostic services are also available during normal working hours | <TCS>, <TCS(A)> |
| **49** | **TCS access to diagnostic services** (HcS 2, 3) W6 | Access to the following diagnostic services should be available:  
a) PET scanning  
b) Signal averaged ECG  
c) Endomyocardial biopsy | Details of services available | <TCS>, <TCS(A)> |
| **50** | **Community-based LHFT access to diagnostic services** (HcS 2, 3) W6 | Access to the following diagnostic services should be available for patients with suspected heart failure:  
a) Echocardiography assessment  
b) Nuclear imaging  
c) Cardiopulmonary exercise testing  
d) Angiography  
e) Rhythm analysis  
f) Ambulatory blood pressure measurement. | Details of services available, including contact details for referrals. Referral guidelines for each service. | <LHFT> |
|   | Echocardiography staff training (HcS 22) W15 | All echocardiograms should be performed and reported by an appropriately trained and experienced member of staff. | Details of staff performing echocardiography, with training and CPD details.  
1 Staff newly performing echocardiography should be trained to BSE Adult Accreditation, or equivalent, standard.  
2 This QR applies to echocardiographs performed in whatever settings (i.e. in community or hospital). | <DGH>, <EDGH>, <LHFT>, <TCS>, <TCS(A)> |
|---|---|---|---|---|
|   | Rapid access chest pain service (DGH, EDGH, TCS) (HcS 2, 28) W9 | A daily rapid access chest pain assessment service should be available. The operational policy for the service should cover, at least, handling test results, referral for investigations and advice to be given to the patient. | Details of service available and operational policy  
1 Arrangements may vary at weekends and Bank Holidays but the service should still be available.  
2 The service should comprise, at least, someone to supervise and assess an exercise test and counsel the patient appropriately. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
|   | Heart failure diagnostic clinic (DGH, LHFT, EDGH, TCS) (HcS 2, 6) W9 | A diagnostic heart failure clinic at which a consultant cardiologist / physician with a special interest in heart failure and heart failure specialist nurse are both present should be held at least weekly. Echocardiography12-lead ECG and chest radiology should be available during the clinic time. The arrangements for accessing this clinic should have been communicated to local practices and local acute hospitals admitting patients as emergency (QR162). | Details of clinic times, staff usually available and operational policy for clinic.  
1 The diagnostic heart failure clinic may not require a whole clinic session.  
2 For community-based or DGH LHFTs, the consultant role in the clinic may be taken by an associate specialist, or GP with a special interest, working under the direction of a consultant.  
3 This QR applies to tertiary cardiac services acting as the LHFT for the local population. | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 54 | Heart failure diagnostics (timeliness) (DGH, LHFT, EDGH, TCS) (HcS 2, 3) W9 | Echocardiography should be available according to agreed referral guidelines, with routine reports available within four weeks. | Arrangements for access to echocardiography. Referral guidelines. Details of waiting times for echocardiography and for reports.  
1. “Four weeks” refers to the time from echocardiography to the report being received by the referring clinician. | <DGH>,<EDGH>,<LHFT>,<TCS>,<TCS(A)> |
| 55 | Heart failure - Further investigations and treatment (DGH, LHFT, EDGH) (HcS 2, 6) W20 | There should be agreed arrangements for accessing advice on and/or referring patients with heart failure for: a) Implantable cardioverter defibrillators (ICDs) b) Cardiac resynchronisation therapy (CRT) c) Home oxygen therapy d) Home continuous positive air pressure (CPAP) e) Transplantation f) LV assist devices g) Valve surgery h) Revascularisation (angioplasty and cardiac surgery) i) Intra-aortic balloon pumping j) Artificial heart k) Clinical genetics | Details of arrangements, with contact details. Referral guidelines (covering the types of patient / clinical condition to be referred).  
1 For LHFTs, including those in DGHs and EDGHs, services may be provided locally, through referral to a service at another hospital or through referral to the THFT. | <LHFT>,<DGH>,<EDGH> |
| 56 | TCS THFT clinic (HcS 2) W6 | The Tertiary Heart Failure Team should hold a clinic at least monthly to which local teams can refer patients for specialist investigations and advice. | Details of clinic arrangements. Communication of arrangements to referring LHFT (QR163). | <TCS>,<TCS(A)> |
|   | Heart failure - Further investigations and treatment (TCS) (HcS 2, 6) W20 | The following services should be available for patients with heart failure:  
a) Implantable cardioverter defibrillators (ICDs)  
b) Cardiac resynchronisation therapy.  
c) Home oxygen therapy.  
d) Home CPAP.  
e) Referral for transplantation.  
f) LV assist devices.  
g) Valve surgery. 
h) Revascularisation (angioplasty and cardiac surgery).  
i) Intra-aortic balloon pumping.  
j) Referral for artificial heart.  
k) Clinical genetics. | Details of arrangements, with contact details. Referral guidelines (covering the types of patient / clinical condition to be referred). | <TCS>, <TCS(A)> |
|---|---|---|---|
| 58 | Rapid access arrhythmia service (DGH, EDGH, TCS) (HcS 2, 28) W9 | A rapid access arrhythmia service should be available. The operational policy for the service should cover, at least, handling test results, referral for investigations and advice to be given to the patient. | Details of service available and operational policy  
1 The service should be available at least weekly.  
2 The service should comprise, at least, ECG recording, 24 hour ECG testing, echocardiography and patient activated monitoring, and advice from a heart rhythm specialist. | <EDGH>, <TCS>, <TCS(A)> |
| 59 | Temporary pacing and device re-programming (DGH) (HcS 2) W15 | There should be arrangements for the following services to be available at all times:  
a) Temporary pacing  
b) Pacemaker and ICD reprogramming  
If these services are not available on site at all times, referral guidelines, covering where the patient should be referred and clinical management of patients prior to referral, should be available. | Details of arrangements including, if necessary, referral guidelines and guidelines on the clinical management of patients prior to referral.  
1 Staff with the competences to provide these services may sometimes be available on site.  
The guidelines should be clear about the circumstances and staffing needed to provide these services locally and the action to be taken when staff with relevant competences are not available.  
2 As QR104. | <DGH> |
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| **60** | **Temporary pacing and device re-programming (EDGH & TCS) (HcS 2) W20** | The following services should be available at all times:  
a) Temporary pacing  
b) Pacemaker and ICD reprogramming | Details of arrangements | <EDGH>, <TCS>, <TCS(A)> |
| **61** | **EDGH normal hours services (HcS 2) W9** | The following services should be available during normal working hours:  
a) Pacemaker implantation  
b) ICD implantation  
c) Loop recorder implantation | Details of arrangements | <EDGH> |
| **62** | **EDGH adult congenital heart disease services (HcS 2) W15** | Local access to the following services should be available for adults with congenital heart disease:  
a) Medical genetics  
b) Anticoagulation clinic  
c) General dental services | Details of arrangements | <EDGH>, <TCS> |
| **63** | **TCS 24 hour services (HcS 2) W20** | The following services should be available at all times:  
a) Pacemaker implantation  
b) ICD implantation  
c) Loop recorder implantation  
d) PCI  
e) Cardiac surgery | Details of arrangements  
1. Access to dental services may be through ensuring patients have a general dental practitioner, a specific dental clinic for adults with congenital heart disease or other arrangements. | <TCS>, <TCS(A)> |
| **64** | **TCS normal hours services (HcS 2) W12** | Catheter ablation should be available during normal working hours. | Details of arrangements | <TCS>, <TCS(A)> |
| **65** | **BCIS inspection (HcS 12, 21) W12** | All angiography and PCI services should conform to the standards laid down by the British Cardiovascular Intervention Society and participate in the BCIS inspection process. | BCIS inspection reports showing compliance with relevant standards.  
1. This QR also applies to DGHs if angiography services are provided. | <EDGH>, <TCS>, <TCS(A)> |
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<th>Details of arrangements</th>
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| **66** | **TCS (Adult Congenital Heart Disease) services (HcS 2, 11, 12, 22) W15** | The following services, including staff with appropriate training and expertise in the care of adults with all types of congenital heart disease, should be available:  
   - Cardiovascular imaging including echocardiography and cardiovascular radiology  
   - Anaesthesia, including specialist expertise in:  
     - Obstetric anaesthesia for adults with congenital heart disease  
     - Anaesthesia of adults with learning disabilities  
   - Medical genetics  
   - Dental surgeon, dental nurse and dental hygienist  
   - Contraception and sexual health services  
   - Obstetric services  
   - Fetal medicine specialist and fetal echocardiography service  
   - Learning disabilities service  
   - Anticoagulation clinic | 1 Anaesthetic advice should be easily available as well as anaesthetic care during procedures. |   |
| **67** | **Adult congenital heart disease shared care clinic (EDGH, TCS) (HcS 11, 12) W8** | A clinic for the review of adults with congenital heart disease should be held regularly:  
   - The local cardiologist with an interest in the care of adults with congenital heart disease, an adult congenital cardiologist and an adult congenital heart disease specialist nurse should all be present.  
   - A member of staff with competence in echocardiography of adults with congenital heart disease should be available.  
   - Appointment times should be a minimum of 30 minutes per patient. | 1 Appointment times should exclude time for echocardiography.  
   2 Additional clinic time should be allowed when a doctor in training is present |   |
| **68** | **TCS (Adult Congenital Heart Disease) access to services (HcS 2) W15** | Access to the following services should be available:  
   - Pulmonary hypertension  
   - Heart transplantation  
   - Cardiac surgery team with training and expertise in congenital cardiac surgery | 1 These services may be available on site or through agreed referral arrangements to other tertiary cardiac services. |   |
| 69 | Rehabilitation and support services during acute stay (DGH, EDGH, TCS) (HcS 2) W8 | The following rehabilitation and support services should be available for patients with cardiac disease during their acute hospital treatment:  
a) Occupational therapy  
b) Physiotherapy  
c) Counselling and psychological support  
d) Social work  
e) Specialist dietary advice  
f) Pharmacy  
These services should be available during normal working hours. | Details of services available to patients during their acute hospital treatment.  
Name of lead person for each service responsible for linking with the cardiac team.  
1 Services may be combined as a cardiac rehabilitation service or may exist as separate services.  
2 The services should provide both advice and direct patient care.  
3 Staff providing these services should be competent in the care of patients with cardiac disease and should have sufficient time within their job plan to maintain these skills. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 70 | Rehabilitation services for patients with heart failure (HcS 12) W12 | The following rehabilitation and support services should be available to patients with heart failure during the ongoing treatment, monitoring and care of their condition:  
a) Occupational therapy  
b) Physiotherapy  
c) Sports and exercise physiology / therapy  
d) Counselling and psychological support  
e) Mental health services  
f) Social work | Details of services available and referral guidelines.  
Name of lead person for each service responsible for linking with the Local Heart Failure Team.  
1 These services should be available to patients in the community and in each hospital to which | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 71 | Organisation of cardiac services (HcS 28) W12 | Operational policies should be in use covering at least:  
|    |   | a) Arrangements to ensure that patients are assessed and thrombolysis given to appropriate patients within 30 minutes of arrival in the hospital (if not already given).  
|    |   | b) Admission to cardiac care unit and cardiac ward  
|    |   | c) Ambulation  
|    |   | d) Arrangements to ensure that all patients with a presenting diagnosis of acute coronary syndrome or arrhythmias are assessed by a consultant cardiologist within 24 hours of admission.  
|    |   | e) Arrangements to ensure that patients with a presenting diagnosis of acute coronary syndrome or arrhythmias who are not on the cardiac care unit or cardiac ward have access to the support, information and care of the cardiac team.  
|    |   | f) Arrangements for liaison with Care of the Elderly and diabetes teams for appropriate patients.  
|   |   | Operational policies  
|   |   | Audit of thrombolysis times  
|   |   | 1 Policies covering administration of thrombolysis should be in use in all places within the hospital where patients may present.  
|   |   | 2 Patients with a presenting diagnosis of acute coronary syndrome, or where the arrhythmia was a significant contributory factor to the patient being admitted, should be assessed by a consultant cardiologist within 24 hours of admission even if they are not admitted to the cardiac care unit or cardiac ward.  
|   |   | 3 Audit of whether patients were assessed by a consultant cardiologist within 24 hours is a desirable demonstration of compliance. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 72 | ACS assessment and initial management (HcS 12, 27, 28) W9 | Clinical guidelines should be agreed and in use covering the assessment and initial management of patients with a suspected diagnosis of acute coronary syndromes, including:  
  a) Resuscitation and stabilisation  
  b) Relief of pain and breathlessness  
  c) Diagnostic work-up  
  d) Reperfusion  
  • Administration of thrombolysis  
  • Assessment of the effectiveness of thrombolysis  
  • Referral for primary / rescue PCI  
  e) Early in-hospital care  
  f) Stratification of the risk of a further cardiac event  
  g) Management of right ventricular infarction  
  h) Management of myocardial infarction in patients with diabetes  
  i) Investigations and discharge of patients where a diagnosis of acute coronary syndromes is not confirmed | Clinical guidelines easily available in all areas where patients with suspected acute coronary syndromes may arrive at the hospital, the cardiac care unit and cardiac ward.  
  1 *Guidelines should be based on network-agreed guidance.*  
  2 *Ambulance ACS management is covered in QRs 16 and 17.* | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 73 | Interventions guidelines (CHD) (HcS 12, 28) W9 | Clinical guidelines should be agreed and in use covering:  
  a) Indications for angiography  
  b) Indications for PCI  
  c) Indications for CABG | Clinical guidelines  
  1 *Guidelines should be based on network-agreed guidance.* | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 74 | Primary PCI (HcS 12, 28) W12 | An operational policy should be in use covering the arrangements to ensure that primary PCI takes place within 90 minutes of arrival at hospital. | Operational policy  
  1 *Audit of time from arrival to PCI is a desirable demonstration of compliance.*  
  2 *This QR also applies to EDGHs if they form part of a network-wide PCI service.* | <TCS>, <TCS(A)> |
| 75 | Clinical guidelines ventricular performance (HcS 12) W9 | Clinical guidelines should be agreed and in use covering assessment of cardiac structure and function, including:  
a) Indications for use of different assessment techniques  
b) Frequency of assessment | Clinical guidelines  
1 These guidelines should cover transthoracic and transoesophageal echo Doppler, MRI, radionuclide perfusion analysis, cardiovascular CT angiography, cardiopulmonary exercise testing and invasive haemodynamic assessment.  
2 Guidelines should be based on network-agreed guidance. | <EDGH>, <TCS>, <TCS(A)> |
| 76 | Risk stratification (HcS 7, 26, 28) W12 | Operational policies should be in use covering at least:  
a) Discussion of the level of risk of a further cardiac event with the patient and communication of the level of risk to the patient’s GP  
b) Arrangements for giving patients and carers their patient held record / other information (QR81) prior to discharge from hospital  
c) Discharge from cardiac care unit and cardiac ward, including ensuring information on the patient’s condition reaches the GP within 48 hours. | Operational policies  
1 The patient held record and other information may be given, with appropriate support and advice, by the Cardiac Rehabilitation Team, by ward-based staff, or by specialist nurses.  
2 Audit of time for patient information to reach their GP is a desirable demonstration of compliance.  
3 For EDGHs and TCSs, these policies should include communication with the cardiac team in the patient’s local DGH within 48 hours of discharge. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 77 | MDT meetings (ACS) (HcS 11) W6 | Regular multi-disciplinary meetings should be held to discuss the care of patients with acute coronary syndromes. | Operational policy covering meeting arrangements.  
1 Multi-disciplinary meetings should involve, at least, cardiologist, nurse and, for tertiary cardiac services, a cardiac surgeon. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 78 | Management of high risk ACS patients (HcS 12, 28) W12 | An operational policy should be in use covering the arrangements to ensure that, in patients at high risk of a further cardiac event:  
a) An angiogram is undertaken within 48 hours of completion of risk stratification  
b) PCI or cardiac surgery is undertaken within 48 hours of angiography, if required. | Operational policy, based on network-agreed guidance.  
1 Audit of times to angiogram and PCI / cardiac surgery is a desirable demonstration of compliance. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 79 | ACS complications management (HcS 12, 28) W20 | Clinical guidelines should be agreed and in use covering the management of complications of acute coronary syndromes, including the management of: 
a) Deep vein thrombosis and pulmonary embolism 
b) Intraventricular thrombus and systemic emboli 
c) Pericarditis 
d) Post-infarction angina and ischaemia 
e) Mild and moderate heart failure 
f) Severe heart failure and cardiogenic shock 
g) Mechanical complications, including cardiac rupture and mitral regurgitation 
h) Arrhythmias and conduction disturbances | Clinical guidelines 
1. *Guidelines should be based on network-agreed guidance.* | <DGH>, <EDGH>, <TCS>, <TCS(A)> |

| 80 | ACS ongoing treatment guidelines (HcS 12, 28) W16 | Clinical guidelines should be agreed and in use covering the ongoing treatment for patients with acute myocardial infarction, covering at least: 
a) Antiplatelet and anticoagulation therapy 
b) Control of hypertension 
c) ACE inhibitors 
d) Lipid reduction therapy | Clinical guidelines 
1. *Guidelines should be based on network-agreed guidance.* | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 81 | Patient held record CHD (HcS 26) W8 | For patients with coronary heart disease, a patient held record should be available covering at least:  
- Self-management, including advice (where applicable) on:  
  - Activity and exercise  
  - Diet, including salt and fluid intake  
  - Weight monitoring  
  - Smoking  
  - Alcohol  
  - Anxiety, depression and irritability  
  - Return to work and resuming other activities  
- Medicines  
- Side effects of medicines  
- Recording of medication and test results  
- Who to contact for advice and support  
- Arrangements for cardiac rehabilitation  
- Access to basic life support training  
- Symptoms of acute coronary syndromes and action to take should these occur  
- Sources of further information and advice, including support groups  
- Aetiology, diagnosis, treatment and care of acute coronary syndromes  
- Management of symptoms of angina (if applicable) | Examples of patient held records and other information  
1. Information should be available in formats and languages appropriate to the needs of the patients. This may include large print and taped information.  
2. The contact for advice and support may be a member of the patient’s primary health care team, Cardiac Rehabilitation Team, the DGH / EDGH team or, for a few patients, a member of the tertiary cardiac service.  
3. The information offered to individual patients should be tailored to their individual needs.  
4. This information may include reference to Expert Patient Programmes where they are available locally  
5. This QR is linked to QR76. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 82 | Referral to rehabilitation and smoking cessation (HcS 28) W8 | Guidelines should be agreed and in use covering:  
- Referral to cardiac rehabilitation, including referral criteria  
- Referral of patients who smoke to smoking cessation services. | Referral guidelines  
1. Guidelines should be based on network-agreed guidance.  
2. The guidelines for referral to cardiac rehabilitation should have been agreed with the local Cardiac Rehabilitation Team/s and should cover all patients for whom evidence-based cardiac rehabilitation is indicated. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
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<td>83</td>
<td>Discharge and follow up (general) (HcS 28) W9</td>
<td>Guidelines should be agreed and in use covering: a) Follow up and monitoring arrangements following discharge from hospital. b) Discharge of patients from the care of the cardiology team for ongoing monitoring and care in general practice. c) Follow up of patients after implantation of a cardiac device.</td>
<td>Guidelines 1 Guidelines should be based on network-agreed guidance and have been agreed with LHBs from which patients are usually referred. 2 Guidelines should cover CHD, arrhythmias and congenital heart disease. 3 For EDGHs and TCSs, these guidelines should include communication with the cardiac team in the patient’s local DGH.</td>
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<td>84</td>
<td>TCS discharge (HcS 28) W9</td>
<td>An operational policy should be in use covering discharge of patients to a DGH / EDGH nearer their home.</td>
<td>Operational policy 1 The operational policy should be based on the network-agreed care pathway. 2 This QR is linked to QR20 on transport arrangements. 3 The operational policy should include arrangements for handover between Cardiac Rehabilitation Teams. 4 The operational policy should cover patients with CHD and patients with arrhythmias.</td>
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<td>85</td>
<td>Heart failure specialist nurse consultation (HcS 2) W3</td>
<td>Following confirmation of their diagnosis of heart failure, each patient should be offered the opportunity to see a heart failure specialist nurse for advice on their condition and self-management.</td>
<td>Audit or arrangements or details of numbers of patients seen. 1 This QR is linked with QR86 and QR92.</td>
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<td>&lt;LHFT&gt;, &lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
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| Page | Heart failure patient information (HcS 6) W6 | The following information should be offered to patients and carers following confirmation of their diagnosis:  
1. Membership of the Local / Tertiary Heart Failure Team and how to contact them.  
2. Self-management, including advice (where applicable) on:  
   - Activity and exercise.  
   - Diet, including salt and fluid intake.  
   - Weight monitoring.  
   - Smoking.  
   - Alcohol.  
   - Anxiety and depression.  
   - Sexual activity and pregnancy.  
   - Vaccination.  
   - Air travel.  
   - Driving.  
   - Self-monitoring for signs of deterioration.  
   - Symptom control.  
3. Drug therapy.  
4. Side effects of drug therapy.  
5. Who to contact for advice and support.  
6. What to do in an emergency.  
7. Self-help and other support groups.  
8. Aetiology, diagnosis, treatment and care of heart failure. | Information for patients and carers  
1. Information should be available in formats and languages appropriate to the needs of the patients. This may include large print and taped information.  
2. The contact for advice and support may be a member of the patient’s primary health care team, a member of the LHFT or, for a few patients, a member of the THFT.  
3. The information offered to individual patients should be tailored to their individual needs.  
4. Where appropriate, LHFT information should have been distributed to local general practices.  
5. This information may include reference to Expert Patient Programmes where they are available locally.  
6. ‘A thematic approach to information for the patient with heart failure and their family’; The Task Force of the European Society of Cardiology; Guidelines for the diagnosis and treatment of Chronic Heart Failure; 2005. | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| --- | --- | --- | --- | --- |
| Page | Heart failure guidelines (HcS 12, 27, 28) W9 | Clinical guidelines should be agreed and in use covering:  
1. Diagnosis, management and monitoring of patients with heart failure.  
2. Accessing advice and support from the Local Heart Failure Team.  
3. Referral to the Local Heart Failure Team.  
4. Referral to the weekly heart failure diagnostic clinic.  
5. Management of acute exacerbations of heart failure. | Clinical guidelines easily available in all areas of the hospital where patients with heart failure may be assessed and treated.  
1. These guidelines should be based on network-agreed guidance and the guidelines of the LHFT (QRs 53, 88 to 94, 96, 99 and 100).  
2. In tertiary cardiac services, the THFT may act as the LHFT for the local population | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
|   | Heart failure diagnosis guidelines (LHFT) (HcS 12, 28) W9 | The Local Heart Failure Team should have agreed guidelines for the diagnosis of heart failure. These guidelines should include:  
   a) Diagnostic tests.  
   b) Indications for BNP and NTProBNP testing (if available).  
   c) Indications for echocardiography.  
   d) Alternative methods of imaging if a poor image is produced on echocardiography.  
   e) Assessment for exacerbating factors.  
   f) Action to be taken if exacerbating factors are found.  
   g) Indications for seeking advice from the Tertiary Heart Failure Team.  
   h) Indications for referral to the Tertiary Heart Failure Team for assessment or specialist investigations. | Diagnosis guidelines  
   Evidence of agreement with local practices and local acute hospitals.  
   
   1 These guidelines should be based on network guidance, NICE chronic heart failure guidance and should be consistent with the locally agreed heart failure pathway. | <LHFT>,<DGH>,<EDGH> |
|---|---|---|---|
|   | Heart failure diagnosis guidelines (THFT) (HcS 12, 28) W6 | The Tertiary Heart Failure Team should have agreed guidelines for the diagnosis of heart failure. These guidelines should include:  
   a) Diagnostic tests.  
   b) Indications for BNP and NTProBNP testing (if available).  
   c) Indications for echocardiography.  
   d) Alternative methods of imaging if a poor image is produced on echocardiography.  
   e) Assessment for exacerbating factors.  
   f) Action to be taken if exacerbating factors are found. | Diagnosis guidelines  
   1 These guidelines should be based on network guidance, NICE chronic heart failure guidance and should be consistent with the locally agreed heart failure pathway. | <TCS>,<TCS(A)> |
| 90 | Heart failure clinical management guidelines (HcS 12, 28) W9 | The Local / Tertiary Heart Failure Team should have agreed guidelines for the clinical management of patients with heart failure. These guidelines should include:
   a) Pharmacological management.
   b) Non-pharmacological management.
   c) Management of patients with resistant, unstable or reversible heart failure.
   d) Indications for seeking advice from the Tertiary Heart Failure Team (LHFT only).
   e) Indications for referral for assessment by the Tertiary Heart Failure Team (LHFT only).
   f) Indications for cardiac resynchronisation therapy (biventricular device therapy) (THFT only).
   g) Indications for ICD (THFT only).
| Clinical management guidelines. 1 These guidelines should be based on network guidance, NICE chronic heart failure guidance and should be consistent with the locally agreed heart failure pathway. | <LHFT>,<DGH>,<EDGH>,<TCS>,<TCS(A)> |

| 91 | Heart failure exacerbation management (HcS 12, 28) W9 | The Local Heart Failure Team should agree guidelines for the management of acute exacerbation of heart failure with each acute hospital accepting emergency admissions within the area served by the team. These guidelines should include:
   a) Heart failure management plan.
   b) Pharmacological and non-pharmacological management.
   c) Monitoring.
   d) Seeking advice from the Local Heart Failure Team.
   e) Referral to the Local Heart Failure Team.
   f) Information to be given to patients prior to discharge.
   g) Information to be given to patients who have been given a confirmed diagnosis of heart failure and who are discharged prior to their first meeting with the specialist heart failure nurse (QR85).
   h) Discharge arrangements.
| Guidelines on the management of acute heart failure agreed with each acute hospital accepting emergency admissions within the area served by the Local Heart Failure Team. 1 The guidelines should be based on network-agreed guidelines. They may be the same for all acute hospitals served by the Local Heart Failure Team or may be different. | <LHFT> |
| 92 | Heart failure patient information prior to discharge (HcS 6) W6 | Information should be available for patients with heart failure covering:  
a) Information to be given to patients prior to discharge.  
b) Information to be given to patients who have been given a confirmed diagnosis of heart failure and who are discharged prior to their first meeting with the specialist heart failure nurse (QR85). | Information for patients and carers available in local acute hospitals.  
1 As QR81 notes 1, 3 and 4.  
2 This QR is linked to QR85 and 86. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 93 | Heart failure rehabilitation guidelines (HcS 12, 28) W6 | The Local / Tertiary Heart Failure Team should have agreed referral and communication guidelines with rehabilitation and support services (QR70). These guidelines should specify the arrangements for communication about changes to the patient’s condition and management plan. | Guidelines, agreed with rehabilitation and support services.  
1 Guidelines should be based on network-agreed guidance. | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 94 | Heart failure monitoring guidelines (HcS 12, 28) W6 | The Local / Tertiary Heart Failure Team should have agreed guidelines for the monitoring of patients with heart failure. These guidelines should specify:  
a) Details of the monitoring programme (frequency and types of assessment).  
b) The types of patients who will be monitored in different settings.  
c) The person with lead responsibility for monitoring in each setting.  
d) The reasons for triggering further action.  
e) For all nurse-led monitoring, ‘fast-track’ access to advice from a consultant cardiologist / physician with a special interest in heart failure. | Agreed monitoring guidelines.  
1 It is likely that these guidelines will build on the three levels of care: a) primary care and self-management b) care management and c) case management.  
2 Monitoring will usually be patient or nurse-led. This may not always be possible because of travel distances and time or availability of trained staff.  
3 The monitoring guidelines should be based on network-agreed guidance, NICE guidance and should cover pharmacological and non-pharmacological aspects of treatment and care. | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 95 | Heart failure self-monitoring information (HcS 6) W6 | Information should be given to patients and/or carers who are taking some responsibility for monitoring their own condition covering:  
a) Monitoring tests.  
b) What to do if results fall outside agreed limits. | Information for patients and carers.  
1 This information should be consistent with the local monitoring guidelines (QR94). | <LHFT>, <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 96 | THFT/LHFT agreement of referral guidelines (HcS 12, 28) W6 | Referral guidelines should be agreed between the Tertiary Heart Failure Team and its linked local teams (QR163) covering:
- a) Indications for referral to the Tertiary Heart Failure Team.
- b) Arrangements for in-patient transfers.
- c) Information about the patient to be communicated by the Local Heart Failure Team. | Agreed referral guidelines. 
Agreement of guidelines with linked LHFTs. 
1 These guidelines should be consistent with relevant LHFT guidelines (QRs 87, 88 and 90). 
2 This QR may be met through agreement between the LHFT and THFT of the relevant LHFT guidelines (QRs 87, 88 and 90). | <TCS>, <TCS(A)> |
| 97 | THFT/LHFT agreement of discharge guidelines (HcS 12, 28) W6 | Discharge guidelines should be agreed between the Tertiary Heart Failure Team and its linked local teams (QR163) covering:
- a) The types of patient / condition that should be discharged from the Tertiary Heart Failure Team to the care of the Local Heart Failure Team.
- b) Arrangements for in-patient transfers.
- c) Information about the patient to be communicated to the Local Heart Failure Team. | Agreed discharge guidelines. 
Communication of guidelines to linked LHFTs. 
1 These guidelines should be based on network-agreed guidance. | <TCS>, <TCS(A)> |
The Local / Tertiary Heart Failure Team should have an agreed operational policy covering, at least:

a) Arrangements whereby primary care staff and staff in acute hospitals can gain access to the team for advice (LHFT only).
b) Arrangements whereby members of Local Heart Failure Teams can gain access to the team for advice (THFT only).
c) Arrangements for offering each newly-diagnosed patient the opportunity to see a heart failure specialist nurse for advice on their condition and self-management.
d) Arrangements for ensuring that all patients have been given relevant information.
e) Offering patients a copy of their management plan.
f) Arrangements whereby patients with heart failure can gain access to a member of the heart failure team for advice and support.
g) Arrangements for notifying the patient’s General Practitioner whenever a patient is given a diagnosis of heart failure.
h) Arrangements for sending a copy of the patient’s echocardiogram report to their GP.
i) Arrangements for informing the patient’s GP of the patient’s management plan.
j) Communication required in the event of changes to the management plan.
k) Arrangements for accessing equipment needed to support patients at home.
l) Arrangements for liaison with Care of the Elderly teams for appropriate patients.

Operational policy of the heart failure team.

1 The arrangements for giving advice and support to patients, primary care acute hospitals and Local Heart Failure Teams should include clear timescales within which a response will be guaranteed.
2 The arrangements for notifying the patient’s general practitioner whenever a patient is given a diagnosis of heart failure should reach the GP by the end of the next working day and should specify the contact point for advice and support that has been given to the patient.
3 The operational policy should be clear about responsibility for recording information in patients’ notes.
4 The LHFT aspects of this QR also apply to tertiary cardiac services acting as the LHFT for their local population.
| Referral to specialist palliative care (HcS 12, 28) W9 | The Local Heart Failure Team should have agreed guidelines with the specialist palliative care services serving the local population covering, at least:
   a) Arrangements for accessing advice and support from the specialist palliative care team.
   b) Agreement of key worker.
   c) Arrangements for shared care between the Local Heart Failure Team and palliative care services.
   d) Indications for referral of patients to the specialist palliative care team for advice.
   e) Arrangements for accessing equipment to support patients at home.
   f) Arrangements for handover of patients to the specialist palliative care team. | Guidelines, agreed with specialist palliative care service/s serving the local population.
   1 Guidelines should address the needs of patients with complex symptom control problems; patients with complex psychological, social or spiritual needs and patients with young children or elderly carers in need of support.
   2 Arrangements for accessing equipment may be the same as QR98 but may be different for patients nearing the end of their life.
   3 Guidelines will need to reflect the local availability of palliative care services for patients with heart failure.
   4 This QR applies to tertiary cardiac services acting as the LHFT for the local population. | <LHFT>,<DGH>,<EDGH>,<TCS>,<TCS(A)> |
|---|---|---|---|
| End of life care (HcS 8, 12,28) W9 | The Local Heart Failure Team should be aware of local guidelines for the end of life care of patients. | Availability of guidelines relating to end of life care that are used by specialist palliative care services in the local area.
   1 This QR applies to tertiary cardiac services acting as the LHFT for the local population. | <LHFT>,<DGH>,<EDGH>,<TCS>,<TCS(A)> |
| Transient loss of consciousness guidelines (HcS 12, 28) W9 | Clinical guidelines should be agreed and in use covering the investigation and management of patients with transient loss of consciousness. | Clinical guidelines available in all areas where patients with transient loss of consciousness may be seen.
   1 This QR is linked to QR104 and 105 relating to referral to a heart rhythm specialist.
   2 Guidelines should be based on network-agreed guidance. | <DGH>,<EDGH>,<TCS>,<TCS(A)> |
| 102 | Arrhythmia patient information (HcS 6) W6 | Information should be available for patients with arrhythmias, covering at least:  
  a) Aetiology, diagnosis and treatment of arrhythmias  
  b) Management of arrhythmias  
  c) Medicines  
  d) Side effects of medicines  
  e) ECG records  
  f) Access to basic life support training  
  g) Who to contact for advice and support  
  h) Sources of further information and advice, including support groups.  
Examples of information available.  
1 The contact for advice and support may be a member of the patient’s primary health care team or a named arrhythmia coordinator.  
2 As QR81 notes 1, 3 and 4. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 103 | Arrhythmia assessment and initial management (HcS 12, 27, 28) W9 | Clinical guidelines should be agreed and in use covering the assessment and initial management of patient with arrhythmias, including patients already fitted with a pacemaker or ICD.  
Clinical guidelines easily available in all areas of the hospital where patients with suspected arrhythmias may be assessed and treated.  
1 Guidelines should be based on network-agreed guidance. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 104 | Referral to heart rhythm specialist (DGH) (HcS 12, 28) W9 | Guidelines should be in use covering referral of patients with possible arrhythmias to a heart rhythm specialist in either an EDGH or tertiary cardiac service.  
The guidelines should specify which patients should be assessed by a heart rhythm specialist prior to discharge as well as those for whom urgent and routine referral is appropriate.  
Referral guidelines.  
1 Guidelines should be based on network-agreed guidance.  
2 Referral guidelines will vary depending on the availability of EDGH services for patients with arrhythmias.  
3 This QR is linked to QR20 relating to the transfer of patients. | <DGH> |
| 105 | Referral to heart rhythm specialist (EDGH) (HcS 12, 28) W6 | Guidelines should be in use covering referral of patients with possible arrhythmias to a heart rhythm specialist in a tertiary cardiac service.  
The guidelines should specify which patients should be assessed by a heart rhythm specialist prior to discharge as well as those for whom urgent and routine referral is appropriate.  
Referral guidelines.  
1 Guidelines should be based on network-agreed guidance.  
2 This QR does not apply to EDGHs with an on-site heart rhythm specialist.  
3 This QR is linked to QR20 relating to the transfer of patients. | <EDGH> |
| 106 | Interventions guidelines arrhythmia (HcS 12, 28) W9 | Clinical guidelines should be agreed and in use covering indications for: a) Implantable Cardioverter Defibrillators b) DC cardioversion c) Permanent pacemaker implantation | Clinical guidelines 1 Guidelines should be based on network-agreed guidance. | <EDGH>, <TCS>, <TCS(A)> |
| 107 | Electrophysiological intervention guidelines (HcS 12, 28) W9 | Clinical guidelines should be agreed and in use covering indications for: a) Diagnostic electrophysiological studies b) Catheter ablation | Clinical guidelines 1 Guidelines should be based on network-agreed guidance. | <TCS>, <TCS(A)> |
| 108 | Patient information interventions (HcS 6) W9 | Information should be available for patients covering: a) Procedure to be undertaken b) Device to be implanted c) Care following the procedure, including self-care d) Possible complications | Examples of information available 1 As QR81 notes 1, 3 and 4. 2 Information should be available on all types of procedures undertaken and devices implanted by the service. | <EDGH>, <TCS>, <TCS(A)> |
| 109 | Allocation of arrhythmia coordinator (HcS 11, 28) W3 | An operational policy should be in use covering: a) Identification of patients and families for ongoing support by a named arrhythmia coordinator. b) Arrangements for allocation of a named arrhythmia coordinator for these patients. | Operational policy 1 Guidelines should be based on network-agreed guidance. 2 Support from an arrhythmia coordinator should be available to at least those patients and families listed in standard 5 of the NSF. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 110 | Arrhythmia: assessment of support needs (HcS 12, 28) W6 | An operational policy should be in use covering: a) The formal assessment of support needs of patients with arrhythmias and their carers b) Provision of additional support for patients with arrhythmias at increased risk of anxiety, depression or poor quality of life. c) Referral of appropriate patients to services providing additional support. | Operational policy, based on network-agreed guidance. 1 Services providing additional support may include counselling and mental health services. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 111 | Arrhythmia patients ECG copy (HcS 6, 28) W6 | An operational policy should be in use to ensure that all patients with arrhythmias are given a copy of any ECG taken during typical symptoms and patients are advised to bring it to future cardiology appointments or if they experience problems related to their arrhythmia. | Operational policy in use in all areas of the hospital where patients with arrhythmias may be initially managed. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 112 | Anti-coagulant monitoring policy (HcS 6) W8 | An operational policy should be in use covering arrangements and choice of location for anti-coagulation monitoring. This policy should include the option of home anti-coagulation monitoring for appropriate patients. | Operational policy  
1. All young people previously on home anti-coagulation monitoring should have the option of continuing with home monitoring. | <EDGH>, <TCS>, <TCS(A)> |
| 113 | Sudden cardiac death post mortem (HcS 28) W5 | An operational policy should be in use to ensure that all post mortems on young adults who died suddenly and where sudden cardiac death is a possible cause of death are undertaken according to the relevant Royal College of Pathologists standard post mortem. | Operational policy | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 114 | Sudden cardiac death genetics (HcS 28) W5 | An operational policy should be in use to ensure:  
a) With consent, DNA samples of young adults with sudden cardiac death are sent to an accredited molecular diagnostics laboratory through the Wales genetics service.  
b) Notification to the national coordinating team. | Operational policy  
1. This QR is included subject to agreement on participation. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 115 | Advice to families following cardiac arrest <40 years (HcS 28) W4 | An operational policy should be in use covering advice and support to families following a cardiac arrest in a relative aged less than 40 years including indications for referral for genetic testing. | Operational policy | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
### 116 TCS (Adult Congenital Heart Disease) Transition to adult care protocol (HcS 12) W12

<table>
<thead>
<tr>
<th>Protocol should be in use covering transition to adult care. This should cover:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Age guidelines for timing of the transfer.</td>
</tr>
<tr>
<td>b) Involvement of the young person in the decision about transfer.</td>
</tr>
<tr>
<td>c) Allocation of a named coordinator for the transfer of care.</td>
</tr>
<tr>
<td>d) A preparation period and education programme relating to transfer to adult care.</td>
</tr>
<tr>
<td>e) Communication of clinical information to the adult service and to primary care.</td>
</tr>
<tr>
<td>f) Arrangements for anti-coagulation monitoring.</td>
</tr>
<tr>
<td>g) Arrangements for dental care.</td>
</tr>
<tr>
<td>h) Arrangements for monitoring during the time immediately after transfer to adult care.</td>
</tr>
</tbody>
</table>

- Protocol agreed with service for children and young people from which patients are usually transferred.
  1. The named coordinator may change during the young person’s transition to adult care.
  2. The protocol should ensure that all young people are given appropriate information, including about transfer to adult care (QR117 and 120).
  3. Information for the patient’s GP should include the risk of endocarditis and the need for antibiotic prophylaxis for dental and surgical procedures.
  4. This QR is linked to QR112 on anti-coagulation.

### 117 Adult congenital heart disease - transition to adult care patient information (HcS 6) W6

| Information should be available on transition to adult care. This information should cover all aspects of the transition (QR116). |

- Examples of age-appropriate information for young people and information for parents.
  1. Information should be simple and consistent. Age-appropriate formats, including electronic information, should be used wherever possible.

### 118 Referral guidelines adult congenital heart disease (HcS 12) W9

| Guidelines should be in use covering referral of patients with previously undiagnosed congenital heart disease to an adult congenital cardiologist in a tertiary cardiac service. |

- Referral guidelines.
  1. Guidelines should be based on network-agreed guidance.
  2. The adult congenital cardiologist may see the patient in an EDGH nearer their home or in a tertiary centre.
<table>
<thead>
<tr>
<th>119</th>
<th>TCS (Adult Congenital Heart Disease) clinic (HcS 2, 11, 12) W16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A clinic for the review of adults with congenital heart disease should be held regularly:</td>
</tr>
<tr>
<td></td>
<td>a) The adult congenital cardiologist and an adult congenital heart disease specialist nurse should both be present.</td>
</tr>
<tr>
<td></td>
<td>b) A member of staff with competence in echocardiography of adults with congenital heart disease should be available.</td>
</tr>
<tr>
<td></td>
<td>c) Appointment times should be a minimum of 30 minutes per patient.</td>
</tr>
<tr>
<td></td>
<td>Details of arrangements</td>
</tr>
<tr>
<td></td>
<td>1 Appointment times should exclude time for echocardiography.</td>
</tr>
<tr>
<td></td>
<td>2 Additional clinic time should be allowed when a doctor in training is present.</td>
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<tr>
<th>120</th>
<th>Adult congenital heart disease patient information (HcS 6) W6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Written information for patients with congenital heart disease and their families should be available covering at least:</td>
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<tr>
<td></td>
<td>a) An explanation and description of the condition, how it might affect the individual, possible complications and treatment.</td>
</tr>
<tr>
<td></td>
<td>b) Details of the services available locally including:</td>
</tr>
<tr>
<td></td>
<td>• Clinic times and how to change an appointment</td>
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<tr>
<td></td>
<td>• Key contact name and number</td>
</tr>
<tr>
<td></td>
<td>• Who to contact for advice out of hours</td>
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<tr>
<td></td>
<td>c) Health promotional material including</td>
</tr>
<tr>
<td></td>
<td>• Inheritance and implications for other family members</td>
</tr>
<tr>
<td></td>
<td>• Dental health</td>
</tr>
<tr>
<td></td>
<td>• The importance of a good diet and regular exercise</td>
</tr>
<tr>
<td></td>
<td>• Implications for travel and insurance</td>
</tr>
<tr>
<td></td>
<td>• Reducing the risk of endocarditis</td>
</tr>
<tr>
<td></td>
<td>• Contraception and sexual health</td>
</tr>
<tr>
<td></td>
<td>d) Self-monitoring, including home INR (International Normalised Ratio) testing</td>
</tr>
<tr>
<td></td>
<td>e) Where to go for further information, including useful websites and national voluntary organisations.</td>
</tr>
<tr>
<td></td>
<td>Examples of written information available</td>
</tr>
<tr>
<td></td>
<td>1 Information should be simple and consistent. Age-appropriate formats, including electronic information, should be used wherever possible.</td>
</tr>
<tr>
<td></td>
<td>2 Information should be available in formats and languages appropriate to the needs of the patients. This may include large print and taped information.</td>
</tr>
<tr>
<td></td>
<td>3 Information may be given at different stages in the patient’s care, as appropriate.</td>
</tr>
</tbody>
</table>

<TCS(A)>
| 121 | Patient held record - adult congenital heart disease (HcS 6) W4 | An operational policy should be in use which ensures that all adults with congenital heart disease have an up to date record of:  
a) Their condition  
b) Current management plan  
c) Regular medication  
d) Named contact for queries and advice  
e) Action to take in an emergency | Operational policy  
1 The patient record could be in a variety of formats, including electronic.  
2 This QR is linked with QR129. | <EDGH>, <TCS>, <TCS(A)> |
| 122 | Clinical guidelines - adult congenital heart disease (HcS 12) W9 | Clinical guidelines for the care of adults with congenital heart disease should be agreed and in use covering:  
a) Antibiotic prophylaxis  
b) Anticoagulant therapy  
c) Therapeutic phlebotomy  
d) Treatment of iron deficiency  
e) Management of abnormal renal function  
f) Management of pulmonary vascular disease  
g) Management of infective endocarditis  
h) Management of arrhythmias in patients with congenital heart disease  
i) Assessment of risk of unexpected life-threatening arrhythmias in patients with complex congenital heart disease  
j) Referral for cardiac rehabilitation. | Clinical guidelines  
1 Arrhythmia management guidelines should be consistent with those in QRs 103, 105 and 106.  
2 Guidelines should be based on network-agreed guidelines. | <EDGH>, <TCS>, <TCS(A)> |
<table>
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<tr>
<th>Page</th>
<th>Reference</th>
<th>Description</th>
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<tbody>
<tr>
<td>123</td>
<td>Adult congenital heart disease referral back to specialist team guidelines (HcS 12) W10</td>
<td>Guidelines should be in use covering referral of patients with congenital heart disease to an adult congenital cardiologist. The guidelines should cover at least: a) Indications for seeking urgent advice from the adult congenital cardiologist b) Indications for assessment by an adult congenital cardiologist, including: • initial assessment of all patients • assessment early in pregnancy c) Referral of all patients for whom interventional cardiac procedures are being considered and patients with moderate or severe disease where surgery or general anaesthesia is being considered (QR130).</td>
</tr>
<tr>
<td>124</td>
<td>TCS (Adult Congenital Heart Disease) MDT meetings (HcS 11) W20</td>
<td>Regular multi-disciplinary meetings should be held to discuss the care of adults with congenital heart disease involving, at least, the adult congenital cardiologist, adult specialist nurse, transition specialist nurse, member of staff with competence in echocardiography of adults with congenital heart disease and cardiac imaging specialist.</td>
</tr>
<tr>
<td>125</td>
<td>TCS (Adult Congenital Heart Disease) interventional procedures (HcS 12) W9</td>
<td>The agreed range of interventional procedures normally undertaken on adults with congenital heart disease should be documented.</td>
</tr>
<tr>
<td>126</td>
<td>TCS (Adult Congenital Heart Disease) obstetric clinic (HcS 2, 11, 12) W10</td>
<td>A joint cardiac / obstetric clinic for the care of pregnant women with complex cardiac conditions should be held regularly.</td>
</tr>
</tbody>
</table>

Referral guidelines.  
1 Guidelines should be based on network-agreed guidance.  
2 Guidelines should cover referral of patients who are in-patients as well as out-patient referrals.  
3 Assessment by an adult congenital cardiologist may take place in a joint out-patient clinic or at the tertiary cardiac centre depending on the urgency of the situation.  
4 Interventional cardiac procedures for patients with congenital heart disease should take place only in the tertiary cardiac service where cardiac surgical support is available if required.  

Operational policy covering meeting arrangements.  
1 Cardiologists with an interest in the care of adults with congenital heart disease should have the option to attend this meeting, especially when the care of their patients is discussed.  

List of interventional procedures  

Details of arrangements  
1 Other aspects of the care of pregnant women with congenital heart disease are covered in QR123 and QR127.
<table>
<thead>
<tr>
<th>No.</th>
<th>Section</th>
<th>Text</th>
<th>Guidelines</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>127</td>
<td>Adult congenital heart disease obstetric care (HcS 12) W12</td>
<td>Guidelines should be in use covering which patients are suitable for local obstetric care and which should be offered obstetric care in the tertiary centre.</td>
<td>Guidelines available&lt;br&gt;1. Guidelines should be based on network-agreed guidance.</td>
<td>&lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>128</td>
<td>TCS (Adult Congenital Heart Disease) onward referral (HcS 12) W9</td>
<td>Guidelines should be agreed and in use covering indications for referral of patients with congenital heart disease to other tertiary cardiac services for: a) Pulmonary hypertension services b) Consideration for heart transplantation c) Management of highly complex arrhythmias</td>
<td>Guidelines agreed by service to which patients are usually referred.</td>
<td>&lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>129</td>
<td>Adult congenital heart disease - monitoring and follow up (HcS 12) W8</td>
<td>An operational policy should be in use covering monitoring of adults with congenital heart disease. This should cover: a) Frequency and location of review b) Indications for early review c) Documentation of review d) Ensuring the patient-held record is updated with the outcome of the review. e) Informing the patient’s GP and, if necessary, the patient’s dentist of the outcome of the review.</td>
<td>Operational policy&lt;br&gt;1. For patients discharged from the care of the Adult Congenital Heart Disease Service, the GP information should include indications for referral back to the team. 2. The patient-held record is covered in QR121.</td>
<td>&lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>130</td>
<td>Adult congenital heart disease surgery / anaesthesia (HcS 12) W5</td>
<td>Guidelines should be in use which ensure that: a) The Adult Congenital Heart Disease service is notified whenever an adult with complex congenital heart disease is admitted as an in-patient. b) No surgery or general anaesthesia is carried out on adults with moderate or complex congenital heart disease without prior discussion with the patient’s adult congenital heart disease specialist team.</td>
<td>Guidelines and details of distribution</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>131</td>
<td>TCS (Adult Congenital Heart Disease) audit (HcS 11) W8</td>
<td>The Adult Congenital Heart Disease Service should be collecting data and undertaking regular audit of the care of all patients, including patients being cared for jointly with EDGH teams.</td>
<td>Data set and audit reports. 1. ‘EDGH teams’ includes teams in tertiary cardiac services which do not provide a specialist service for patients with congenital heart disease.</td>
<td>&lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>132</td>
<td>TCS liaison with referring services (HcS 24) W12</td>
<td>The tertiary cardiac team should meet at least annually with its referring DGH / EDGH teams to: a) Identify any changes needed to network-wide policies, procedures and guidelines b) Review results of audits undertaken c) Review any critical incidents involving liaison between the teams d) Consider the content of future training and awareness programmes (QR182 to 184).</td>
<td>Evidence of review meeting/s having taken place 1. Meetings may be with referring teams together or separately.</td>
<td>&lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>133</td>
<td>L/THFT annual review (HcS 11) W6</td>
<td>The Local / Tertiary Heart Failure Team should meet at least annually to: a) Review local policies, procedures and guidelines. b) Review results of audits undertaken. c) Review the summary of the learning plans of the team.</td>
<td>Minutes of review meeting/s.</td>
<td>&lt;LHFT&gt;,&lt;DGH&gt;, &lt;EDGH&gt;,&lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>134</td>
<td>CCAD audit participation (HcS 28) W16</td>
<td>The cardiac service should be participating in relevant CCAD audit programmes.</td>
<td>Inclusion of service in relevant Annual Reports 1. Relevant audit programmes are listed in the cardiac NSF.</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>135</td>
<td>Heart failure audit participation (HcS 11) W8</td>
<td>The Local / Tertiary Heart Failure Team should participate in the CCAD national heart failure audit.</td>
<td>Inclusion of team in reports of the National Audit of Heart Failure services.</td>
<td>&lt;LHFT&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
<tr>
<td>136</td>
<td>Smoking cessation - hospital programmes (HcS 31) W8</td>
<td>All hospitals should have implemented a programme to achieve the Welsh Health Circular Guidance on Smoking Cessation for NHS Organisations</td>
<td>Details of local programme.</td>
<td>&lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt;</td>
</tr>
</tbody>
</table>
| 137 | Patient feedback and involvement (HcS 1, 15) 6 | Operational policies should be in use covering at least:  
a) Mechanisms for receiving feedback from patients and carers about the treatment and care they receive.  
b) Mechanisms for involving patients and carers in decisions about the organisation of the services for patients with cardiac disease. | Operational policies  
1 The mechanisms for user-involvement may be part of LHB-wide systems of patient involvement but should ensure that issues specific to the range of services for patients with cardiac disease are addressed.  
2 Feedback mechanisms may include discovery interviews. | <DGH>, <EDGH>, <TCS>, <TCS(A)> |
| 138 | LHFT - patient feedback and involvement (HcS 1, 2, 15, 28) W4 | Operational policies should be in use covering at least:  
a) Mechanisms for receiving feedback from patients and carers about the treatment and care they receive.  
b) Mechanisms for involving patients and carers in decisions about the organisation of the services for patients with heart failure. | Operational policies  
1 The mechanisms for user-involvement may be part of LHB/hospital-wide systems of patient involvement but should ensure that issues specific to patients with heart failure are addressed.  
2 Feedback mechanisms may include discovery interviews. | <LHFT> |
<p>| 139 | Staff training programmes 3 (HcS 22) W6 | The cardiac service should contribute to and participate in relevant staff training and awareness programmes (QRs 182 to 184). | Details of training and awareness programme/s. | &lt;DGH&gt;, &lt;EDGH&gt;, &lt;TCS&gt;, &lt;TCS(A)&gt; |
| 140 | Staff training programmes 4 (HcS 22) W4 | The Local Heart Failure Team should contribute to and participate in relevant staff training and awareness programmes (QRs 182 to 184). | Details of training and awareness programme/s. | &lt;LHFT&gt; |</p>
<table>
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<th>141</th>
<th>Cardiac Rehabilitation Team clinical leadership (HcS 22, 24) W9</th>
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<tr>
<td></td>
<td>The Cardiac Rehabilitation Team should have a Clinical Team Leader with responsibility for: a) Leadership of the Cardiac Rehabilitation Team b) Ensuring Quality Requirements relating to the work of the Cardiac Rehabilitation Team are met. c) Development of cardiac rehabilitation services across the area served by the team. d) Coordination of the cardiac rehabilitation services across the area served by the team. e) Liaison with primary care, acute cardiac services and Local Heart Failure Teams serving the local population in relation to cardiac rehabilitation.</td>
</tr>
<tr>
<td></td>
<td>Names of Team Leader</td>
</tr>
<tr>
<td></td>
<td>1 The Team Leader should be a core member of the Cardiac Rehabilitation Team.</td>
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<tr>
<th>142a</th>
<th>Cardiac Rehabilitation Team membership – cardiologist (HcS 24) W6</th>
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<tr>
<td></td>
<td>A cardiologist or lead physician with an interest in cardiac rehabilitation should be a core member of the Cardiac Rehabilitation Team.</td>
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<tr>
<td></td>
<td>Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work.</td>
</tr>
<tr>
<td></td>
<td>1 The consultant role may be taken by an associate specialist or GP with a special interest, working under the direction of a consultant.</td>
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<tr>
<td></td>
<td>2 Members of the team may spend only part of their time working on cardiac rehabilitation.</td>
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<td></td>
<td>2 Core members of the team should have at least one session per week specified for cardiac rehabilitation.</td>
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<tr>
<td></td>
<td>3 All members of the team should have the competences needed for their role. The Skills for Health National Workforce Competences may be helpful in designing role profiles and developing and reviewing competence.</td>
</tr>
<tr>
<td></td>
<td>4 Members of the team may be employed by different healthcare organisations within the area served.</td>
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<td></td>
<td>5 The team may choose to identify additional members.</td>
</tr>
</tbody>
</table>

Cardiac QRs for distribution September 2009
| 142b | Cardiac Rehabilitation Team membership - administrative support (HcS 24) W8 | A secretary / administrator / team coordinator should be a core member of the Cardiac Rehabilitation Team. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work. 
As QR142a | Cardiac Rehabilitation Team |
| 142c | Cardiac Rehabilitation Team membership - BACR trained instructor (HcS 24) W9 | A BACR trained instructor should be a core member of the Cardiac Rehabilitation Team. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work. 
As QR142a | Cardiac Rehabilitation Team |
| 142d | Cardiac Rehabilitation Team membership - cardiac nursing (HcS 24) W16 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in cardiac nursing. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work. 
As QR142a | Cardiac Rehabilitation Team |
| 142e | Cardiac Rehabilitation Team membership – physiotherapy (HcS 24) W16 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in physiotherapy. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work. 
As QR142a | Cardiac Rehabilitation Team |
| 142f | Cardiac Rehabilitation Team membership - occupational therapy (HcS 24) W12 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in occupational therapy. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work.  
As QR142a | Cardiac Rehabilitation Team |
| 142g | Cardiac Rehabilitation Team membership – dietetics (HcS 24) W12 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in dietetics. | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work.  
As QR142a | Cardiac Rehabilitation Team |
| 142h | Cardiac Rehabilitation Team membership – pharmacy (HcS 24) W12 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in pharmacy | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work.  
As QR142a | Cardiac Rehabilitation Team |
| 142i | Cardiac Rehabilitation Team membership - psychological support (HcS 24) W16 | Core membership of the Cardiac Rehabilitation Team should include staff with skills and competence in psychological support | Names of Cardiac Rehabilitation Team members and details of time allocated for cardiac rehabilitation work.  
As QR142a | Cardiac Rehabilitation Team |
| 143 | Cardiac Rehabilitation Team cover (HcS 24) W6 | The cover arrangements for each member of the Cardiac Rehabilitation Team should be identified. | Details of cover arrangements  
1 These arrangements should ensure that, during periods of leave, the cardiac rehabilitation service available to patients does not change significantly and that the individual’s role within the team is covered. | Cardiac Rehabilitation Team |
| Cardiac Rehabilitation Team referral to support services (HcS 2, 31) W6 | The Cardiac Rehabilitation Team should have agreed arrangements for referral of appropriate patients to:  
a) Smoking cessation services  
b) Specialist dietary advice  
c) Clinical psychology service  
d) Counselling and psychological support | Details of services available  
Name of lead person for each service responsible for linking with the Cardiac Rehabilitation Team  
1 These services should be available to patients in the community and in each hospital to which patients with heart failure may be admitted. Patients may, however, access different services in the community from those available to them while in hospital.  
2 The services should provide both advice and direct patient care.  
3 The team may also refer to other organisations and services. | Cardiac Rehabilitation Team |
|---|---|---|---|
| Patient held record cardiac rehabilitation (HcS 1, 6) W4 | In addition to the patient held record (QR81) and information which is available in primary care (QR8), information should be available covering, at least:  
a) The types of cardiac rehabilitation programme from which patients may choose  
b) Locally available basic life support training  
c) Contact details for members of the Cardiac Rehabilitation Team. | Examples of written information available. | Cardiac Rehabilitation Team |
| Referral to cardiac rehabilitation (HcS 12, 28) W8 | The Cardiac Rehabilitation Team should have agreed guidelines, including referral criteria, for referral for cardiac rehabilitation with:  
a) the Local Health Board on behalf of local general practices (QR7)  
b) the cardiac team in each hospital with which the service is linked (QR164)  
c) the Local Heart Failure Team/s within the local area (QR163) | Agreed referral guidelines  
1 These guidelines should ensure that patients are normally referred to the Cardiac Rehabilitation Team within two working days of diagnosis.  
2 Guidelines should be based on network-agreed guidance. | Cardiac Rehabilitation Team |
| Cardiac rehabilitation during acute hospital stay (HcS 12, 28) W6 | Clinical guidelines should be in use covering the early rehabilitation of patients admitted to hospital with acute coronary syndromes or diagnosed with angina or heart failure during an acute hospital stay. These guidelines should cover at least:  
a) initial assessment of patients  
b) an initial exercise and mobilisation programme. | Clinical guidelines  
1 Guidelines should be based on network-agreed guidance. | Cardiac Rehabilitation Team |
<table>
<thead>
<tr>
<th>QR</th>
<th>Description</th>
<th>Guidelines</th>
<th>Referral Team</th>
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<tr>
<td>148</td>
<td>Cardiac rehabilitation post-discharge consultation clinical guidelines (HcS 6, 12, 28) W6</td>
<td>Clinical guidelines should be in use covering the first consultation after discharge (or the first consultation for patients referred by their GP) and ongoing support from the team. These guidelines should cover: a) The patient and their carer’s understanding of their diagnosis b) Assessment of symptoms c) Risk factors and targets for reduction d) Symptom recognition and management e) Activity advice and goals f) Medication and compliance awareness g) Functional assessment of activities of daily living h) Advice on return to work and leisure activities i) Assessment of patient and carer’s psychological support needs. j) Indications for further investigations (if required)</td>
<td>Clinical guidelines 1 This QR is linked to QR153. 2 Guidelines should be based on network-agreed guidance. Cardiac Rehabilitation Team</td>
</tr>
<tr>
<td>149</td>
<td>Cardiac rehabilitation programme (HcS 7, 12, 28, 31) W6</td>
<td>Clinical guidelines should be in use covering structured programmes of cardiac rehabilitation. These programmes should cover at least: a) Health education b) Supervised exercise sessions c) Home exercise programmes d) Psychological support e) Patient feedback and goal setting</td>
<td>Clinical guidelines 1 This QR is linked to QR150 relating to referral to other services and QR155 relating to ongoing assessment of needs. 2 Guidelines should be based on network-agreed guidance. Cardiac Rehabilitation Team</td>
</tr>
<tr>
<td>150</td>
<td>Cardiac rehabilitation support services referral guidelines (HcS 12, 28, 31) W6</td>
<td>Guidelines should be in use covering referral to other services. These should include, at least: a) Referral for specialist dietary advice b) Referral to smoking cessation services c) Referral to clinical psychology service d) Referral for counselling and psychological support</td>
<td>Referral guidelines agreed with the service to which referrals are made. 1 Referral guidelines for other services may also be available. 2 Guidelines should be based on network-agreed guidance. Cardiac Rehabilitation Team</td>
</tr>
<tr>
<td>151</td>
<td>Cardiac rehabilitation in-patient referral (HcS 28) W9</td>
<td>An operational policy should be in use covering referral of in-patients to their local Cardiac Rehabilitation Team prior to discharge.</td>
<td>Operational policy 1 This QR is not applicable if the same Cardiac Rehabilitation Team serves in-patients and patients in the community. Referral of these patients is covered by QR82. Cardiac Rehabilitation Team</td>
</tr>
</tbody>
</table>
| QR | Cardiac rehabilitation post-discharge consultation timescale (HcS 6, 28) W9 | An operational policy should be in use covering arrangements for contacting patients following discharge or initial GP referral. This policy should ensure that the patient is contacted within 7 days of referral and an appointment made. | Operational policy  
1 Audit of time to first contact is an additional desirable demonstration of compliance. | Cardiac Rehabilitation Team |
| QR | Cardiac rehabilitation post-discharge consultation operational policy (HcS 6, 28) W9 | An operational policy should be in use covering the first consultation after discharge (or the first consultation for patients referred by their GP) and ongoing support from the team. This policy should cover: a) Updating patient hand-held record  b) Giving any additional information that is required (QR145)  
c) Agreement of the structured programme of cardiac rehabilitation (QR149), including involvement of the patient’s partner / carer  
d) Advice on the importance of basic life support training  
e) Giving a contact number for further advice  
f) Arrangements for further visits / contacts. | Operational policy  
1 This QR is linked to QR148. | Cardiac Rehabilitation Team |
| QR | Cardiac rehabilitation assessment tool (HcS 14) W12 | Validated assessment tools should be used by all members of the team covering: a) Quality of life assessment  
b) Exercise assessment  
c) Psychological assessment | Details of tools used  
1 HAD or the Dartmouth Cooperative are examples of validated tools for psychological assessment. | Cardiac Rehabilitation Team |
| 155 | Cardiac rehabilitation assessment arrangements (HcS 6, 14, 28) W12 | An operational policy should be in use covering the ongoing assessment of the needs of patients and carers. This policy should cover:  
   a) Frequency of assessment  
   b) Items to be assessed, including at least:  
      • clinical status,  
      • risk factors and risk stratification,  
      • activity and progress towards goals,  
      • psychological needs,  
      • social / vocational / leisure / occupational support  
      • functional assessment of activities of daily living  
   c) Documentation of assessment  
   d) Updating patient-held record | Operational policy | Cardiac Rehabilitation Team |
| 156 | Cardiac rehabilitation discharge arrangements (HcS 6, 28) W12 | An operational policy should be in use covering discharge from the cardiac rehabilitation programme at the end of the structure programme. This should cover:  
   a) Communication with the patient’s primary care team about:  
      • Current risk factors  
      • Progress in cardiac rehabilitation  
      • Future goals  
   b) Referral to community-based exercise programmes and vocational support  
   c) Information for patients contacting the Cardiac Rehabilitation Team for further advice and support. | Operational policy | Cardiac Rehabilitation Team |
<p>| 157 | Cardiac rehabilitation communication to LHFTs (HcS 6) W6 | Guidelines for communication with the Local Heart Failure Team/s in the local area should have been agreed (QR93). These guidelines should specify the arrangements for communication about changes to the patient’s condition and management plan. | Guidelines agreed with Local Heart Failure Team/s | Cardiac Rehabilitation Team |
| 158 | Cardiac rehabilitation audit participation (HcS 11) W8 | The Cardiac Rehabilitation Team should participate in the National Audit of Cardiac Rehabilitation | Inclusion of team in reports of the National Audit of Cardiac rehabilitation | Cardiac Rehabilitation Team |</p>
<table>
<thead>
<tr>
<th>159</th>
<th>Staff training programmes 5 (HcS 22) W6</th>
<th>The Cardiac Rehabilitation Team should contribute to and participate in relevant staff training and awareness programmes (QRs 182 to 184).</th>
<th>Details of training and awareness programme/s.</th>
<th>Cardiac Rehabilitation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>160</td>
<td>Cardiac rehabilitation - LHB liaison (HcS 11) W4</td>
<td>The Team Leader of the Cardiac Rehabilitation Team (QR141) should meet at least annually with representatives of the Local Health Board and / or local general practices, the cardiac team in local hospital/s and Local Heart Failure Team/s within the local area in order to review: a) Referral guidelines and criteria b) Communication between different aspects of the service for patients.</td>
<td>Evidence of annual meeting 1 The annual meeting may form part of the work of the Local Implementation Group. 2 Where a tertiary cardiac service provides acute hospital services, and / or acts as the LHFT, for its local population then the Cardiac Rehabilitation Team Leader should meet at least annually with representatives of this service.</td>
<td>Cardiac Rehabilitation Team</td>
</tr>
<tr>
<td>161</td>
<td>Cardiac rehabilitation patient feedback and involvement (HcS 1, 2, 15) W4</td>
<td>Operational policies should be in use covering at least: a) Mechanisms for receiving feedback from patients and carers about their rehabilitation programme b) Mechanisms for involving patients and carers in decisions about the organisation of the cardiac rehabilitation service.</td>
<td>Operational policies 1 The mechanisms for user-involvement may be part of LHB/hospital-wide systems of patient involvement but should ensure that issues specific to cardiac rehabilitation are addressed.</td>
<td>Cardiac Rehabilitation Team</td>
</tr>
</tbody>
</table>
| 162 | Configuration - acute hospital services (HcS 2, 6) W16 | The Cardiac Network Board should have agreed the configuration of acute hospital cardiac services within the network. As part of this configuration, each LHB should have agreed:
1. The DGH/EDGH/TCS at which people with a suspected diagnosis of acute coronary syndrome will normally receive their initial treatment.
2. The location of any EDGH/s to which patients will normally be referred.
3. The tertiary cardiac service to which patients with complex needs (other than adults with congenital heart disease) will normally be referred.
4. The tertiary cardiac service providing adult congenital heart disease specialist care to which patients will normally be referred.
5. The location of any hospitals providing immediate treatment only. | Configuration of services for the network, agreed by the Cardiac Network Board and therefore by Chief Executives of organisations within the network.
1. Local Health Boards may link with one or more than one DGH.
2. The patients of some practices may normally be treated at a hospital in another network because of distance and ease of communication.
3. For clinical, geographical or patient choice reasons, individual patients may not always be treated at the identified hospital.
4. Chief Executives of organisations within the network are represented on the Cardiac Network Board.
5. Tertiary services which do not provide specialist care for adults with congenital heart disease should provide an EDGH-level service for this group of patients.
6. Only one tertiary cardiac service in Wales will be designated as providing specialist care for adults with congenital heart disease. | Planning and funding (Cardiac Networks) |
The Cardiac Network Board should have agreed the configuration of Local Heart Failure Teams within the network. Local Heart Failure Teams may be community-based or integrated with hospital cardiac services. The configuration should ensure that:

a) Each acute hospital accepting emergency admissions has an identified Local Heart Failure Team to which patients will normally be referred.
b) Each Local Health Board has agreed the Local Heart Failure Team/s to which people with a suspected diagnosis of heart failure will normally be referred.
c) Each Local Heart Failure Team has agreed the Tertiary Cardiac Service to which patients with more complex needs will normally be referred.

Configuration of Local Heart Failure Teams for the network, agreed by the Cardiac Network Board and therefore by Chief Executives within the network.

1 Local Health Boards may link with one, or more than one, Local Heart Failure Team. The patients of each practice should, however, be linked to only one team. All practices should be linked to one local team.

2 Some practices may normally refer to a Local Heart Failure Team in another network because of distance and ease of communication.

3 For clinical, geographical or patient choice reasons, individual patients may not always be referred to the local team identified.

Planning and funding (Cardiac Networks)

The Cardiac Network Board should have agreed the configuration of Cardiac Rehabilitation Teams within the network. This configuration should ensure that:

a) Each DGH, EDGH and TCS has an identified Cardiac Rehabilitation Team to which patients will normally be referred.
b) Each Local Health Board has agreed the Cardiac Rehabilitation Team/s to which patients will normally be referred.

Configuration of Cardiac Rehabilitation Teams for the network, agreed by the Cardiac Network Board and therefore by Chief Executives within the network.

1 Local Health Boards may link with one or more than one Cardiac Rehabilitation Team. The patients of each practice should, however, be linked to only one team. All practices should be linked to one local team.

2 Some practices may normally refer to a Cardiac Rehabilitation Team in another network because of distance and ease of communication.

3 As QR162 notes 4 and 6.
<table>
<thead>
<tr>
<th></th>
<th>Needs assessment – interventions (HcS 29) W12</th>
<th>The Cardiac Network working with partner organisations and NPHS should have undertaken an assessment of the population’s need for: a) Angiography and revascularisation b) Electrophysiological studies, ICDs, catheter ablation and permanent pacemaker implantation. c) Cardiac resynchronisation therapy (biventricular device therapy)</th>
<th>Needs assessment, agreed by the Cardiac Network Board, undertaken within the last five years. 1 The needs assessment should take account of national and international guidelines on access and effectiveness. 2 The revascularisation needs assessment should include consideration of the need for primary PCI. 3 The needs assessment should identify the needs of each LHB taking account of the age, ethnicity and risk factors of the population served. 4 The needs assessment should take into account all patients covered by the updated NSF.</th>
<th>Planning and funding (Cardiac Networks)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Development plan - TCS access (HcS 2) W16</td>
<td>Health Commission Wales [or successor organisation] should have developed a plan for ensuring: a) access to angiography, PCI and cardiac surgery for appropriate patients (QR73) b) access to ICDs and permanent pacemaker implantation for appropriate patients (QR106) c) access to electrophysiological studies and catheter ablation for appropriate patients (QR107) d) development of a primary PCI service (QR74) e) access to a nominated cardiac pathologist for Wales f) access to clinical genetics services for testing and counselling of families of young adults who have had a cardiac arrest.</td>
<td>Strategic plan 1 This plan should take account of the volume of angiography needed to meet the expected level of revascularisation. 2 This plan should take account of the assessment of need (QR165). 3 The plan should include appropriate transport services (QR20) 4 The nominated cardiac pathologist for Wales should have responsibility for the development of advice and guidance for coroners and pathology services in relation to cardiac / pathology and in therefore linked to QRs 113, 114 and 181.</td>
<td>Planning and funding (HCW)</td>
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<td>Section</td>
<td>Description</td>
<td>Notes</td>
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| 167 | **Staffing, support services and facilities gap analysis (HcS 24)** W12 | The Cardiac Network Board should have:  
- a) compared the staffing, support services and facilities of each DGH, Local Heart Failure Team, EDGH, Tertiary Cardiac Service and Cardiac Rehabilitation Team within its area with the levels expected in QRs 24 to 70 and 141 to 144.  
- b) compared the services with the levels recommended by the British Cardiovascular Society.  
Review of staffing of network cardiac services, agreed by the Cardiac Network Board.  
1. **The staffing review should specifically consider whether staff are seeing sufficient patients or undertaking sufficient procedures to maintain competence in the roles they are fulfilling.**  
2. For tertiary cardiac services, this review should cover all aspects of the service provided, including THFTs and, where applicable, the Adult Congenital Heart Disease Service.  
3. This analysis should include the needs of patients referred back from tertiary services. |
| 168 | **Development plan - DGH / LHFT / EDGH / CRT services (HcS 2)** W12 | Each Local Health Board within the network should have a development plan to address the staffing, support services and facilities needed to achieve the network’s strategic plan for the main DGHs, Local Heart Failure Teams, EDGHS and Cardiac Rehabilitation Teams to which its patients are referred (QR162, 163 and 164).  
Development plan for each DGH, LHFT and EDGH.  
11. **LHB plans may be combined when they relate to a single DGH / LHFT / EDGH/CRT.**  
2. LHB plans should be consistent with the Cardiac Network strategic plan.  
3. LHB plans should include services to meet the needs of patients referred back from tertiary cardiac services |
| 169 | **Development plan - TCS services (HcS 2)** W15 | Health Commission Wales [or successor organisation] should have a development plan to address agreed shortfalls in the staffing, support services and facilities needed to achieve the network’s strategic plan for tertiary cardiac services to which Welsh patients are referred (QR162).  
Development plan  
1. **This plan should include tertiary cardiac services for Wales residents from English service providers.**  
2. Tertiary heart failure teams and tertiary cardiac services for adults with congenital heart disease are included within this QR. |

Cardiac QRs for distribution September 2009
| QR | Development plan - ambulance services (HcS 2) W15 | Health Commission Wales [or successor organisation] should have a development plan to ensure that the Wales Ambulance Services Trust is able to meet QRs 15 to 21. | Development plan
1 This plan should take account of the network strategic plan, network-agreed configuration of services, clinical guidelines and planned levels of angiography and revascularisation. A 'gap' analysis should be undertaken as part of preparing this plan. | Planning and funding (HCW) |
| QR | Development plan - familial hypercholesterolaemia (HcS 2) W4 | Local Health Boards should have:
a) An agreed development plan for services for patients with familial hypercholesterolaemia and other dyslipidaemias, including “cascade testing” in families and entry of information into an All Wales register.
b) Arrangements for implementation of the agreed development plan, including arrangements for monitoring progress with implementation. | Development plan and implementation arrangements.
1 This QR may be met through collaboration with other LHBs.
2 LHB plans should be consistent with the network strategic plan. | Planning and funding (LHB) |
| QR | Network strategic development plan (HcS 2, 30) W20 | The Cardiac Network Board should have agreed a strategic development plan for the network’s services for the prevention and treatment of cardiac disease. This plan should take account of:
a) The development of current services (QR167 to 172)
b) Progress with achieving key indicators (QR178)
c) The assessment of the population’s need for cardiac interventions (QR165)
d) Financial planning and resource mapping. | Network strategic development plan for the prevention and treatment of cardiac disease, agreed by the Cardiac Network Board
1 The network strategic development plan should have been agreed within the last three years. | Planning and funding (Cardiac Networks) |
1 The workforce development advice should be based on the network strategic development plan (QR173) and the development plans of constituent LHBs and HCW [or successor organisations] (QR166 to 172).  
2 Workforce development should utilise the Skills for Health CHD and Arrhythmia National Workforce Competences.  
3 The need for public health support should be included in the network’s advice. | Planning and funding (Cardiac Networks) |
| 175 | Network service improvement (HcS 24, 28) W15 | The Cardiac Network Board should liaise with the National Leadership and Innovation Agency for Healthcare on the service improvement activity needed to support implementation of its strategic development plan. Evidence of liaison with National Leadership and Innovation Agency for Healthcare. | Planning and funding (Cardiac Networks) |
| 176 | Network IT development (HcS 25) W12 | The Cardiac Network Board should liaise with Informing HealthCare on the electronic communication on the information systems needed to support implementation of its strategic development plan. Evidence of liaison with Informing HealthCare. | Planning and funding (Cardiac Networks) |
| 177 | Network audits (HcS 11, 28) W8 | The Cardiac Network Board should have: a) Agreed any network-wide audits that should be undertaken across the network (in addition to the CCAD audit programmes). b) Receive reports on completed network audits and agree any action necessary as a result. Network audit programme Examples of completed network-wide audit reports and action plans  
1 The Network Board may decide that no additional audits are required. | Planning and funding (Cardiac Networks) |
| 178 | Network key indicators monitoring report (HcS 3, 28) W12 | At least every two years, the Cardiac Network Board should receive a report on progress with key indicators of the prevention and treatment of cardiac disease. Progress report to the Cardiac Network Board | Planning and funding (Cardiac Networks) |
| 179 | Network-agreed clinical and referral guidance (HcS 12, 28) W15 | The Cardiac Network Board should have agreed and distributed clinical and referral guidance to constituent organisations as expected by these Quality Requirements. | Network-agreed guidance  
1 Guidance should be based on national guidance and evidence of effectiveness as indicated in the NSF.  
2 The following network-agreed guidance is expected:  
a) Guidance for primary care services (QRs 6, 7, 9 to 13)  
b) Guidance for ambulance services (QRs 16 to 20)  
c) Guidance for acute hospitals providing immediate treatment only (QRs 22 and 23)  
d) Guidance for community-based local heart failure teams, district general hospitals, enhanced district general hospitals and tertiary cardiac services (QRs 72, 73, 75, 78 to 80, 82 to 84, 87, 91, 93, 94, 97, 101, 103 to 107, 109, 110, 118, 122, 123 and 127)  
e) Guidance for Cardiac Rehabilitation Teams (QRs 146 to 150). | Planning and funding (Cardiac Networks) |
| 180 | Information for genetics services about arrhythmia services (HcS 2, 6) W2 | The Cardiac Network should have distributed information to clinical genetics services used for its residents covering:  
a) The configuration of arrhythmia services within the network  
b) Names and contact details of heart rhythm specialists to whom family members found to be at risk of sudden cardiac death should be referred. | Information sent to clinical genetics service/s  
1 This QR is linked to QR166 | Planning and funding (Cardiac Networks) |
| 181 | Information for coroners (HcS 6) W2 | The Cardiac Network should have distributed information to local coroners for families of young adults with sudden cardiac death covering:  
a) Causes of sudden cardiac death  
b) Implications for family members.  
c) Preservation of tissue or the whole heart  
d) Genetic testing and how to access it  
e) DNA storage  
f) Support groups | Information sent to local coroners. | Planning and funding (Cardiac Networks) |
| 182 | Staff training programmes 6 (HcS 20, 22) W9 | The Cardiac Network and its constituent Local Health Boards, ambulance services and the National Public Health Service should ensure a programme of training and awareness is run for local general practices covering  
a) Care of patients at high risk of CVD or with established CHD  
b) Clinical guidelines for the diagnosis and management of angina.  
c) Clinical guidelines for the diagnosis and management of arrhythmias.  
d) ECG interpretation  
e) Initial management of acute coronary syndromes  
f) Diagnosis, management and monitoring of patients with heart failure  
g) Monitoring and follow up of patients following discharge  
h) Advice and support to families following a cardiac arrest in a relative aged 40 years or less.  
i) Cardiac rehabilitation  
j) Resuscitation training | Details of training and awareness programme/s  
1 Training and awareness programmes will differ in their frequency, approach and method of delivery in order to reflect local circumstances  
2 Training and awareness programmes should be based on network-agreed guidance and, where possible, locally agreed clinical and referral guidelines.  
3 All resuscitation training should be compliant with European Resuscitation Council guidelines. | Planning and funding (Cardiac Networks) |
|---|---|---|---|---|
| 183 | Staff training programmes 7 (HcS 6, 22) W9 | The Cardiac Network and its constituent LHFT/s and hospital-based cardiac services should ensure a programme of training and awareness is run for staff involved in the management of patients admitted as emergencies covering:  
a) Acute hospital heart failure guidelines  
b) Clinical guidelines for the assessment and initial management of patients with acute coronary syndromes  
c) Clinical guidelines for the assessment and initial management of patients with arrhythmias, including those patients already fitted with an ICD.  
d) Clinical guidelines for the investigation and management of patients with transient loss of consciousness.  
e) Advice and support to families following a cardiac arrest in a relative aged less than 40 years | Details of training and awareness programme  
1 Training and awareness programmes will differ in their frequency, approach and method of delivery in order to reflect local circumstances  
2 Training and awareness programmes should be based on network-agreed guidance and, where possible, locally agreed clinical and referral guidelines.  
3 All resuscitation training should be compliant with European Resuscitation Council guidelines | Planning and funding (Cardiac Networks) |
<table>
<thead>
<tr>
<th>184</th>
<th>Staff training programmes 8 (HcS 22) W9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Cardiac Network and its constituent hospital-based cardiac services should ensure a programme of training and awareness is run for: a) Staff involved in the management of cardiac disease in its DGHs and EDGHs. b) Local Heart Failure Teams c) Cardiac Rehabilitation Teams</td>
</tr>
<tr>
<td></td>
<td>Details of training and awareness programme delivery in order to reflect local circumstances 2 Training and awareness programmes should be based on network-agreed guidance and, where possible, locally agreed clinical and referral guidelines, and should cover the care of all patients with cardiac disease. 3 All resuscitation training should be compliant with European Resuscitation Council guidelines.</td>
</tr>
<tr>
<td></td>
<td>Planning and funding (Cardiac Networks)</td>
</tr>
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</table>
Appendix 1: Definitions and Abbreviations

Definitions:

The following definitions are used throughout the Quality Requirements:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Normal working hours</td>
<td>9am to 5pm, Monday to Friday excluding bank and public holidays.</td>
</tr>
<tr>
<td>Consultant cardiologist</td>
<td>A consultant cardiologist is someone on the GMC’s specialist register with a CCT or CCST in cardiovascular medicine or cardiology, who is employed as a consultant, spends the majority of their direct clinical care programmed activities caring for patients with heart disease and who undertakes regular CPD or relevance to the care of patients with heart disease.</td>
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<tr>
<td>Heart rhythm specialist</td>
<td>A heart Rhythm specialist in a EDGH should be a consultant with sub-speciality training, or an interest in, arrhythmia management.</td>
</tr>
<tr>
<td>Electrophysiologist</td>
<td>A consultant cardiologist with recognised sub-speciality training in electrophysiology.</td>
</tr>
<tr>
<td>Agreed guidelines</td>
<td>Throughout the Quality Requirements “should have agreed guidelines” means that the guidelines are agreed within the cardiac team – not that they are agreed between teams (except where this is specified)</td>
</tr>
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</table>

Abbreviations:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>Ace inhibitors</td>
<td>Angiotensin Converting Enzyme Inhibitors</td>
</tr>
<tr>
<td>AED</td>
<td>Automatic External Defibrillator</td>
</tr>
<tr>
<td>AWSCS</td>
<td>All Wales Smoking Cessation Service</td>
</tr>
<tr>
<td>BACR</td>
<td>British Association for Cardiac Rehabilitation</td>
</tr>
<tr>
<td>BCIS</td>
<td>British Cardiovascular Intervention Society</td>
</tr>
<tr>
<td>BNP</td>
<td>Brain natriuretic Peptide</td>
</tr>
<tr>
<td>BSE</td>
<td>British Society of Echocardiography</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>CABG</td>
<td>Coronary Artery Bypass Grafting</td>
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<tr>
<td>CCAD</td>
<td>Central Cardiac Audit Database</td>
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<tr>
<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
</tr>
<tr>
<td>CCT</td>
<td>Certificate of Completion of Training</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous Positive Airways Pressure</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>DC</td>
<td>Direct Current</td>
</tr>
<tr>
<td>DGH</td>
<td>District General Hospital</td>
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<tr>
<td>DNA</td>
<td>Deoxyribonucleic Acid</td>
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<tr>
<td>EASR</td>
<td>European Age Standardised Rate</td>
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<tr>
<td>ECG</td>
<td>Electro Cardiograph/Cardiogram</td>
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<tr>
<td>EDGH</td>
<td>Enhanced District General Hospital</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Commission Wales</td>
</tr>
<tr>
<td>ICD</td>
<td>Implantable Cardioverter Defibrillator</td>
</tr>
<tr>
<td>ITO</td>
<td>Immediate Treatment Only</td>
</tr>
<tr>
<td>JRCALC</td>
<td>Joint Royal Colleges Ambulance Liaison Committee</td>
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<tr>
<td>LHB</td>
<td>Local Health Board</td>
</tr>
<tr>
<td>LHFT</td>
<td>Local Heart Failure Team</td>
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<tr>
<td>LV</td>
<td>Left Ventricular</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial Infarction</td>
</tr>
<tr>
<td>MINAP</td>
<td>Myocardial Ischaemia National Audit Project</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<tr>
<td>NTProBNP</td>
<td>N-terminal pro BNP</td>
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<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PCI</td>
<td>Percutaneous Coronary Intervention</td>
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<tr>
<td>PET</td>
<td>Positron Emission Tomography</td>
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<tr>
<td>PEDW</td>
<td>Patient Episode Database for Wales</td>
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<tr>
<td>QOF</td>
<td>Quality Outcomes Framework</td>
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<tr>
<td>QR</td>
<td>Quality Requirement</td>
</tr>
<tr>
<td>SAFF</td>
<td>Services and Financial Framework</td>
</tr>
<tr>
<td>TC</td>
<td>Tertiary care</td>
</tr>
<tr>
<td>TCS</td>
<td>Tertiary Cardiac Services</td>
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<tr>
<td>THFT</td>
<td>Tertiary Heart Failure Team</td>
</tr>
<tr>
<td>WAG NHS HR</td>
<td>Welsh Assembly Government NHS Human Resources</td>
</tr>
</tbody>
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