FOCUS ON HEART FAILURE SERVICES

Networks Merge
Welcome to the South Wales Cardiac Network Heart Failure Newsletter. This Newsletter has been produced following the merger between the Mid and South West Wales Cardiac Network and the South East Wales Cardiac Network. This new single network for South Wales has enabled joint working between the two heart failure specialist nurse leads, who are currently combining their previous work programs into future joint plans. We hope to give an overview of heart failure services as they exist throughout South Wales and highlight inequities of service and the good work that is taking place, by the people who are doing it.

The two Network lead heart failure nurses Helen Llewellyn-Griffiths (Hywel Dda Health Board) and Trudi Phillips (Cwm Taf Health Board) have brought together information which should be useful. Both leads have been heavily involved with the work of the two regional Network Heart Failure sub-groups. These multi-disciplinary groups meet regularly and have provided a forum for sharing expertise, developing guidelines, advising on appropriate management and participating in baseline reviews of palliative care and heart failure services.

The Cardiac Networks have been instrumental in promoting the work within heart failure services. They were jointly responsible with the British Heart Foundation for setting up nine heart failure nurse posts over the last few years. Both Networks have undertaken baseline reviews of services in their areas based on the Cardiac Disease NSF Quality Requirements. Recommendations have been produced for Local Health Boards to action. Issues common to all such as insufficient MRI access, inaccurate coding for heart failure, the future recruitment and retention of cardiac physiology students, general lack of cardiac rehabilitation, especially exercise and standardisation of patient information has been highlighted.

Palliative Care Services
In addition palliative care for heart failure patients has been problematic, but recent developments in this field are encouraging. Links to primary care have been established in many areas and more work is needed.

BNP Testing
The 2010 NICE guidelines (http://guidance.nice.org.uk/CG108) strongly recommended the role of BNP testing as a key to diagnosis. However the provision for BNP testing remains patchy throughout the region. Many of these issues are discussed in more detail within the newsletter.

Although heart failure services have been growing steadily over the last 10 years there are still parts of South Wales that do not have heart failure teams/specialist nurses especially in more rural areas. With the burden that heart failure places on an ever demanding health system and hospital beds, the role that specialist nurses and heart failure teams play in keeping patients at home is proven to be vital. The Cardiac Networks have played a key role in the past and will continue to do so with their new remit in a reorganized NHS. The current financial squeeze makes communication very important and we hope this newsletter will be helpful to all who read it.

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The Welsh Regional Primary Care Cardiovascular Society will take place on Wednesday 18th May 2011 at the Village Hotel, Swansea. This all day meeting will cover a broad range of primary care cardiology issues; there is no charge for delegates. The content of the meeting is designed for general practitioners, nurses and practice managers. Other healthcare professionals are welcome. Early registration is recommended.
For further details please contact PCCS:
020 8994 8775;  office@pccs.org.uk;  www.pccs.org.uk
Jackie Austin, Consultant Nurse for Heart Failure Services and Cardiac Rehabilitation in North Gwent was appointed in 2005 to meet the heart failure population needs. The Local Heart Failure service operating across the boroughs of Blaenau Gwent and North Monmouthshire has been in existence since 2001, originally funded through the Inequalities in Health Fund. It is a multidisciplinary service led by two nurse specialists with close cardiologist liaison, using the principles of chronic disease management (cross boundary working) and incorporating rehabilitation.

Caerphilly
The Caerphilly service comprises two cardiologist led one-stop diagnostic clinics per month. Nursing support has been primarily community based.

Torfaen
Torfaen Heart Failure Nurse post was funded in 2003 from Wanless money. This was a full time permanent post to set up a heart failure care pathway locally where previously no service existed. This has developed and grown providing two nurse led clinics per week, two one stop echo clinics per month, home visits and telephone support. A telemonitoring project is currently expanding from 10 to 16 units. Recruitment of a second nurse to support heart failure services, for two days per week has recently been successful.

Newport
Following the employment of a part-time specialist Heart Failure nurse for Newport a service will be provided which will work towards replicating the model of care currently provided within the north of the LHB and Torfaen.

Current team members for Aneurin Bevan HB
Cardiologists
(Caerphilly Miners Hospital) Dr Philip Campbell
(Royal Gwent Hospital) Dr Nigel Brown
(Nevill Hall Hospital) Dr Shahid Ikram
Dr Chris Madler
Dr Tony Davies
Dr Steve Hutchison
Support Physician Dr Javed (Associate Specialist)
Consultant Nurse Dr Jackie Austin
Specialist Nurses Lynda Davies (Torfaen)
Karen Davey (Newport)
Jane Brooks (Blaenau Gwent)
Denise Hockey (North Monmouthshire)
Dawn Parry, Caerphilly
Clerical support Cheryl Saunders
Hayley Rees
Cathryn Burchell

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The Welsh Heart Failure Forum (WHFF) was established in December 2006 by clinicians with an interest in Heart Failure. The inaugural meeting was held at the Metropole Hotel, Llandrindod Wells chaired by Dr Zaheer Yousef (Consultant Cardiologist and Heart Failure Device Specialist at Cardiff and Vale UHB and Honorary Secretary WHFF). The delegates (consisting mainly of Specialist Heart Failure Nurses, Consultant Cardiologists and Trainees in Cardiology) were given a series of presentations by invited speakers followed by discussion. Subsequently bi-annual meetings of the Forum have been held around Wales with the support of local cardiologists and with generous educational grants with in excess of 30 delegates attending.

Meetings
The successful format of the inaugural meeting has remained largely unchanged. Each meeting focuses on different key areas of heart failure management. The guest speakers have included notable national and international specialists. The meetings have provided an excellent opportunity to share experiences, discuss cases, develop services and network. It is hoped that with the continued support of heart failure clinicians the WHFF will go from strength to strength.

2011 Welsh Heart Failure Forum
The 7th Welsh Heart Failure Forum to be held in 2011 is being organised.
Contact: Dr Zaheer Yousef, Cardiff & Vale UHB:
029 2074 2972; Zaheer.Yousef@wales.nhs.uk

The All Wales Heart Failure Nurses Group was formed in 2002. Many heart failure specialist nurses were working in isolation and it was felt that a national group would ensure sharing of good practice and help establish guidelines through networking. By 2010 the initial group had grown to over 25 specialist nurses and other multidisciplinary team members. The group meets several times a year and the current chair is Trudi Phillips and Secretary is Joanne Davies.

From 2011 the group will be organising an annual conference in addition to two meetings which will be held regionally in North and South Wales. If you have an interest in heart failure and are keen to become a member of the group or would like further information please contact:
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Joanne Davies, Cardiff & Vale UHB:
029 2071 5080; Joanne.Davies@wales.nhs.uk
Cardiff and Vale UHB Tertiary Heart Function Service

The heart function service at the University Hospital of Wales has undergone a restructuring process over the last 5 years. These developments are ongoing as we strive to offer a first class tertiary heart function service to patients in South East Wales (and beyond) and a local heart failure service to patients in our catchment areas.

Friday Morning Clinic
The Friday morning clinic serves as the central hub of the tertiary service from where patients (after consultant review) are channelled to the appropriate multi-disciplinary team member(s) for additional specialist input. We request consultant referrals to the service and ask for local investigations (e.g. coronary angiography and echo) to be transferred to our servers electronically at the time of referral.

Aims of the Service
We aim to offer:
- A diagnostic service with the help of additional investigations (e.g. advanced imaging, cardio-pulmonary exercise testing, cardiac biopsy, right and left heart studies, cardio-genetic pedigree analyses etc)
- Assimilation of patients into specialist units and support groups
- Transplant/high-risk cardiac surgical assessments
- A cardiac resynchronisation/ICD service

Where possible, patients are enrolled into clinical studies. In each case we are keen to discharge patients back to their local centres as soon as possible. In the case of device patients, our protocol involves 12-month post-implant clinical follow-up to optimise responses to resynchronisation therapy.

Cardiff and Vale UHB Heart Failure Service

The Heart Failure service has developed since 2002, initially with Dr Victor Sim, Consultant Physician and the Day ward staff at Llandough Hospital followed by the appointment of Linda Edmunds as Consultant Nurse in 2002. Dr Zaheer Yousef took up the lead for this service in 2003. The team expanded in 2006 through a BHF funded heart failure nurse post and a second BHF funded nurse in 2008.

The service provides a diagnostic clinic; follow up clinics as well as tertiary services. Funding for one nurse has now been taken over by the Health Board and the second BHF nurse post is due for review in 2011. The specialist nurses provide both a primary and secondary care service offering home visits as required. Support and education is provided to primary care staff so that they are able to manage their patients appropriately. The team works closely with the BHF funded specialist nurse for cardiogenetics particularly regarding inherited cardiovascular conditions.

Current Team members for Cardiff & Vale UHB Cardiologist/Consultant Dr Zaheer Yousef in Heart Failure

Consultant Physician  
Dr Victor Sim

Consultant Nurse  
Linda Edmunds

Specialist Nurses  
Joanne Davies  
Hayley Rose

Cardiogenetics  
Sarah Finch

Day centre staff  
Sue Ozwaladi  
Bun Little

Clerical support  
Julie McHugh

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Cwm Taf Health Board

Prince Charles Hospital
The heart failure service commenced in 2001 with the appointment of one Heart Failure Specialist Nurse. The service has expanded to include a second specialist nurse and 18.5 hours clerical support. Cardiology services generally in north Cwm Taf have been under resourced, however the recent appointment of two cardiology consultants has improved access to specialist advice and interventions.

Patients referred to the specialist nurses are contacted within seven days of referral. The specialist nurses offer a bespoke service to promote quality of life and management throughout all the stages of the disease.

The service offers home visits and clinic appointments to provide timely and responsive care. Data from the service is used to contribute to the Central Cardiac Audit Database.

Current Team members for Prince Charles Hospital
Cardiologists
Dr Justin Taylor (HF Lead)
Dr Margaret Egan
Support physicians
Dr B Ed Griffiths
Dr K Giebally
Specialist nurses
Betty Davies (HF lead)
Sian Thomas

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01685 728646; Betty.Davies@wales.nhs.uk;

Royal Glamorgan Hospital
The heart failure service commenced in 2001 with the appointment of three Specialist Nurses funded through the Welsh Assembly Government’s Inequalities in Health Fund. They were an addition to the heart failure clinic which ran weekly, staffed by a cardiology registrar and overseen by a cardiologist.

The Specialist Nurses provide both a primary and secondary care service offering home visits to all and seeing patients wherever they are in order to offer a seamless service. The funding continued for 6 years until the Trust took over when the Inequalities Inequalities in Health Fund was withdrawn.

Current Team members for Royal Glamorgan Hospital
Cardiologists
Dr Gethin Ellis
Dr Robert Bleasdale
Dr Claire Williams
Specialist nurses
Val Buller
Trudi Phillips
Lorraine Leahy
Clinical Assistant
Dr Owain Thomas
Clerical support
Julia Patrick

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Ceredigion Heart Failure Service
Following a successful bid from the British Heart Foundation (BHF) Ceredigion appointed a Heart Failure Nurse in 2008. The Nurse was employed to develop a heart failure service across Ceredigion and to work in partnership with the Cardiologist to establish a service providing post discharge follow up for all patients with heart failure irrespective of etiology of the syndrome in the first instance.

Heart Failure Service
A bilingual service was designed to provide a seamless journey for the patient between primary and secondary care ensuring evidence based therapy for all. The service provides follow up clinics in five sites across Ceredigion and serves a population of approximately 78,000. Home visits are offered only when absolutely essential as it is often those housebound patients who are at most risk of re-hospitalization. The service also offers support to the patient and family through the terminal phase of this palliative disease.

The service has recently been awarded funding from the BHF to develop a Cardiac Health Care Assistant role over the next two years. The role will expand the service by providing pre-hospital discharge contact with the patient and establishing a teaching programme for those without a previous hospitalization for heart failure. This new role will be evaluated as part of a National BHF project.

Current Team members for Ceredigion
Cardiologist
Dr Donogh Mckeogh
BHF HF Specialist Nurse
Gwenllian Parry
BHF Cardiac Health Care Assistant
Sharon Williams
Administrative Support
Glenys Evans

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Gwenllian.Parry@wales.nhs.uk
In an ever increasing cost conscious health environment the BHF Cymru continues to be positive in its contribution to preventing and reducing heart disease. This will be especially so in our 50th anniversary this year.

**Mending broken hearts**

Look out for one of our latest national campaigns, “Mending Broken Hearts” aimed at raising £50m for research into regenerative medicine.

**BHF Funding**

More locally BHF funding has continued to support the South Wales Cardiac Network through its Healthcare Professional programme, Hearty Lives projects, community development and targeted resources. This means that there has been a progressive increase in BHF funding to the people of Wales which compares favourably to the rest of the UK.

**Support for Healthcare Professionals**

Our support for Healthcare professionals (HCP) continues to grow. We fully fund approx 12 HCPs in South and Mid Wales with a generous support package including education and training assistance, conference programme and many networking opportunities. We also help many other BHF “Supported” HCPs (including Heart Failure nurses, Arrhythmia nurses, Paediatric nurses, Genetics nurses (as well as other professions including dieticians, cardiac physiology trainers and psychologists) who enjoy similar benefits to a BHF fully funded HCP but without assistance for salaries. We currently assist an additional 19 supported HCPs in South and Mid Wales and this number is expected to increase.

Through our support of HCPs we aim to add quality to Cardiovascular Disease (CVD) services by promoting and sustaining new and effective clinical services. One example of this is the newly funded Health Care Assistant post we are supporting in Ceredigion. We are also working to fund nurses developing I.V. diuretics services. These innovations are achieved by multidisciplinary working with our partners in healthcare, including the Welsh Cardiac Networks. It certainly seems that partnership working is very strong in Wales.

**Specific Projects**

Specific projects involving our HCPs include support for the Wales Familial Hypercholesterolemia (FH) cascade screening programme which includes 3 BHF FH nurses. This nationwide project jointly funded by the Welsh Assembly Government is the first national FH screening programme in the UK and aims to identify, assess and treat up to 6000 patients in Wales. Other BHF projects include our national multi million pound Hearty Lives project which involves targeting specific areas noted for their high rates of CVD. We are pleased to support a comprehensive weight management programme in Torfaen focusing on obesity and our Smokefree Blaenau Gwent programme.

**BHF Resources**

We are improving our BHF resources including a number available in Welsh as well as our continuing support for schools and schemes including Heart Start. We have increased our support for local events including the National Eisteddfod. We will be in Wrexham in 2011. Of course we can only continue to these roles if the public continue to contribute to the BHF. I am pleased to say the people in Wales are very generous whether it’s by participating at some of our Wales Events including the North and South Wales Bike Rides, and the Cardiff Santa Jogs, as well as volunteering in local fundraising branches or our main campaigns such as National Heart Month, or at one of our local shops. Though there appear many challenges in the future, the role of Wales within the BHF is most important, which we hope will continue to flourish with the newly reorganised health services.

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**Palliative Care Peer Learning for Heart Failure Patients**

2011 sees the beginning of an exciting new project for peer learning in the palliative care of heart failure patients. The aim is to encourage joint working between Heart Failure, and Palliative Care Specialists to understand the difficulties in managing heart failure patients in the palliative care stage of their condition.

This has been initiated and supported by the Cardiac Networks Coordinating Group and involves heart failure and palliative care teams working together in group settings over a period of 6 months looking at all aspects of palliative care in heart failure. The project is being piloted in North Wales (Wrexham) and South Wales (Cwm Taf) and will be rolled out to all areas of Wales. Accreditation is being applied for and it should prove to be a valuable template for a learning method for palliative care in all life limiting conditions.

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Our Heart Failure Service objectives are to provide an individualised and supportive service for heart failure patients and their carers. We promote the pharmacological and non-pharmacological management of heart failure to minimise symptoms, prevent hospital admissions, and improve quality of life whilst adhering to evidence based practice and empirical guidelines.

Education
Patients are provided with education regarding the comprehensive management of their condition which aims for patient self care and autonomy. We also educate the primary and secondary care health and social care community in the management of heart failure.

Heart Failure Clinics
Historically the heart failure service consisted of nurse led clinics and a nurse led home-based service. We have recently commenced a consultant cardiologist Heart Failure Clinic. Patients are referred to the service by the general practitioner through the local “Open Access Referral” system. Once the diagnosis and aetiology is confirmed by the cardiologist the patient is referred to the heart failure nurses for optimising the pharmacological and non-pharmacological measures. Alternatively patients may be referred directly by primary care services to the heart failure nurses if the patient’s needs are more complex. Patients are also referred following a hospital admission. These patients are seen at home within two weeks of hospital discharge.

Patients are seen by the heart failure nurses as inpatients, in out-patient clinics or in their own homes, depending on the severity of their symptoms and their individual circumstances. The frequency of consultations responds to the patients needs. In addition we encourage patients to telephone the nurses for further support. Patients who have previously been discharged from formal appointments may self refer to the heart failure nurse.

Liaison is promoted within the multidisciplinary team as heart failure patients may have co-morbidities including palliative care needs.

Current Team Members for Neath Port Talbot and Bridgend
Cardiologist
Dr Andrew Owen

BHF Specialist Nurses
Moira Ashton (Bridgend)
Kathryn Roberts (Neath Port Talbot)

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The Nurse led Heart Failure Service was a joint initiative between Carmarthen Local Health Board and Carmarthenshire NHS Trust.

Three heart failure specialist nurses were appointed in 2006 following a health needs review which identified inadequacy and inequality in the deliverance of structured, evidence based heart failure care. As part of their modernisation strategy, the NHS Trust and Local Health Board [LHB] were developing innovative plans to address the increasing burden of chronic disease.

The heart failure team is part of the chronic disease service, consisting of:
- One co-ordinator
- Three diabetic specialist nurses
- Two chronic obstructive pulmonary disease specialist nurses [COPD]
- One COPD physiotherapist
- Two administrators

The heart failure service was designed to provide a seamless journey for the patient between primary and secondary care ensuring evidence based therapy for all and catering for the needs of patients and their relatives/carers from diagnosis through to palliative care and death.

Service provision includes:
- One-stop diagnostic clinics supported by the Cardiologists
- Inpatient reviews
- Follow-up and drug titration clinics delivered in hospital and community locations in Llanelli, Crosshands, Glanamman, Llandovery, Carmarthen, Whitland and Newcastle Emlyn, thereby providing patients with a choice of location and easy access. House bound and hard to reach individuals are visited at home, including residential and nursing homes.

Current Team Members for Carmarthen
Cardiologists
Dr Eiry Edmunds
Dr Adrian Raybould
Dr Pavel Stepanek
Dr Philip Avery
Dr Lena Izzat
Dr Louise Meredith

(Best Wales General Hospital)

(Prince Philip Hospital)

BHF Specialist Nurses
Helen Llewellyn-Griffiths (Carmarthen)
Wendy Churchouse
Alison Downing (Llanelli)
Rhoswen Davies (Amman&Gwendraeth)

Administrative Support
Sarah Tomlinson

Contact: Helen Llewellyn-Griffiths, Hywel Dda HB 01267 224212; 07980 727974; Helen.Llewellyn-Griffiths@wales.nhs.uk
B-type Natriuretic Peptide testing - has the penny finally dropped?

The overwhelming evidence supporting the use of this extensively researched peptide as a means of excluding heart failure (often avoiding the need for an echocardiogram) has led to the inclusion of this simple biochemical test into national and international guidelines relating to the diagnosis of heart failure. Cardiac Network recommendations published in 2007 have been followed more recently by NICE Guidance with accompanying cost benefit data (a concern raised by some in the past) and partly through pressure exerted by the Cardiac Networks and more joined up thinking within the reconfigured health boards is leading to a gradual introduction of B-type Natriuretic Peptide testing availability in Wales.

The ‘positive’ experience of using B-type Natriuretic Peptide testing had been exemplified by practical projects across Wales supported by the Cardiac Networks; in North West Wales led by Dr Graham Thomas and in South Wales by Dr Jonathan Goodfellow. A key report by a group chaired by Dr Armon Daniels and Dr Zaheer Yousef helped sustain the momentum to roll-out the introduction of B-type Natriuretic testing to routine heart failure management.

At Cwm Taf, a pilot study undertaken in 2004 involving the local Heart Failure team and the biochemistry department supported by the Pontypidd and Rhondda LHB had shown the usefulness of the assay. In October 2010, B-type Natriuretic Peptide testing was finally made available to primary care as a ‘rule out’ test in the heart failure pathway. The introduction of this service was long overdue but is viewed as an excellent example of the benefit of joined up primary care and secondary care working within a reconfigured Health Board. It highlights collaborative working between primary care, biochemists and cardiologists supported by managers that have grasped the potential clinical and cost benefits of the assay. The early experience of rolling out B-type Natriuretic peptide testing at Cwm Taf using a carefully constructed request proforma has dispelled the fears that the demand for the test would overwhelm heart failure services.

Further pressure on all Health Boards to introduce B-type Natriuretic Peptide testing follows the recent recommendation by the ‘Heart Failure Workstream’ (a group put together within the context of the WHSCC-led Cardiac Services Review) that this issue should be ‘fast-tracked’. It is hoped that this will direct WHSCC to oversee its long-awaited implementation across Wales.

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Intelligent Targets 1000 Lives Plus Programme Chronic Heart Failure

Chronic Heart Failure presents significant challenges to individuals, their families, and the health care system. With an ageing population the incidence and prevalence of heart failure continues to rise, the average age of first diagnosis being 76 years.

It is estimated that each General Practitioner will have 30 patients with a diagnosis of heart failure on their clinical registers with the potential of 10 new cases being diagnosed each year.

Hospital admissions are expected to increase by 50% over the next 25 years and re-admissions within 30 days for these patients are common experience.

Programme Goals
Initially introduced as Intelligent Targets, the overarching goals for the Chronic Heart Failure Programme are:

- To reduce re-admissions for patients with established CHF
- To reduce mortality rates through provision of evidenced based care
- To evaluate patient satisfaction with services delivered

A diagnosis of heart failure requires patients to make significant life-style changes and to actively participate in their disease management process. Likewise care providers are required to implement the evidenced based care for these patients and to reliably implement and sustain the improvements and continually evaluate the service through assessment.

Guide for Improving Care for Chronic Heart Failure Patients
The Guide for Improving Care for Chronic Heart Failure Patients provides the drivers and interventions for appropriate diagnosis and subsequent treatment which can be found at www.1000livesplus.wales.nhs.uk. Examples of practical solutions that have been developed across Wales have been inserted as resources within the guide.

The purpose is to optimize the outcome for this patient group across Wales by applying the evidence based care using the Model for Improvement ensuring the changes can be sustained and spread across the ward, department, hospital or General Medical Practice.

All Health Boards are committed to taking this work programme forward providing clinically effective and equitable care to their patients.

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THE NATIONAL HEART FAILURE AUDIT

The National Heart Failure Audit was launched in 2007 to provide comparative data to help improve the quality and outcomes of services. The Central Cardiac Audit Database (CCAD) is used to collate information from participating hospitals. The National Heart Failure audit is run jointly by The NHS Information Centre and the British Society for Heart Failure, and is funded by the Healthcare Quality Improvement Partnership (HQIP). Patients discharged from secondary care are entered into the database.

Impact of Specialist Services

The third audit report for 2010 presents the most robust findings to date about patient mortality for heart failure. In 2010 more than 21,000 patient records were analysed and it suggests about 32% of Heart Failure patients will die within a year of their hospital admission. It revealed a big difference in mortality rates between those who receive specialist cardiology services when they are admitted to hospital and those who do not. However the mortality rate falls to 23% for those are seen by a Cardiologist or have access to specialist Heart Failure services. In-patient mortality is also twice as likely for a Heart Failure patient if they are on a non cardiac ward; at 12% compared to 6%. Beta blockers were underused but specialist services are associated with better prescribing and better outcomes.

The report recommends that all Health Boards in Wales should take part in the audit. Uptake within the South Wales Cardiac Network area has been slow with only some of the hospitals within Aneurin Bevan, Cwm Taf and Hywel Dda Health Boards taking part. Participating in CCAD is part of the 1000 Lives Plus Intelligent Targets and as such all Health Boards are aware of its importance. The main stumbling block for non-participants seems to be the data inputting with limited resources already being stretched. However to strengthen the data nationally all centres should participate and ways around the issues need to be addressed. Some areas have recently been developing new systems to accommodate the data collection, so it may well be that next year’s audit will have greater input from more hospitals.

3rd Annual National Heart Failure Audit 2010

The 3rd Annual National Heart Failure Audit can be viewed on http://www.ic.nhs.uk/webfiles/publications/002_Audits/NHS_IC_National_Heart_Failure_Audit_2010_04-01-11.pdf

Internet:
http://www.sewcn.wales.nhs.uk
http://www.mswcardiacnet.wales.nhs.uk
Intranet:
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