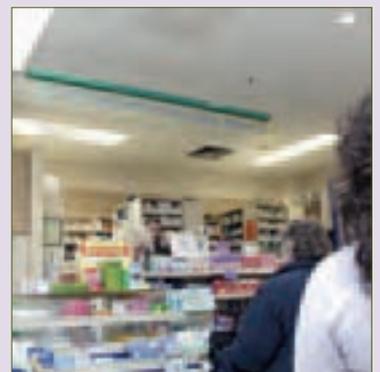
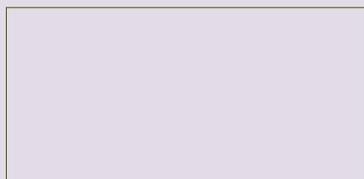
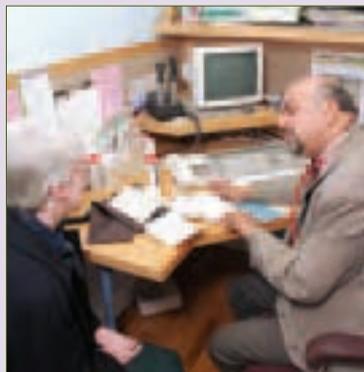
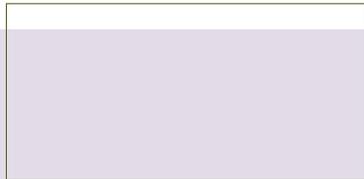


Pushing the boundaries

Improving services for people with heart failure



First published in July 2007

© 2007 Commission for Healthcare Audit and Inspection

Items may be reproduced free of charge in any format or medium provided that they are not for commercial resale. This consent is subject to the material being reproduced accurately and provided that it is not used in a derogatory manner or misleading context.

The material should be acknowledged as © 2007 Commission for Healthcare Audit and Inspection with the title of the document specified.

Applications for reproduction should be made in writing to:
Chief Executive, Commission for Healthcare Audit and Inspection,
Finsbury Tower, 103-105 Bunhill Row, London, EC1Y 8TG.

ISBN: 978-1-84562-147-6

Contents

Executive summary	3
Introduction	11
Detailed findings	21
Criterion 1: Are patients with suspected heart failure being effectively diagnosed?	21
Confirmation of diagnosis	21
Waiting times for echocardiography	22
Quality of echocardiography services	24
Heart failure diagnostic clinics	25
Criterion 2: Are patients receiving evidence-based treatment consistent with NICE guidelines and are they being monitored effectively to ensure optimum treatment and quality of life?	28
Evidence-based treatment	28
Monitoring and review	29
Criterion 3: Are there adequate and effective multidisciplinary services and care processes in place, which provide patients and carers with adequate education and support?	30
Systematic care	30
End-of-life care	36
Education and support	38
Involving patients in the development of services	39
Provision of funding	40
Criterion 4: Are services having a positive impact on hospital admissions, mortality and patient experience?	41
Outcomes for patients	41
Clinical audit	42
The experience of patients	42
Conclusions	44
Recommendations	45
Next steps	47
References	49

The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales.

In England, the Healthcare Commission is responsible for assessing and reporting on the performance of NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. The Healthcare Commission also encourages providers to continually improve their services and the way they work.

In Wales, the Healthcare Commission is more limited and relates mainly to working on national reviews that cover both England and Wales, as well as our annual report on the state of healthcare. In this role we work closely with the Health Inspectorate Wales, which is responsible for the NHS and independent healthcare in Wales.

The Healthcare Commission aims to:

- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public
- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in our decision making, and consultative about our processes

Executive summary

Heart failure is a clinical syndrome (that is, a collection of symptoms) caused by a reduction in the heart's ability to pump blood around the body. The prognosis is poor and survival rates are worse than, for example, breast and prostate cancer, with a high risk of sudden death. Up to 40% of patients die within the first year of diagnosis.

Heart failure affects around 900,000 people in the UK and is particularly common among older people, with prevalence expected to increase over the next 20 years.

The condition can be extremely debilitating and there is evidence that people with heart failure have a worse quality of life than those suffering from most other chronic conditions.

As a result, heart failure impacts significantly on the availability of hospital beds, and on the number of emergency admissions and re-admissions to hospital. Heart failure accounts for about 5% of all medical admissions to hospital and is the largest single reason for emergency bed days due to a chronic condition. Rates of re-admission are also among the highest for any of the other common conditions in the UK.

Chapter six of the *National Service Framework for Coronary Heart Disease*, published by the Department of Health in March 2000, defined the standard of care for patients with heart failure that the NHS should aim for:

“Doctors should arrange for people with suspected heart failure to be offered appropriate investigations (e.g. electrocardiography, echocardiography) that will confirm or refute the diagnosis. For those in whom heart failure is confirmed, its cause should be identified – the treatments most likely to both relieve symptoms and reduce their risk of death should be offered.”

The national service framework described the desired models of delivering multidisciplinary specialist services. These included clear protocols and guidance specifying the indications and routes of referral within the local network of cardiac care, structured consultations in general practice surgeries, heart failure clinics for investigation and/or follow-up, specialist advice from outpatients or specialist heart failure clinics, follow-up of patients discharged from hospital by specialist nurses, and multidisciplinary support in the community with access to social care and specialist palliative care. The national service framework also set milestones for achievement of the overall goals for primary care teams and hospitals to ensure that all patients with heart failure are receiving a full package of effective investigations and interventions, demonstrated by clinical audit data no more than 12 months old. In July 2003, the National Institute for Health and Clinical Excellence (NICE) published its guideline on the *Management of chronic heart failure in adults in primary and secondary care*. This set out advice for best practice in the care of adults with symptoms or a diagnosis of heart failure. The guideline made 92 recommendations in total, with the following issues being identified as priorities:

- all patients with suspected heart failure should be effectively diagnosed using recommended investigations (including echocardiography), and only those with a confirmed diagnosis should be managed in accordance with the remainder of the guideline
- all patients with heart failure due to left ventricular systolic dysfunction should be considered for treatment firstly with an ACE inhibitor, and then with beta-blockers licensed for use in heart failure

- all patients with chronic heart failure should be regularly monitored to detect and manage fluctuations in their clinical condition, thereby helping to avoid unnecessary admission to hospital
- patients with heart failure should only be discharged from hospital once their clinical condition has been stabilised and their management plan optimised. This plan must be shared with the primary care team, the patient and their carer
- all patients should be supported, with their care management being seen as a shared responsibility between the patient and the healthcare professional

A further report on progress made against the national service framework, published by the Department of Health in 2003, recognised that while some progress had been made, there was still a long way to go in improving services. Heart failure was therefore made a priority in the Department's Planning and Priorities Framework for 2003-2006¹, which set a target to improve the management of patients with heart failure in line with the clinical guideline from NICE, and set local targets to reduce the number of patients admitted to hospital with a diagnosis of heart failure.

The Commission for Health Improvement (which was replaced by the Healthcare Commission in 2004) undertook broad reviews of the progress on implementing the national service framework in 26 localities* across England between 2003 and 2004. These reviews concluded that more attention needed to be given to the standards relating to primary prevention, heart failure and cardiac

rehabilitation. The particular issues of concern relating to heart failure included the wide disparity in the levels of service being offered in different localities, the reliance on charitable and short-term funding, problems with confirming diagnosis, low rates of prescribing for the key treatments, a lack of shared clinical guidelines and little evidence of clinical audit.

In addition, the Department of Health introduced the General Medical Services Quality and Outcomes Framework in April 2004. This incentivised aspects of managing chronic diseases in primary care, and incorporated three measures on the diagnosis and management of heart failure.

It was against this background that the Healthcare Commission undertook a review of heart failure services as part of a programme of service reviews. Each local community, comprising a primary care trust (PCT) and the acute trusts that provide at least 10% of the PCT's activity for inpatients with heart failure**, received a detailed local assessment of their services, using data relating to 2005/2006. We measured performance using a four-point scale of 'excellent', 'good', 'fair' and 'weak'. Of the 303 communities assessed, 9.2% scored 'excellent' and 52.8% scored 'good'. However, 29% of communities scored 'fair' and 8.6% scored 'weak'. While all organisations need to make improvements in the areas highlighted by the assessment, our attention will be focused on those communities with an overall score of 'weak'. These communities will be required to produce an improvement plan to address the issues of most concern.

* Based on the population of a local area and the primary care trusts, NHS hospitals, ambulance services, local authorities, and voluntary organisations that work together to promote, maintain and improve cardiac health.

** Based on organisations in existence as at March 31st 2006.

Key findings

Our review shows that there has been substantial progress in developing services for

patients with heart failure since the earlier reviews of 2003/2004 were completed, although it is still a mixed picture. The main changes are summarised in table 1.

Table 1: Summary of progress since reviewing implementation of the National Service Framework for Coronary Heart Disease in 2003/2004

Issue	Summary of findings	
	Reviews of progress against the national service framework 2003/2004	Heart failure service review 2005/2006
Availability of, and investment in, services	Additional investment was required to develop services for heart failure and there was wide disparity in the levels of service offered (with no service at all in some communities).	Most communities had established some form of specialist service for patients with heart failure, with 81.6% of communities having a specialist nursing service and 86.5% of acute trusts having a lead consultant. However, our review indicated that these services were not widely accessible to all patients who were admitted to hospital with heart failure. In addition, some existing services may be financially unsustainable, and a third of planned developments may not come to fruition due to lack of funding.
Identification of people with heart failure	Little progress had been made on the identification of people with heart failure in primary care.	National recorded prevalence (1.8%) was lower than expected (2.3%) based on estimates, and there was considerable variation by PCT (0.19% to more than 5%).
Continues overleaf		

Table 1 (continued): Summary of progress since reviewing implementation of the National Service Framework for Coronary Heart Disease in 2003/2004		
Issue	Summary of findings	
	Reviews of progress against the national service framework 2003/2004	Heart failure service review 2005/2006
Confirmation of diagnosis	Diagnosis was confirmed by echocardiogram infrequently.	Nationally, 92.5% of patients had a confirmed diagnosis, but local variation exists at PCT and practice level (ranging from 69.6% to 100%).
Access to echocardiography	Access to, and waiting times for, echocardiography varied widely.	Waiting times for echocardiography have improved and continue to do so, with more than 70% of patients waiting less than 13 weeks. Average waiting times as an inpatient are less than one week.
Prescribing rates	Less than half the patients with confirmed heart failure were prescribed ACE inhibitors.	Nationally, 82.5% of patients with confirmed heart failure are prescribed an ACE inhibitor, but there is still wide local variation.
Guidelines for the management of patients with heart failure	There was a lack of shared and fully implemented guidelines on the management of patients with heart failure.	The vast majority of organisations have guidelines in place that are consistent with recommendations from NICE and the NSF.
Clinical audit and evaluation of services	There was a lack of clinical audit and evaluation of the impact on admissions and re-admissions.	Fewer than 20% of organisations were able to meet all the audit criteria within the NSF and NICE guideline.

These and other key findings are summarised below:

Diagnosis of heart failure

Access to, and waiting times for, the key diagnostic tests to confirm a diagnosis of heart failure have improved. As at March 31st

2006, 92.5% of patients registered on GPs' systems with a diagnosis of heart failure (diagnosed since April 2003) have had their diagnosis confirmed by echocardiography and 71.6% of all patients waited less than 13 weeks for this key defining test, with virtually

all acute trusts having average waiting times for echocardiography as an inpatient of less than one week. The Department of Health set a target of a maximum wait for patients, by the end of 2008, of 18 weeks from referral by a GP to treatment in hospital. This has resulted in improved performance from commissioners and providers of services. There has been continued progress in this area, with the percentage of patients waiting less than 13 weeks for echocardiography at the end of February 2007 rising to 88.6%.

Echocardiography services are also being delivered in line with the British Society for Echocardiography quality standards.

However, there is still wide variation at practice level in the number of patients registered on GPs' systems with suspected heart failure that have had their diagnosis and its cause confirmed, and local prevalence of recorded heart failure mostly falls short of predicted levels that are based on evidence from research. This could mean that there is a largely unseen demand for investigations, clinical assessment and care.

The model of a heart failure diagnostic clinic proposed by the national service framework has not been universally adopted. Where it has, the 'one stop' nature of these clinics varies, particularly in the primary care setting.

Evidence-based treatment and monitoring

A high percentage of patients are being prescribed initial treatments to reduce symptoms and prolong life. Nationally, 85.2% of patients registered on GPs' systems with a diagnosis of coronary heart disease and left ventricular dysfunction are recorded as being treated with an ACE inhibitor or A2 antagonist. This level of achievement is a vast improvement on the position reported in the 2003/2004 review of implementation of the

national service framework, where less than half of patients were receiving these drugs. However, there is considerable variation in levels of achievement at individual practice level, with percentages ranging from 0% to 100%. Our review also indicates that improvement is required in levels of prescribing for other medications specified in the NICE guidance, such as beta-blockers. These are not currently covered by the quality indicators in the Department of Health's General Medical Services Quality and Outcomes Framework.

Most communities have local guidelines in place for the initiation and optimisation of treatment and monitoring of patients. The documented scope and regularity of arrangements to monitor patients are consistent with the minimum requirements set out in the NICE guidelines, and some organisations are advocating more frequent reviews. This again is a great improvement on the position two to three years ago. However, we were unable to obtain data on the extent to which these guidelines are achieved in practice.

Access to specialist services, systematic care and support

Most communities had established some form of specialist service for patients with heart failure. In 86.5% of acute trusts there was a lead consultant for the care of patients with heart failure, and 81.6% of PCTs had a specialist nurse (based either in primary or secondary care) serving their community. This indicates a substantial development since the reviews of implementation of the national service framework undertaken in 2003/2004, where the development of specialist services was very patchy and still in its infancy.

However, a survey of patients admitted to hospital with heart failure, carried out as part

of the acute hospital portfolio review of admissions management (2005/2006), showed that only 22.3% of patients were referred to the lead clinician or a cardiologist. Access to specialist teams was also shown to be extremely variable, with averages for trusts ranging from 0% to 74%. In addition, services provided to these patients need to ensure that they extend to all specialties and wards, not just to those patients that are admitted to a cardiology ward.

Processes to assess the broader needs of patients were generally comprehensive and in line with the recommendations in the national service framework and NICE guideline. However, more attention needs to be given to considering the mental wellbeing of patients, and that appropriate services are subsequently provided to meet the holistic needs of the patient, for example rehabilitation and counselling.

Patients with heart failure live with a high degree of uncertainty and a risk of sudden death. However, good palliation or end-of-life care can improve symptoms and enhance their quality of life. Patients need to be able to discuss issues that affect them at the end of their lives at all stages of their care, to have their end-of-life needs assessed and managed, and to have access to professionals with appropriate specialist skills.

Our review found that 80% of PCTs had commissioned specialist palliative care services that were accessible to patients with heart failure and that over half of the organisations were establishing nationally-recognised frameworks to manage end-of-life care. This is positive news, but we were unable to confirm how many patients with heart failure actually gain access to these services.

Ninety per cent of communities had comprehensive education and support programmes, which help patients to understand their condition, participate in self monitoring where appropriate, and enjoy a better quality of life.

Outcomes for patients

Research has shown that effective systematic care for patients with heart failure can reduce admissions to hospital, re-admissions and mortality. Data pooled for the years 2002/2003 to 2004/2005 demonstrates wide variation in the level of observed re-admission and mortality across PCTs in England when compared with the expected level (after adjusting for age and sex). This may reflect the capacity and differing levels of maturity of specialist services in different localities. Nevertheless, such variation reinforces the need to apply the NICE guidelines much more assertively. Outcomes for patients are more likely to be improved if treatment is optimised and patients are monitored effectively to detect any deterioration.

Audit of services

Fewer than 20% of organisations were able to meet the criteria for auditing the delivery of their services as proposed by the national service framework and NICE guideline. It is important that appropriate high quality data is routinely collected and evaluated to ensure that patients are receiving the best possible care and that services are improved where necessary. Such data will also be instrumental in demonstrating the cost benefits of specialist services at a local level.

Patient-centred services

The experience of patients is also a key measure of outcomes. We found that only 52% of organisations had evaluated patients' satisfaction with specialist heart failure

services in 2005/2006 and that only 35.6% of organisations had carried out a systematic evaluation of the quality of life for patients with heart failure. As well as better information on audited outcomes for patients, we need to know more about patients' experiences to ensure that services for heart failure are meeting the needs of patients and improving their perceived quality of life.

Conclusions and key recommendations

We found that there had been clear improvements in levels and speed of access to diagnostic services, prescribing levels for ACE inhibitors, developing specialist teams and systematic care processes, implementing services and frameworks in support of end-of-life care, and in the provision of support and education to patients. These findings suggest that the Department of Health's General Medical Services Quality and Outcomes Framework has begun to have a positive influence on the diagnosis and management of heart failure in primary care.

However, there is still room for considerable improvement in the following areas:

- ensuring that **all** patients with suspected heart failure are identified and offered effective investigations to confirm or refute a diagnosis
- ensuring that **all** patients with a confirmed diagnosis have access to specialist staff, services and the full range of recommended treatments to optimise their clinical condition and quality of life
- meeting the more holistic needs of the patient for psychological support and rehabilitation
- assessing patients' experiences

- auditing the delivery of care to ensure the best outcomes for patients and to demonstrate the cost benefits of delivering services

This report makes a number of recommendations to improve the provision of services for people with heart failure. The full list is given in the main body of this report, but some of the most important are highlighted as follows:

1. PCTs and commissioners should review their local recorded prevalence for heart failure against national predicted rates and take action, as necessary, to address shortfalls to ensure that all patients with symptoms of heart failure are identified and properly investigated.
2. PCTs and commissioners should put arrangements in place to ensure that all patients with suspected heart failure have rapid access to the key defining investigations to confirm or refute the diagnosis and its underlying causes in order to determine the most effective course of treatment and care management.
3. Commissioners should work together with service providers to ensure that all patients with confirmed heart failure have access to the specialist advice and services they require, based on a holistic assessment of their needs. This should be achieved by specifying and commissioning cost effective models of multidisciplinary service delivery, which are consistent with the recommendations in the national service framework and NICE guideline. Such a multidisciplinary service should seamlessly encompass both primary and secondary care, with quick and easy access between the two areas. There should also be quick access to specialist clinicians. In the case

of hospital-based services, access to specialist clinicians and teams should be given on the basis of need and not related to the ward or specialty of admission.

4. Service providers should ensure that all patients with confirmed heart failure have access to all recommended medication at the optimal dose, in line with the NICE guidelines, in order to effectively manage their symptoms and maximise their outcomes. In particular, providers should aim to achieve prescribing rates for ACE inhibitors which match those of the best performing communities, and seek significant improvements in prescribing rates for beta-blockers.
5. Service providers should develop or adopt methods for evaluating patients' satisfaction and quality of life, and act on the findings to improve the quality of services from the patients' perspective.
6. Service providers should develop systematic and comprehensive audit arrangements to evaluate whether all people with heart failure are receiving a full package of appropriate investigation and treatment that results in positive outcomes for patients. Commissioners and providers should use this data to evaluate the effectiveness and quality of services and act on the results where necessary.

Trusts can compare their performance in the review with that of other communities and identify areas for improvement. The individual results for each community are available on our website at: www.healthcarecommission.org.uk/improvementreviewheartfailure.

We have already commenced work with the 26 communities who were awarded a score of 'weak' by the review and deemed most in need

of improvement. These communities will be required to produce an improvement plan that addresses the key issues affecting their score and to make these plans accessible to the public by publishing them on their local websites. Our regional staff will monitor communities' progress against these plans and their performance will be managed by the relevant strategic health authority, or in the case of foundation trusts, by their board.

We intend to monitor future performance relating to issues in this review, using a small number of indicators selected from the framework of assessment that focus on areas of most benefit to patients and which have most room for improvement. The specific indicators will be subject to further discussion, but are likely to include those relating to diagnosis, prescribing, re-admission and mortality rates. They will be derived from nationally-available data sources wherever possible, rather than special data collections. The process for monitoring performance against these indicators is currently being developed for our other service reviews, which were completed in 2005/2006. This will apply to the heart failure service review once the organisations involved have had an opportunity to make improvements based on the results of their initial assessment. Further details will be released in due course.

Introduction

Heart failure is a clinical syndrome (that is, a collection of symptoms) caused by a reduction in the heart's ability to pump blood around the body. This weakening of the heart's ability to pump causes:

- blood and fluid to back up into the lungs
- the build-up of fluid in the feet, ankles and legs - called oedema
- tiredness and shortness of breath

Most cases of heart failure are due to coronary heart disease, with the main risk factor being myocardial infarction (heart attack). Other important contributory factors are hypertension (elevated blood pressure) and diabetes. Heart failure is a serious condition and, at present, cannot be cured. The prognosis is poor and survival rates are worse than, for example, breast and prostate cancer, with a high risk of sudden death. Up to 40% of patients die within the first year of diagnosis.

Heart failure affects around 900,000 people in the UK and is particularly common among older people. Over the next 20 years, prevalence is expected to increase due to the rising proportion of older people in the population and the increasing survival rate from heart attacks.² It is closely associated with deprivation³ and co-morbidity (additional diseases present in a patient with heart failure).⁴

The condition can be extremely debilitating and there is evidence that people with heart failure have a worse quality of life (with over a third experiencing severe and prolonged depressive illness⁵) than people with most other chronic conditions.

As a result, heart failure impacts significantly on the availability of hospital beds, and on the number of emergency admissions and re-admissions. Heart failure accounts for

about 5% of all medical admissions to hospital and is the largest single reason for the use of emergency bed days due to a chronic condition⁶ (see table 2). Rates of re-admission are also among the highest for any of the common conditions in the UK.^{7, 8, 9, 10}

Providing services to patients with heart failure costs the NHS an estimated £625 million each year. Research indicates that effective multidisciplinary specialist services can have a positive impact on patients' life expectancy and quality of life.^{11, 12, 13, 14} They can also help to reduce avoidable hospital admissions, therefore releasing resources and contributing to the Government's Public Service Agreement (PSA)¹⁵ target to reduce emergency bed days by 5% by 2008.

Background

The Department of Health published the *National Service Framework for Coronary Heart Disease* in March 2000¹⁶, which set out clear standards for the prevention and treatment of coronary heart disease. Chapter six described the standards, interventions, service models, priorities, milestones and goals relating to heart failure.

Standard 11 stated "Doctors should arrange for people with suspected heart failure to be offered appropriate investigations (e.g. electrocardiography, echocardiography) that will confirm or refute the diagnosis. For those in whom heart failure is confirmed, its cause should be identified – the treatments most likely to both relieve symptoms and reduce their risk of death should be offered."

The national service framework for coronary heart disease also described the desired models of multidisciplinary specialist service delivery. These included clear protocols and

Table 2: Emergency admissions by primary diagnosis 2002/2003		
Top 10 primary diagnoses	Number of emergency admissions	Number of bed days
R69 Unknown and unspecified causes of morbidity	100,179	2,663,736
S72 Fracture of femur	62,281	1,784,340
J18 Pneumonia, organism unspecified	76,905	1,032,265
I50 Heart failure	62,673	977,395
J44 Chronic obstructive pulmonary disease (COPD)	87,942	944,835
J22 Unspecified acute lower respiratory infection	68,503	691,332
I21 Acute myocardial infarction (heart attack)	64,415	657,104
I20 Angina pectoris	89,435	541,421
R10 Abdominal and pelvic pain	154,001	478,434
R07 Pain in throat and chest	161,931	430,799

Source: Hospital Episode Statistics 2002/2003

guidance specifying the indications and routes of referral within the local network of cardiac care, structured consultations in general practice surgeries, heart failure clinics for investigation and/or follow-up, specialist advice from outpatients or specialist heart failure clinics, follow-up of patients discharged from hospital by specialist nurses, and multidisciplinary support in the community with access to social care and specialist palliative care.

The overall goals for this chapter of the national service framework are as follows:

- **every primary care team should** ensure that all those with heart failure are receiving a full package of appropriate investigation and treatment, demonstrated by clinical audit data no more than 12 months old
- **every hospital should** offer complete and correct packages of audited effective interventions to all people discharged with a diagnosis of heart failure, demonstrated by clinical audit data no more than 12 months old

In 2003, the Department of Health published a report on the progress made in implementing the national service framework¹⁷. This recognised that while progress had been made, there was still a long way to go in improving services. Consequently, heart failure was made a priority in the Department's Planning and Priorities Framework for 2003-2006¹, which set a target to: "Improve the management of patients with heart failure in line with the NICE Clinical Guideline due in 2003, and set local targets for the consequent reduction in patients admitted

to hospital with a diagnosis of heart failure.”

The National Institute for Health and Clinical Excellence (NICE) published guidance on the management of chronic heart failure in adults in primary and secondary care in July 2003¹⁸. This set out advice on best practice for the care of adults with symptoms or a diagnosis of heart failure. The guideline made 92 recommendations in total, with the following issues being identified as priorities:

- all patients with suspected heart failure should be effectively diagnosed using recommended investigations (including echocardiography), and only those with a confirmed diagnosis should be managed in accordance with the remainder of the guideline
- all patients with heart failure due to left ventricular systolic dysfunction should be considered for treatment firstly with an ACE inhibitor, and then with beta-blockers licensed for use to treat heart failure
- all patients with chronic heart failure should be regularly monitored to detect and manage fluctuations in their clinical condition, thereby helping to avoid unnecessary admission to hospital
- patients with heart failure should only be discharged from hospital once their clinical condition has been stabilised and their management plan optimised. This plan must be shared with the primary care team, the patient and their carer
- all patients should be supported, with their care management being seen as a shared responsibility between the patient and the healthcare professional

NICE asked local health communities to review how they provided services in relation to this guidance and to take steps to implement the recommendations as quickly as possible, depending on local resources. NICE has also commissioned the NHS Health Technology Assessment Programme to undertake a systematic review to assess the effectiveness of different strategies for the diagnosis of heart failure in primary care. This review is due to be published in mid-2008.

The Healthcare Commission's predecessor, the Commission for Health Improvement, undertook broad reviews of progress in implementing the national service framework for coronary heart disease in 26 localities* across England between 2003 and 2004¹⁹. These concluded that more attention needed to be given to the standards relating to primary prevention, heart failure, and rehabilitation of people with coronary heart disease. The particular areas of concern relating to heart failure were as follows:

- the need for additional investment to develop services for heart failure was recognised, yet it received varying levels of priority from commissioners
- a lack of direction at local level resulted in wide disparity in the levels of service offered (with some communities offering no service at all)
- services were often based around specialist nurses funded through non-recurring charitable sources
- progress in identifying people with heart failure was slow in primary care and, where systems did exist, diagnosis was only infrequently confirmed by echocardiogram

* Based on the population of a local area and the primary care trusts, NHS hospitals, ambulance services, local authorities, and voluntary organisations that work together to promote, maintain and improve cardiac health.

Access to, and waiting times for, echocardiography also varied widely

- less than half the patients with confirmed heart failure were prescribed ACE inhibitors (a class of drug with proven effectiveness in reducing both mortality and hospitalisation due to heart failure) and men were more likely to receive them than women
- a lack of shared and fully implemented guidelines on the management of patients with heart failure
- those communities providing services had rarely audited the care they provided or its impact on admissions and re-admissions

In addition, the Department of Health introduced the General Medical Services Quality and Outcomes Framework in April 2004. This provided incentives for the management of chronic diseases in primary care and incorporated three clinical indicators of quality on the diagnosis and management of heart failure:

- LVD1 – The practice can produce a register of patients with CHD and left ventricular dysfunction
- LVD2 – The percentage of patients with a diagnosis of CHD and left ventricular dysfunction (diagnosed after 1 April 2003) which has been confirmed by an echocardiogram
- LVD3 - The percentage of patients with a diagnosis of CHD and left ventricular dysfunction who are currently treated with ACE inhibitors (or A2 antagonists)

It was against this background that the Healthcare Commission decided to look at

services for heart failure as part of the programme of service reviews.

About the review

The Healthcare Commission's service reviews (formerly known as improvement reviews) look at whether healthcare organisations are improving the care and treatment they provide to patients. They focus on a particular aspect of healthcare of national importance and where there are opportunities for healthcare organisations to make substantial local improvements to the quality of services. Service reviews can be applied in a variety of settings, including the pathways of treatment taken by patients, certain groups of diseases and services provided to specific groups of patients. Their aim is to encourage each organisation taking part, or in the case of the review of heart failure services, each local health community*, to improve the quality of healthcare it provides to patients and the public. Service reviews assess organisations by measuring performance on key questions that are important to patients and the public and to those delivering services.

Service reviews also support the Healthcare Commission's broader aim to promote better healthcare, and therefore better health, for patients and the public by:

- assessing achievement against the standards and recommendations set out in national service frameworks and guidelines from NICE
- encouraging organisations taking part to improve the quality of the services provided to patients where necessary

* The local community is defined as a PCT and the acute trusts providing at least 10% of the PCT's inpatient activity for patients with a diagnosis of heart failure (as in existence as at March 31st 2006).

Service reviews follow a standardised approach based on information and are highly targeted. They have two parts:

- firstly, assessments are made of the performance of all organisations or communities taking part in the review
- secondly, follow-up work is targeted specifically at those organisations in greatest need of improvement. However, all organisations are encouraged to make improvements where indicated in the assessment

The review of heart failure services forms part of our wider programme of work to improve the quality of life for people with long-term conditions. Sources of data used in this review include:

- the Department of Health's Hospital Episode Statistics, data on waiting times for diagnostic services, and the General Medical Services Quality and Outcomes Framework
- the Healthcare Commission's survey of patients admitted to hospital with heart failure (part of the acute hospital portfolio review of admissions management 2005/2006)*
- a bespoke data collection undertaken specifically for this review

Collection of data for the review commenced in April 2006, as part of the first wave of improvement reviews. The assessment is based on data for 2005/2006** (with the

exception of indicators based on Hospital Episode Statistics which are based on aggregated data for three years for 2002/2003 to 2004/2005). The results were intended to contribute to the annual performance rating in October 2006. However, issues with data collection resulted in the service review being delayed and it therefore did not contribute to the 2005/2006 annual health check.

The original improvement review was rebranded as a service review and the provisional results for communities that were assessed were published in February 2007. Final results are being published to coincide with this report, but service reviews will not contribute directly to the annual performance rating for 2006/2007. However, we will use the data as part of our ongoing assurance process of assessing trusts' compliance with core and developmental standards.

The review of heart failure services looks at whether primary care trusts (PCTs) and their associated secondary care trust(s) are ensuring good outcomes for people with heart failure by:

- effectively and swiftly diagnosing patients with heart failure, providing evidence-based treatment, and monitoring patients effectively in order to optimise treatment, detect deterioration and minimise admissions to hospital
- having in place effective and adequate multidisciplinary services and processes of care

* For further information on the survey of patients admitted with heart failure, please refer to the Healthcare Commission's website: www.healthcarecommission.org.uk/acutehospitalportfolio/admissionsmanagement.cfm

** Not all indicators cover the full 2005/2006 financial year. Some are at a point in time, for example, at March 31st 2006, while others are for another defined period. Please refer to our technical guidance on analysis and scoring for further details, available via our website: www.healthcarecommission.org.uk/improvementreviewheartfailure.

- providing patients and their carers with education and support so that they can play an active role in the management of their care

The assessment is based firmly on the requirements and recommendations of the *National Service Framework for Coronary Heart Disease* and guidance from NICE on the management of chronic heart failure in primary and secondary care. However, we focused wherever possible on the key drivers of performance that were defined by our consultation with patients and healthcare professionals (see table 3).

The review covers all services provided to patients with suspected or confirmed chronic

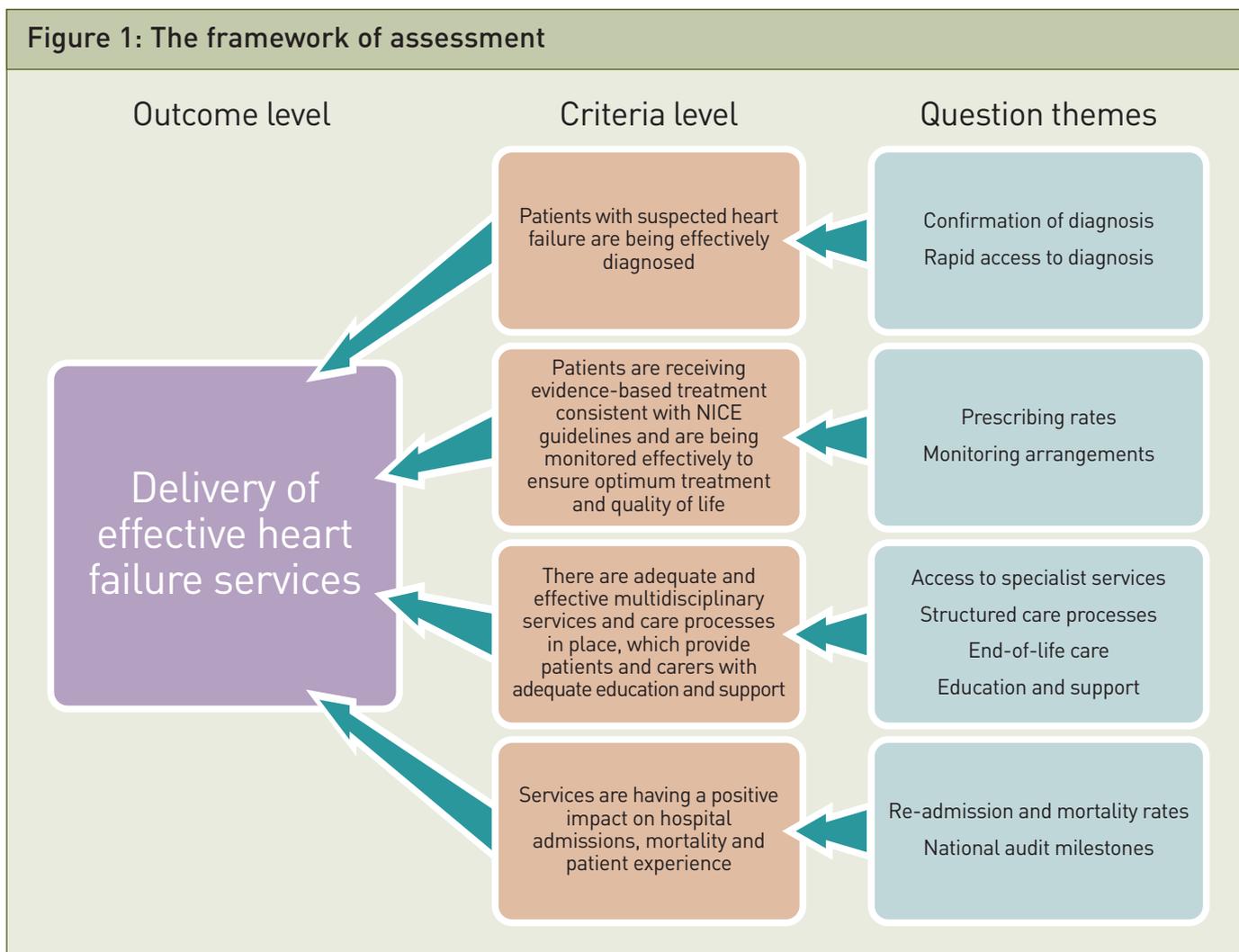
heart failure due to left ventricular dysfunction in a primary and/or secondary care setting in England. The scope does not extend to specialist tertiary care services such as cardiac transplantation. A total of 303 PCTs and 154 acute trusts participated in the review*.

We use the term ‘local community’ to describe each unit that we assessed. Each local community is defined as a PCT and its associated acute trust(s) that provide at least 10% of the PCT’s inpatient activity for patients with a diagnosis of heart failure. Each local community was assessed on the extent to which it was delivering effective heart failure services against a framework of assessment comprising four broad criteria and 10 key questions as summarised in figure 1.

Table 3: Key drivers of performance identified by patients and professionals	
What patients told us was most important	What professionals told us was most important
<ul style="list-style-type: none"> • access to quick and accurate diagnosis, without delays in the pathway • good links between services, organisations and professions • having a point of contact and someone who can coordinate care requirements • easy access to specialist advice and medication • access to specialist services such as rehabilitation and counselling • regular follow-up and ability to seek advice at short notice • information • honesty about their prognosis 	<ul style="list-style-type: none"> • identifying all patients with suspected heart failure • diagnosing heart failure and its causes to ensure that patients get evidence-based treatment • ensuring that treatment is started and titrated to optimum doses

* Based on organisations in existence as at March 31st 2006.

Figure 1: The framework of assessment



Overall results

Local communities were assessed on their performance against the four criteria according to a four-point scale:

Weak – performance that does not meet minimum requirements or the reasonable expectations of patients and the public.

Fair – performance that meets minimum requirements and the reasonable expectations of patients and the public.

Good – performance that goes beyond minimum requirements and the reasonable expectations of patients and the public.

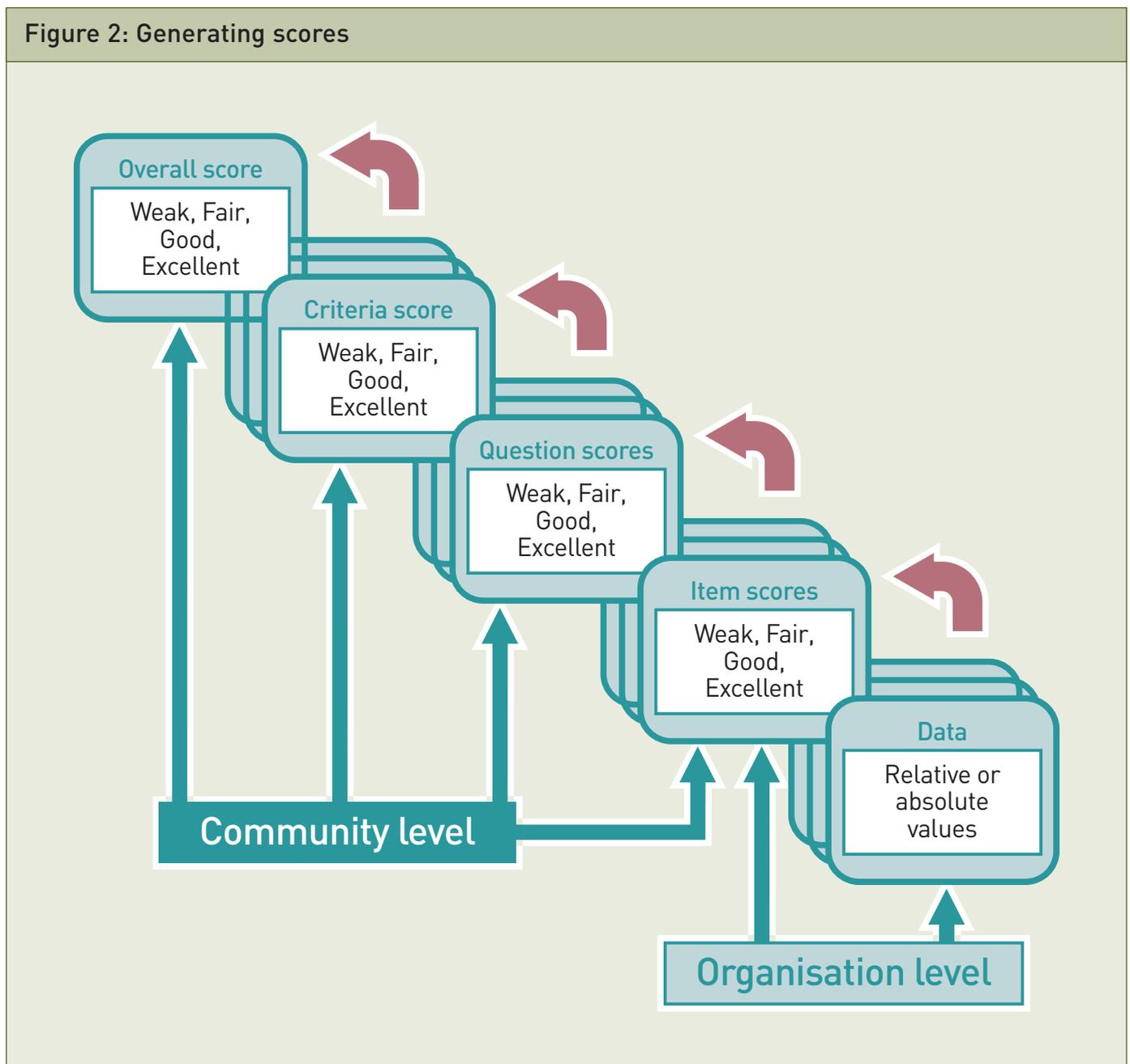
Excellent - performance that goes well beyond minimum requirements and the reasonable expectations of patients and the public. A leader in this aspect of performance.

Three sets of scores were awarded: for the criteria level, for the question themes and for data items. The overall score was determined by aggregating the criteria-level scores and

comparing the points achieved against pre-determined thresholds for each performance category. These thresholds are based on standard scoring rules for all service reviews agreed with the Department of Health.

However, if the score for Criterion 1 was 'weak', then the overall score could not be better than 'weak'. Item-specific rules were used to derive the scores for individual data items at an organisational level.

Figure 2: Generating scores



Of the 303 communities* assessed, the overall scores were as follows:

- 28 communities (9.2%) scored 'excellent'
- 160 communities (52.8%) scored 'good'
- 89 communities (29%) scored 'fair'
- 26 communities (8.6%) scored 'weak'

There were no significant regional variations in the results. However, those communities with an overall score of 'weak' did tend to form geographical clusters.

In general, communities achieved higher scores for Criterion 1 and Criterion 3 (see table 4). Although the highest number of 'weak' scores was attributed to Criterion 2, 26 communities also scored 'weak' for Criterion 1.

Table 4: Distribution of scores by criterion

Criterion	Number of communities scoring:			
	Weak	Fair	Good	Excellent
1 Patients with suspected heart failure are being effectively diagnosed	26	118	107	52
2 Patients are receiving evidence-based treatment consistent with NICE guidelines and are being monitored effectively to ensure optimum treatment and quality of life	43	162	82	16
3 There are adequate and effective multidisciplinary services and care processes in place, which provide patients and carers with adequate education and support	3	103	101	96
4 Services are having a positive impact on hospital admissions, mortality and patient experience	1	212	69	21

Source: Healthcare Commission heart failure service review 2005/2006.

* Based on organisations in existence as at March 31st 2006.

This report

In February 2007, each community received a detailed report of their assessment, which itemised how they had performed on each of the scored indicators. This report presents a national picture of the provision of services for patients with heart failure in England, based on the findings of the review*. It highlights the key areas of success as well as areas where improvement is needed. It also provides feedback on the valuable contextual data that was collected as part of the review, but that did not form part of the formal assessment. The findings are organised according to the key criteria within the assessment framework.

The report is mainly intended for a professional audience, including the boards and managers of primary care and acute trusts, healthcare professionals, and policy makers in the Department of Health. It will also provide valuable information for those supporting national and local activities to improve services, such as professional organisations, the NHS Heart Improvement Programme and local cardiac networks.

Individual results for all communities that participated in the review are available on our website at www.healthcarecommission.org.uk/improvementreviewheartfailure. Members of the public and patients can use this information to see how their local services performed in the assessment.

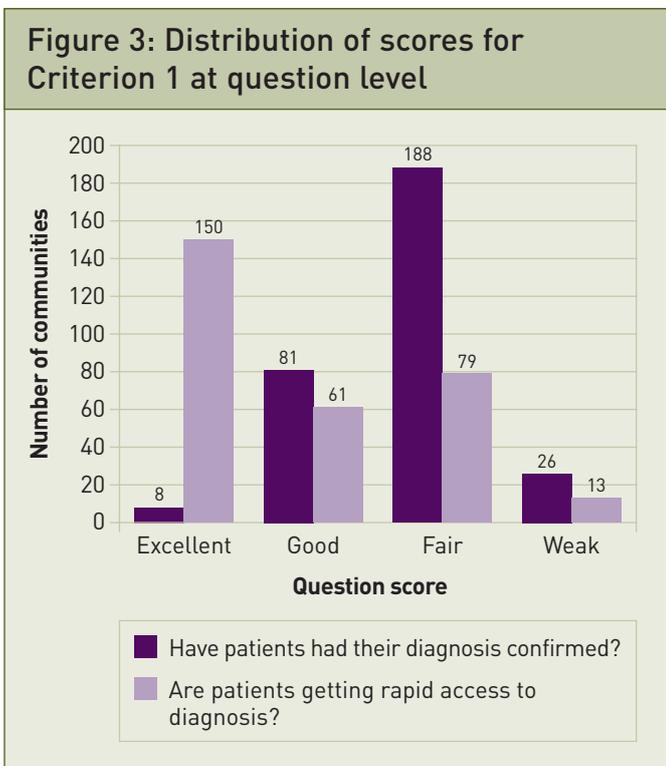
We are also producing an interactive tool incorporating data collected as part of the review, which will enable local organisations to compare their performance with other locally-defined comparator groups.

* Based on data obtained for 2005/2006, unless otherwise stated.

Detailed findings

Criterion 1: Are patients with suspected heart failure being effectively diagnosed?

More than 52% of communities scored 'good' or 'excellent' for Criterion 1, but there were contrasting levels of performance in each of the two key questions asked (see figure 3).



Source: Healthcare Commission heart failure service review 2005/2006

Confirmation of diagnosis

Echocardiography is the key diagnostic test that either confirms or refutes a diagnosis of heart failure. Nationally, 92.5% of patients who have been diagnosed (since April 2003) with coronary heart disease and heart failure, and recorded on GPs' systems, have had their diagnosis confirmed by echocardiography.

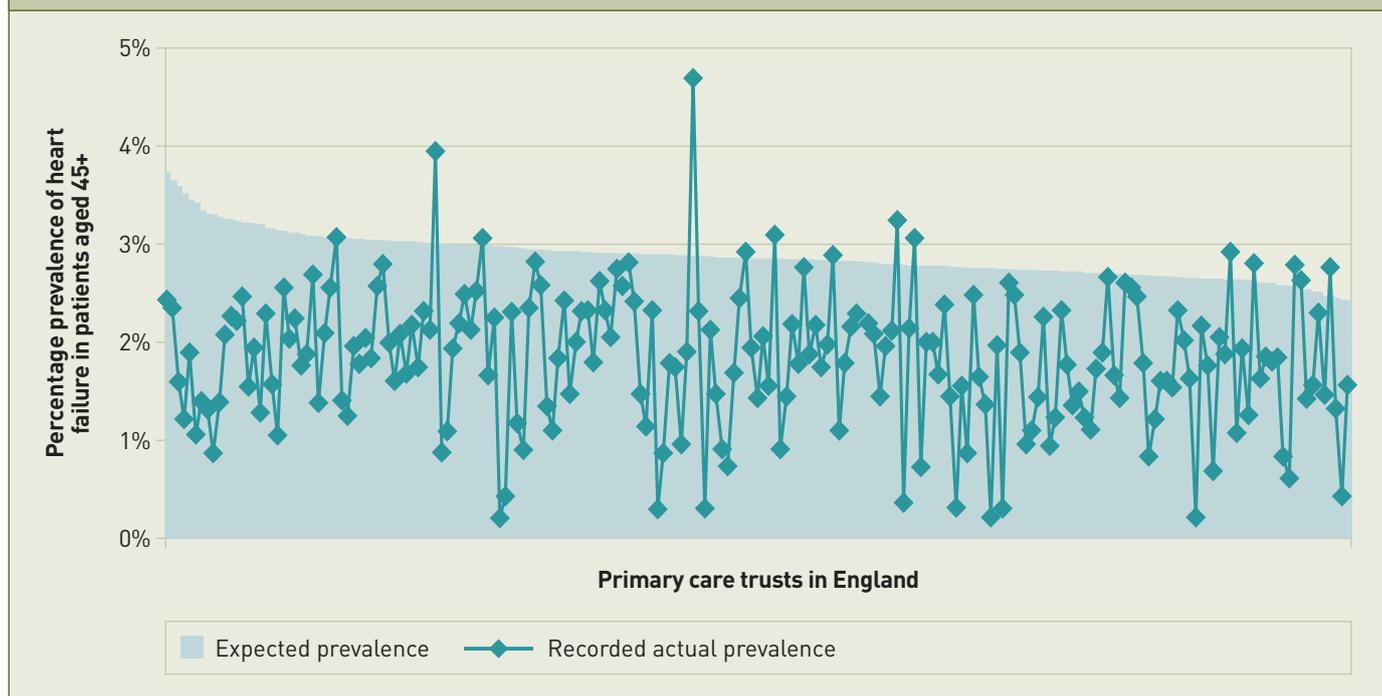
However, this varied considerably by PCT (69.9% to 100%) and further still at practice level*. Both the national service framework and guidance from NICE stress the importance of confirming the diagnosis and its underlying causes to ensure that patients receive the appropriate and optimal treatment.

These results need to be considered in the context of the known local prevalence of heart failure. The Echocardiographic Heart of England Screening Study, which estimates the expected prevalence of definite heart failure, suggests that 2.3% of the population aged 45 or over will suffer from heart failure²⁰. As part of the review we asked PCTs to supply data on the number of patients aged 45 and over with confirmed heart failure or left ventricular systolic dysfunction, based on the most recent audit of 100% of practices. Not all PCTs were able to supply this data. However, of those that did, there was considerable variation in the calculated percentage prevalence, ranging from 0.19% to around 5%, with a national mean of 1.81%.

We compared the recorded prevalence provided by PCTs with age-adjusted synthetic estimates of prevalence based on the Heart of England Screening Study and mid-2004 estimates of resident population (2001 Census based). While the prevalence in a few PCTs was well in excess of what might be expected, the recorded prevalence in most PCTs was well below the expected level of 2.3% (see figure 4). This suggests that some patients may not be getting access to appropriate diagnostic tests and subsequent treatment, while others may be diagnosed with heart failure incorrectly. Clearly, any hidden demand for diagnostic services could have an adverse effect on waiting times if it were to emerge.

* Source: Department of Health General Medical Services Quality and Outcomes Framework 2005/2006: LVD2.

Figure 4: Percentage of patients aged 45 and over with confirmed heart failure or left ventricular systolic dysfunction (based on most recent audit) compared with estimated population prevalence



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006, PCT audit and clinical management form and Echocardiographic Heart of England Screening Study

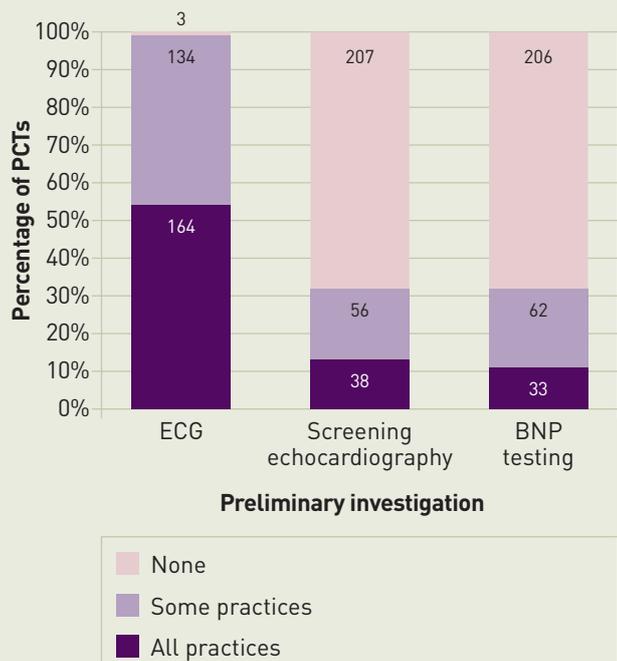
PCTs can help to reduce the demand on hospital-based echocardiography services by carrying out preliminary investigations in primary care to rule out a diagnosis of heart failure. These include electrocardiograms, B-type natriuretic peptide (BNP) testing and screening echocardiography. However the use of these techniques is still fairly minimal (see figure 5).

The ongoing review of strategies for diagnosing heart failure in primary care, as part of the NHS Health Technology Assessment Programme, is expected to result in clear advice to GPs about how best to diagnose heart failure, including the value of different diagnostic tests, such as BNP.

Waiting times for echocardiography

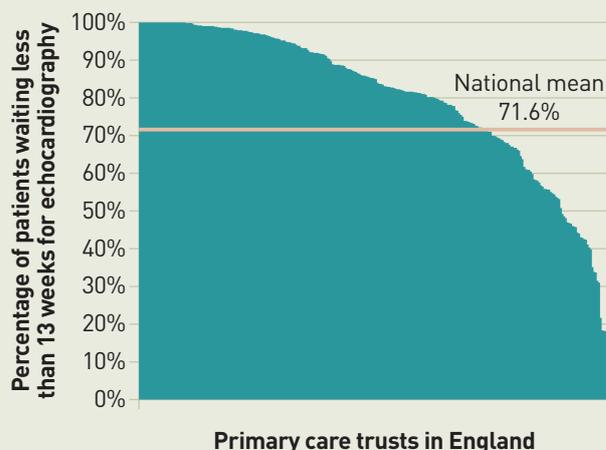
The Department of Health's *NHS Improvement Plan*²¹ set out an ambitious new target of a maximum wait for patients, by the end of 2008, of 18 weeks from referral by a GP to treatment in hospital. Commissioners and providers of services are therefore more focused on improving patients' pathways and waiting times for diagnostic tests and treatment. As at March 31st 2006, patients with suspected heart failure that were referred for echocardiography were getting a fairly rapid service. Data collected for the review show that nationally 71.6% of patients waited less than 13 weeks for all echocardiography referrals, and in 99% of trusts the mean waiting time for echocardiography was less

Figure 5: Availability of preliminary investigations in primary care



Source: Healthcare Commission heart failure service review bespoke data collection (2005/2006), PCT audit and clinical management form

Figure 6: Distribution of percentage of patients waiting less than 13 weeks for echocardiography (commissioner-based data)



Source: Department of Health Diagnostics Return, March 31st 2006

Figure 7: Distribution of waiting times for echocardiography as an inpatient



Source: Healthcare Commission acute hospital portfolio review of admissions management 2005/2006: survey of patients admitted with heart failure

than one week for patients referred as an inpatient. In 27% of trusts the mean waiting time was less than 48 hours. However, there is still considerable room for improvement in some PCTs and acute trusts (see figures 6 and 7).

More recent data published by the Department of Health in February 2007* demonstrates that further progress continues to be made on waiting times for echocardiography, with 88.6% of patients waiting less than 13 weeks.

Despite relatively short waiting times from referral to investigation, data collected for this review indicate that there are still some potential delays in obtaining a diagnosis. The review showed that 13.5% of services required patients to have an outpatient appointment with a consultant before referral, and 23.7% of services reported that a further outpatient appointment with a consultant was required before the patient could receive their results. At present there is no data available to determine what impact these additional steps in the pathway have upon the overall time taken to achieve a diagnosis.

Quality of echocardiography services

The British Society for Echocardiography has established an accreditation system that sets out the standards that hospital-based echocardiography services should aspire to. These cover issues such as:

- leadership, staffing, qualifications and training
- systems for review and alerts for uncertain findings
- reporting and archiving
- facilities, equipment and maintenance
- facilities and information for patients

Accreditation of echocardiography services can be achieved at a basic 'mandatory' level, a 'favoured' level or the highest 'desired' level, depending on the compliance of the service.

While only 24 NHS hospital departments had achieved accreditation through the British Society for Echocardiography process, data collected for this review demonstrates that of the departments assessed:

- 46.5% were able to meet the standards at the mandatory level
- 28.3% were able to meet the standards at the favoured level
- 13.4% were able to meet the standards at the desired level
- 11.8% reported that they could not meet the basic standards or did not know

We can therefore conclude that, at the time of the review, the majority of hospital-based services were meeting at least the minimum standards.

Thirty-one PCTs provided an echocardiography service that was delivered by a GP with a special interest in cardiology. The Department of Health published standards for the delivery of such services in 2002²², which cover aspects such as core activities and competencies, training, facilities and equipment, clinical governance, accountability and monitoring arrangements and local guidelines for using the service.

Our review found that all PCTs providing such services had assured themselves that these standards were being met in all but a few instances relating to training and local guidelines.

The British Society for Echocardiography, the Primary Care Cardiac Society, the British Society for Heart Failure and the former Coronary Heart Disease Collaborative developed a consensus statement on

* Please refer to the Department of Health's website: www.performance.doh.gov.uk/diagnostics/commissioner.html

Table 5: Access to hospital-based echocardiography services by community-based echocardiography services

Aspect of support	Percentage of PCTs reporting 'Yes'	Percentage of PCTs reporting 'No'
Onward referral for more complex echocardiography	80.2%	19.8%
Second opinion for difficult studies	81.3%	18.7%
Clinical back-up for cases where problems are identified by echocardiography	81.3%	18.7%
Quality assurance or peer review	78.0%	22.0%
Regular sessions at a hospital department as part of their continuing professional development	72.5%	27.5%

Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: PCT echocardiography (NHS) form

community-based echocardiography.²³ This set out the arrangements that should be in place within a network of care to ensure safe and high quality services. We asked those PCTs that provided community-based echocardiography services if they had access to hospital-based services for each of the aspects of support listed in table 5, as recommended in the consensus statement.

While this is a very positive picture, it also indicates that about one-fifth of community-based services are operating without appropriate back-up, quality assurance or support for continuing professional development.

Heart failure diagnostic clinics

The national service framework advocates the use of heart failure clinics to investigate and/or provide follow-up for patients as an appropriate model of service for delivering systematic care. It suggests that these clinics should be multidisciplinary and based in

either primary or secondary care. Data collected as part of this review indicates that in 74% of communities, heart failure clinics were available across the whole or part of the community. The data also shows that the 'one-stop' nature and staffing of these clinics varied.

Although the majority of clinics offered clinical assessment and echocardiography on the same day and at the same site, six clinics (3.7%) did not offer an echocardiography service and 28.4% of clinics required the patient to attend a different site or return on a different day for echocardiography. The pattern is much the same for clinics based in secondary or primary care. However, when we consider the other investigations recommended by the national service framework and guidance from NICE to confirm or refute a diagnosis of heart failure, clinics based in primary care are less likely to be able to undertake X-rays, spirometry or blood tests on the same day, and very few clinics offer

24-hour electrocardiographic monitoring on the same day (see figures 8a and 8b). If these services can be more streamlined, patients with suspected heart failure will have shorter waiting times and a better experience of care.

The majority of clinics (68.4%) are run by specialist nurses and a consultant, who is either in attendance or available for advice. About 40% of clinics involve GPs or GPs with a special interest in cardiology. This is particularly the case with clinics based in primary care, where over 60% have input from GPs or GPs with a special interest in cardiology. Around a quarter of clinics (23.4%) involve a consultant, nurse and a GP with a special interest in cardiology. Just over 70% involve an echocardiography technician. There are no nurse-only clinics and very few clinics involving only a consultant or GP with a special interest in cardiology. This shows that the multidisciplinary nature of clinics advocated by the national service framework is being adopted in most places.

Figure 8a: Services offered at heart failure clinics: acute trusts



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute heart failure clinic diagnostic form

Figure 8b: Services offered at heart failure clinics: PCTs



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: PCT heart failure clinic diagnostic form

Criterion 2: Are patients receiving evidence-based treatment consistent with NICE guidelines and are they being monitored effectively to ensure optimum treatment and quality of life?

Just 32% of communities scored ‘good’ or ‘excellent’ for Criterion 2, and over half scored ‘fair’. Once again the distribution of results was quite different for each of the two questions, with more communities scoring highly on having guidelines for monitoring patients and more communities scoring ‘fair’ or ‘weak’ on optimisation of treatment (see figure 9).

Evidence-based treatment

Guidance from NICE states that patients with heart failure due to left ventricular systolic dysfunction should be considered for treatment with angiotensin converting

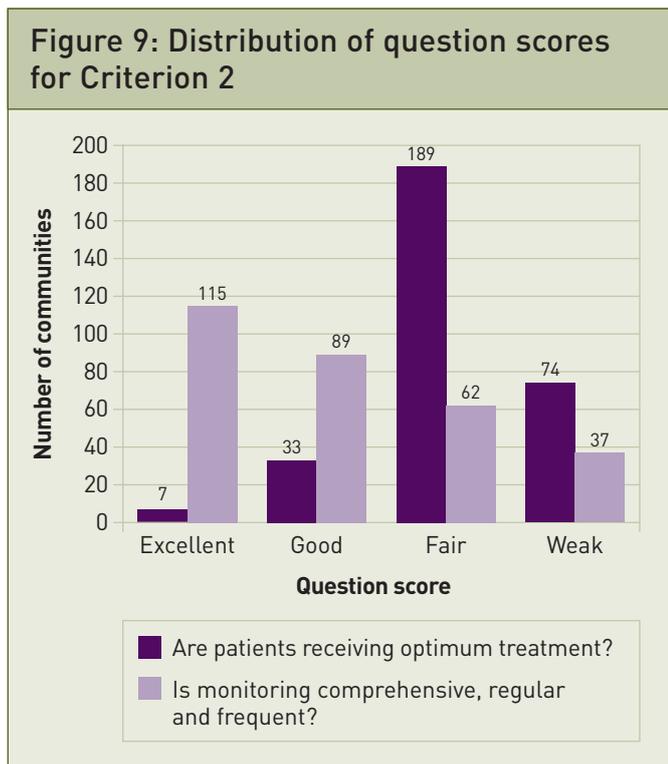
enzyme (ACE) inhibitors or angiotensin-II receptor (A2) antagonists.

Nationally, 85.2% of patients registered on GPs’ systems with a diagnosis of coronary heart disease and left ventricular dysfunction are recorded as being treated with an ACE inhibitor or A2 antagonist. While this level of achievement is considered to be positive at a national level, there is some variation in the average achievement in each PCT, and further still at practice level (see figures 10 and 11).

Guidance from NICE also recommends beta-blockade therapy, following the initiation of ACE inhibitor therapy. Unfortunately there is no nationally-available data on the level of beta-blockade therapy for patients with heart failure due to left ventricular dysfunction. However, our acute hospital portfolio review of admissions management (2005/2006) included a survey of patients discharged with a diagnosis of heart failure. This indicated that nationally, only 33.4% of patients discharged alive with a diagnosis of heart failure were prescribed beta-blockers, with values for individual trusts ranging from 11.1% to 66.7%. Clearly, this leaves considerable room for improvement.

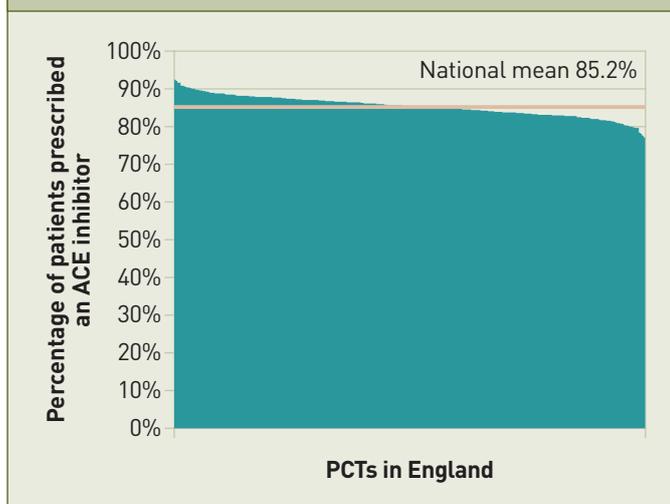
It is important that these treatments are started at a low dose, and then increased under careful monitoring to achieve an optimum dose, which balances management of the symptoms against undesirable side effects. This dose varies from patient to patient, but those not receiving optimal treatment may suffer a reduced quality of life or their condition may worsen, which may result in an unnecessary admission to hospital.

While we were unable to obtain any data on the number of patients treated at optimal dose, we asked organisations whether they had



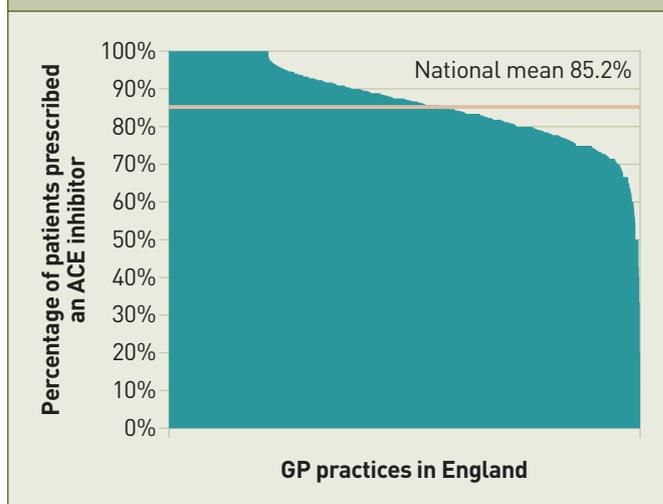
Source: Healthcare Commission heart failure service review 2005/2006

Figure 10: Percentage of patients with a diagnosis of coronary heart disease and left ventricular dysfunction who are prescribed an ACE inhibitor by PCT



Source: Department of Health General Medical Services Quality and Outcomes Framework 2005/2006, Quality Indicator LVD3

Figure 11: Level of variation between GP practices in the percentage of patients with a diagnosis of coronary heart disease and left ventricular dysfunction who are prescribed an ACE inhibitor



Source: Department of Health General Medical Services Quality and Outcomes Framework 2005/2006, Quality Indicator LVD3

clear guidelines in place which specified the arrangements and responsibilities for initiating and modifying medication in line with the guidance from NICE. We found that over 90% of organisations had local protocols that were consistent with NICE guidelines and over 80% of organisations specified where this responsibility lies – in either primary or secondary care.

Monitoring and review

The clinical condition of patients with heart failure may fluctuate considerably, sometimes resulting in repeated admissions to hospital. This is neither satisfactory for the patient nor the health service. It is therefore important that patients are monitored regularly and effectively to reduce the likelihood of deterioration or co-morbidity. The guidance from NICE recommends a maximum interval between reviews of no more than six months

for patients with a proven diagnosis who are stable, and no more than two weeks for patients whose clinical condition or medication has changed. As a minimum the review should cover the following:

- a review of the patient's concordance with their management plan with regard to diet, alcohol, exercise and rehabilitation
- a clinical assessment of functional capacity, fluid status, cardiac rhythm (minimum of examining the pulse), cognitive status and nutritional status
- a review of medication, including the need for changes and possible side effects
- measurement of serum urea, electrolytes and creatinine levels

More detailed monitoring is required for

patients with co-morbidities or who are prescribed multiple medications.

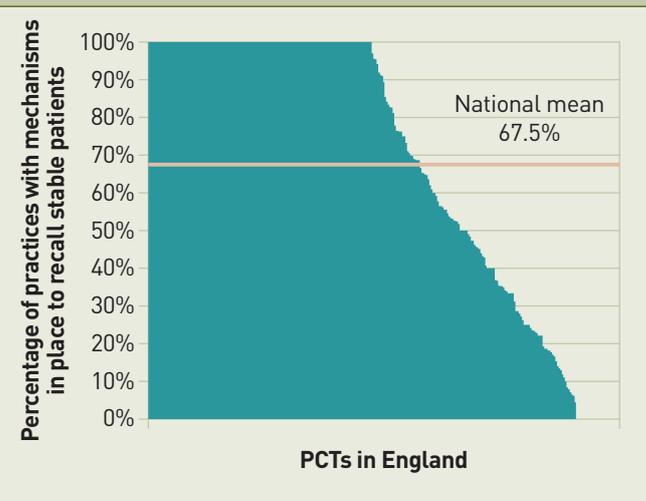
Our review showed that, as at March 31st 2006, 49% of organisations had guidelines that met these minimum requirements for the scope of the review, with a further 40.5% meeting some of the requirements. However, 10% of organisations had no written guidelines on the scope of routine monitoring.

We found that 66.5% of organisations had local guidelines on monitoring intervals, which were consistent with the recommendations from NICE. Many organisations specified more frequent reviews, particularly for patients whose condition was less stable. However, about a third of organisations had no written local guidelines stating the recommended intervals between monitoring patients.

The mere presence of written guidelines does not necessarily mean that all patients are being monitored effectively. However, local agreement on the arrangements and responsibilities for monitoring is an important first step in ensuring systematic care is provided to all patients.

Unfortunately we were unable to obtain any definitive data on the extent to which patients receive a routine review. However, about 50% of PCTs reported that all their practices had mechanisms in place to recall stable patients with confirmed heart failure for a review every six months, and around a third reported that fewer than 50% of practices had mechanisms in place (see figure 12). Clearly these guidelines need to be more firmly implemented in practice to achieve optimum care for patients.

Figure 12: Percentage of practices in the PCT that have mechanisms in place to recall stable patients with confirmed heart failure for a review every six months



Source: Healthcare Commission heart failure service review 2005/2006: PCT audit and clinical management form

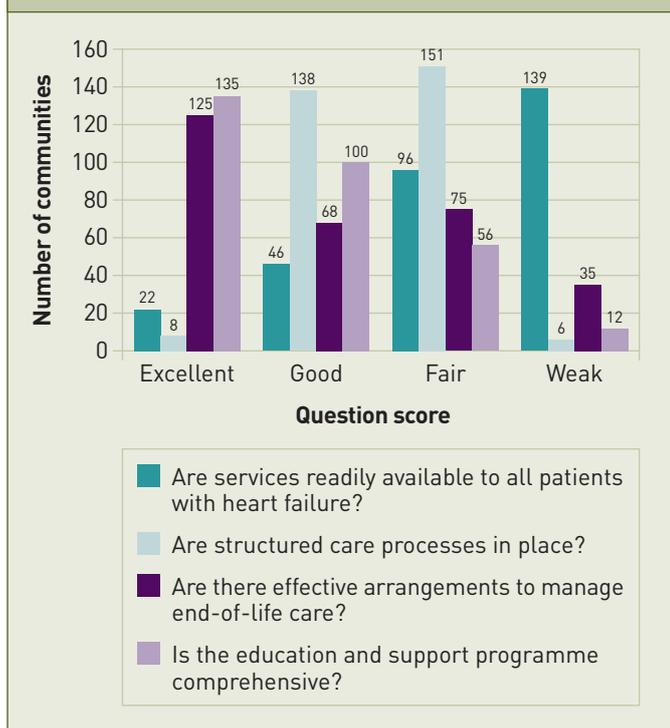
Criterion 3: Are there adequate and effective multidisciplinary services and care processes in place, which provide patients and carers with adequate education and support?

Performance on this criterion was the best overall, with 65% of communities scoring 'good' or 'excellent'. When the overall criterion score is broken down into its component question scores, we can see that the picture is more variable, with better performance on arrangements for education, support, and end-of-life care than for access to specialist services. Performance on care processes was more intermediate (see figure 13).

Systematic care

Heart failure is a complex condition to diagnose and manage. The British Society for Heart Failure recommends that all general hospitals should have one physician or

Figure 13: Distribution of question scores for Criterion 3



Source: Healthcare Commission heart failure service review 2005/2006

cardiologist with a special interest in heart failure responsible for developing and coordinating strategies for providing services for patients with suspected and confirmed heart failure.

The guidance from NICE states that referral to a specialist is required where a patient has severe heart failure, where their heart failure does not respond to treatment as described in the guideline, or where the patient can no longer be managed in the home.

The *National Service Framework for Coronary Heart Disease* also states that systematic care should include:

- 'outreach' follow-up of people admitted to hospital with heart failure by specialist nurses and others in order to provide education and support before they are discharged from hospital
- 'multidisciplinary support in the community' for those with established heart failure, including home-based interventions with access to social care, the local palliative care team for ongoing support, and palliative care advice as needed

Within this review, the level of access to specialist services was assessed according to two key indicators:

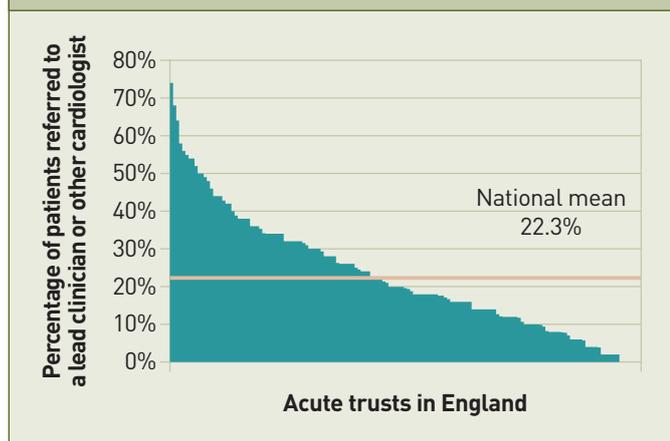
- 1 the percentage of hospital inpatients referred to the lead clinician for heart failure or other cardiologist where the primary cause of their admission was heart failure
- 2 the percentage of patients who were referred to a heart failure service following an admission for heart failure

Both of these indicators were derived from the survey of patients admitted to hospital with a diagnosis of heart failure, carried out as part of the acute hospital portfolio review of admissions management in 2005/2006.

Of the acute trusts in the review, 86.5% reported having a lead consultant for the care of patients with heart failure. However, only 22.3% of the patients in the acute hospital portfolio survey were referred to the lead clinician for heart failure or a cardiologist. Averages for trusts ranged from 0% to 74% (see figure 14).

As part of the review, we asked PCTs if any specialist staff were serving them, regardless of whether they were employed directly by the PCT. The results are summarised in table 6.

Figure 14: Percentage of patients referred to a lead clinician for heart failure or other cardiologist



Source: Healthcare Commission acute hospital portfolio review of admissions management 2005/2006: survey of patients admitted with heart failure

Despite over 80% of communities having some access to specialist heart failure nurses in primary or secondary care, only 24.4% of the patients included in the acute hospital portfolio survey were referred to a heart failure service following admission, with averages for trusts ranging from 0% to 94% (see figure 15).

These data suggest that while many communities have some specialist staff, few of the patients admitted to hospital as a result of their heart failure get access to them. This may be due to limited capacity and the criteria allowing access to services. Other data collected as part of the review showed that:

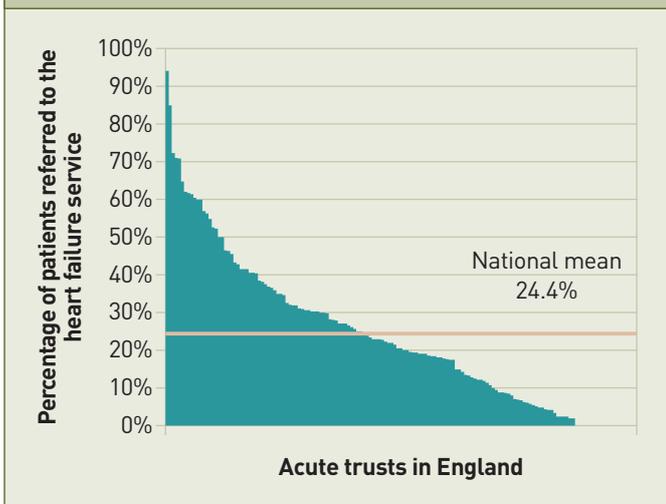
- 93.5% of specialist nurses employed in secondary care provided services to patients admitted with heart failure - regardless of the specialty or the ward of admission

Table 6: Percentage of PCTs served by specialist staff (based on filled sessions)

Staff group	Percentage of PCTs served by staff group
Specialist heart failure nurse working in primary care	64.9%
Specialist heart failure nurse working in secondary care (excluding general nurses in cardiology/care of the elderly, etc.)	46.2%
Specialist heart failure nurse working in primary or secondary care	81.6%
Other healthcare professional with specific responsibility for heart failure (working in primary care)	16.1%
Other healthcare professional with specific responsibility for heart failure (working in secondary care)	11.7%
GP with a special interest in cardiology working alongside consultant in hospital	8.0%
GP with a special interest in cardiology working in primary care	16.7%

Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT staffing forms

Figure 15: Percentage of patients discharged alive who were referred to the heart failure service following admission



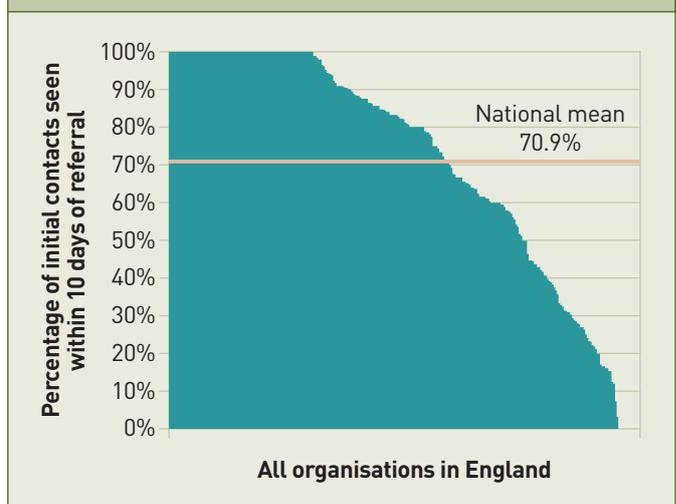
Source: Healthcare Commission acute hospital portfolio review of admissions management 2005/2006: survey of patients admitted with heart failure

- only 57.3% of the specialist nurses employed in primary care who provided 'in-reach' care (care given to patients while in hospital) covered all wards and specialities
- 43.2% of acute trusts employing specialist nurses provided outreach care following a patient's discharge from hospital and 37.3% provided outreach services to patients referred from within primary care
- between 60% and 70% of primary care-based specialist services were accessible by all patients discharged from secondary care, and by those referred from within the community or housebound patients in nursing and residential homes. Others only offered services to some patients. However, we did not ask for information on specific criteria to determine patients' eligibility

The European Task Force report on heart failure²⁴ recommended that patients should

have a first visit from specialist staff within 10 days of discharge from hospital. Similarly the guidance from NICE recommends that patients whose condition or medication has changed should be followed up within two weeks of the previous contact. While not directly comparable, this has tended to become an aspirational standard for waiting times from referral to initial contact with a specialist nurse. We attempted to collect data on waiting times from referral to initial contact with a specialist heart failure nurse as an indicator of access and capacity as part of this review. Not all organisations were able to provide this information, and there were problems in distinguishing between visits made to individual patients from appointments made at clinics. However, from the data supplied, we can see that the percentage of patients seen within 10 days of referral varies considerably (see figure 16). This suggests that many services are under pressure to see

Figure 16: Percentage of patients seen by a specialist nurse within 10 working days of referral (January 1st to March 31st 2006)



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT audit and clinical management forms

all patients referred to them within a reasonable timescale.

We also asked for information on the extent to which the arrangements for employing these specialist staff were consistent with guidance issued by the Department of Health^{25, 26}. We found that around 80% of organisations met the guidelines in areas relating to service specifications, contractual arrangements, competencies, clinical governance, clinical supervision and continuing professional development. Responses were slightly less positive for evaluation of services and clinical audit, which may be because the service had not been established long enough.

Patients with heart failure have a wide range of needs owing to the complexity of their condition and co-morbidities, which can require the input of many different professional groups. This care is most likely to be effective and coordinated if it is delivered by multidisciplinary teams. As part of the review, we collected data on the extent to which specialist heart failure staff worked as multidisciplinary teams, and which other associated professions were involved. Around 60% of organisations reported that specialist staff worked as part of multidisciplinary teams. The extent to which other professional groups were part of an extended multidisciplinary team was less common, and the professions involved varied between acute trusts and PCTs (see figures 17a and 17b).

All patients with long term conditions should have their needs assessed and have a management plan put in place to address those needs. In addition to an assessment of clinical need for patients with heart failure, the NICE guidance states that:

- the diagnosis of depression should be considered in all patients with heart failure

- the palliative needs of patients and carers should be identified, assessed and managed at the earliest opportunity
- patients with heart failure should be encouraged to adopt regular aerobic and/or resistive exercise
- management plans for patients with heart failure should be discussed with non-NHS agencies where they are involved in, or responsible for, the care of a person with heart failure

The national service framework also states that NHS services should:

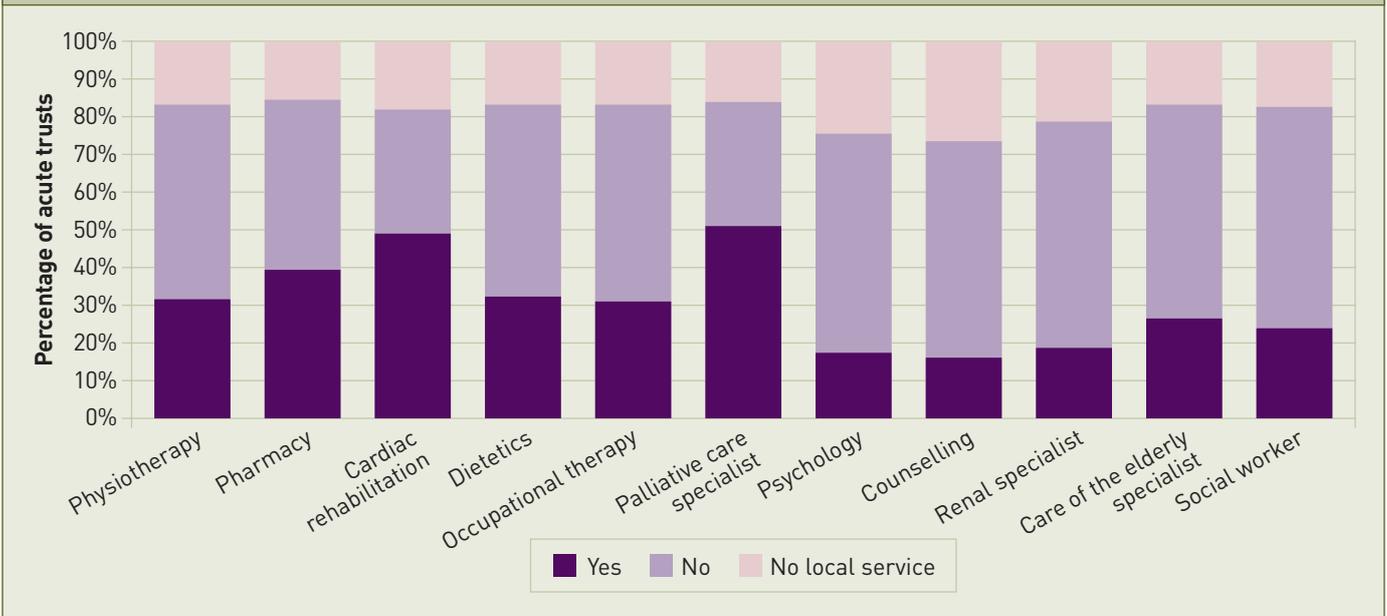
- make links with Social Services and put patients in touch with social support infrastructures
- consider the patient's potential to benefit from cardiac rehabilitation, palliative care services and palliation aids, long term social support and cardiac transplantation
- provide appropriate and timely treatment for other disorders

We assessed the extent to which care processes were structured by looking at the components of the patient assessment process and the percentage of patients who are discharged with a diagnosis of heart failure that are referred to rehabilitation (as a tracer of organisations' ability to meet those needs).

The majority of organisations providing services to patients with heart failure had fairly comprehensive assessment processes that addressed the various needs identified in the national service framework and NICE guidance (see figure 18).

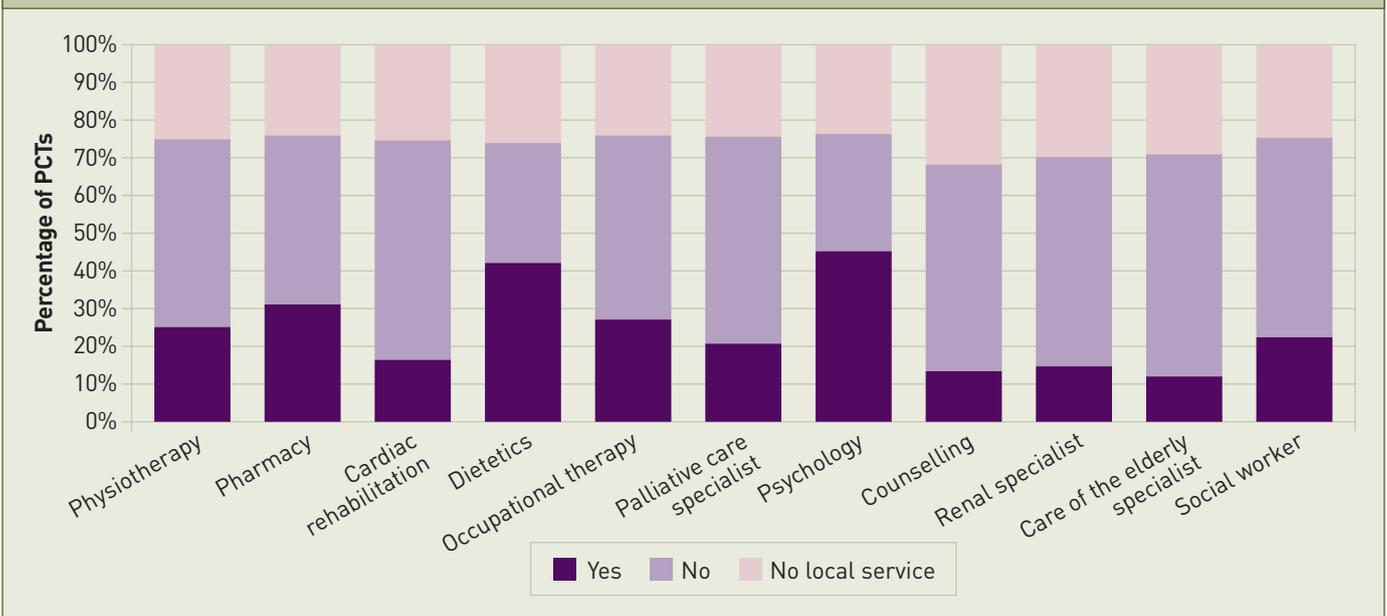
However, more attention could be given to evaluating the level of need for psychological or counselling support, as research indicates

Figure 17a: Professions forming part of the extended multidisciplinary team for heart failure: acute trusts



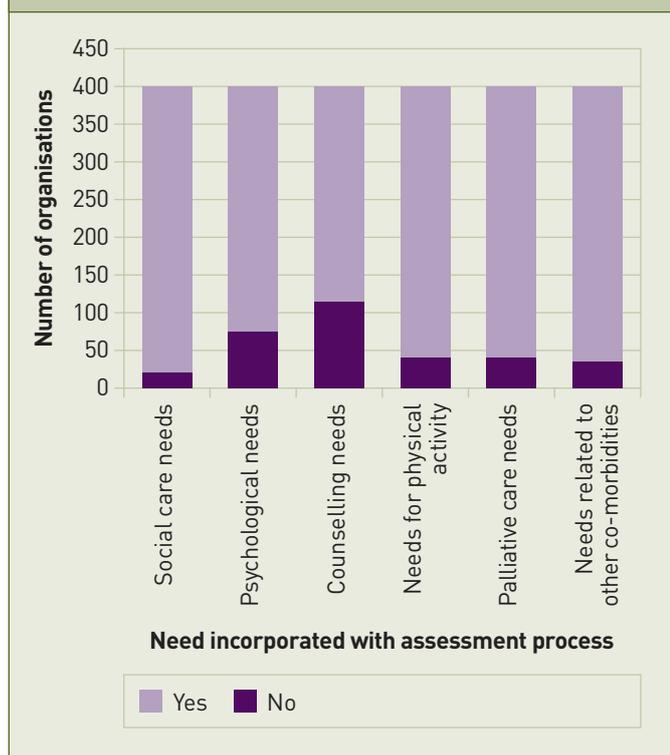
Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute staffing form

Figure 17b: Professions forming part of the extended multidisciplinary team for heart failure: PCTs



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: PCT staffing form

Figure 18: Components of the assessment process



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT coordinating care forms

that over a third of patients with heart failure experience severe and prolonged depressive illness.^{5, 27}

Exercise training has been shown to improve exercise capacity and quality of life in the short term for patients with mild to moderate heart failure. These benefits may extend to patients with more severe heart failure. However, further research is required to fully understand the benefits across a broader spectrum of patients.²⁸ Of the 6,998 patients in our survey of those admitted to hospital with heart failure that were discharged alive, only 5.7% were referred to rehabilitation, and averages for individual trusts varied considerably (see figure 19).

This suggests that while assessment processes may be comprehensive, getting access to the required services may be more difficult.

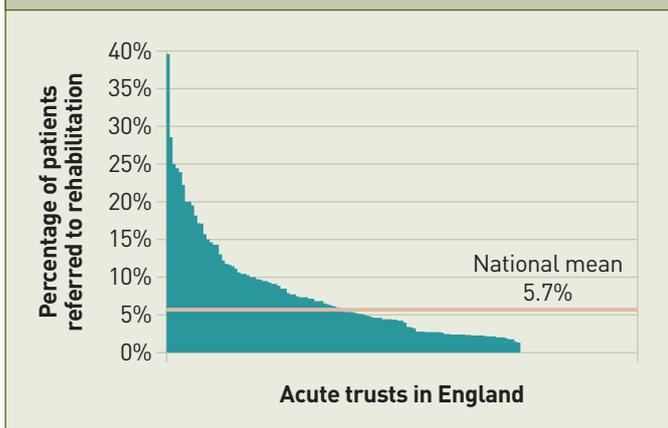
End-of-life care

Heart failure is a life-limiting condition, and patients live with a high degree of uncertainty and a risk of sudden death. However, unlike many cancers, the sporadic improvement and deterioration of the condition makes it difficult to predict when a patient is nearing the end of their life. However, good palliation and end-of-life care can improve symptoms and enhance the quality of life. For these reasons, patients need to be able to discuss end-of-life issues at all stages of their care, as recommended in the NICE guidance. They also need to have their end-of-life care needs assessed and managed, and to have access to professionals with appropriate specialist skills.

Policies on palliative care and services have largely developed around the needs of patients with cancer. However, the core principles and interventions are directly transferable to patients with other conditions such as heart failure.^{29, 18, 30, 31} Yet evidence indicates that patients with non-cancer related diagnoses have difficulty accessing such services.^{32, 33, 34} The Department of Health is developing an End-of-Life Care Strategy, which will provide guidance to those who commission and provide services on how to bring about improvements in end-of-life care at a local level. Its aim is to ensure that high quality care is provided for all patients at the end of their lives, irrespective of their diagnosis. The first report to ministers is expected in the autumn of 2007.

We were unable to obtain data on the numbers of patients with heart failure receiving specific end-of-life services, but as a proxy, we assessed communities by whether they:

Figure 19: Percentage of patients referred to rehabilitation (of those alive at discharge)



Source: Healthcare Commission acute hospital portfolio review of admissions management 2005/2006: survey of patients admitted with heart failure

- commission palliative care beds or services that are accessible to patients with heart failure
- have implemented or are developing systematic models to manage end-of-life care. These include the Liverpool Care Pathway*, the Gold Standards Framework** and the preferred place of care***. Any alternative local models were also accepted

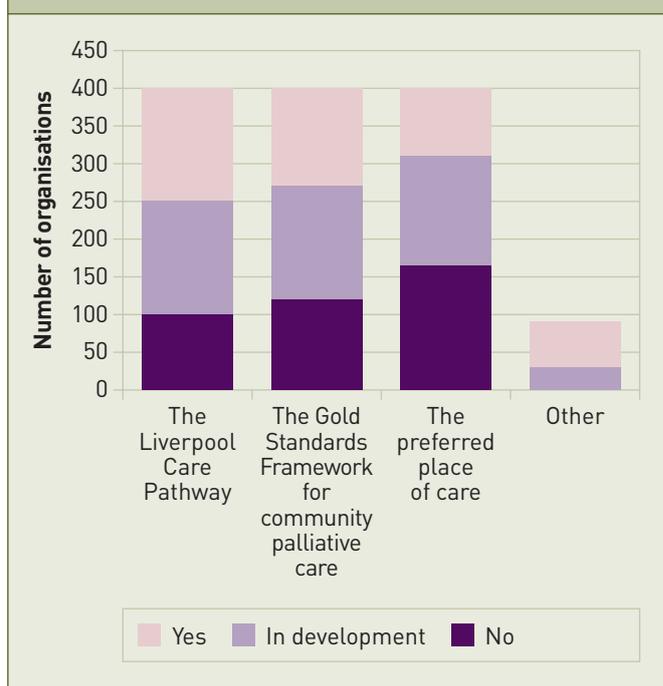
We found that 80% of PCTs commissioned some palliative care beds or services providing access to patients with heart failure and that many organisations had or were implementing recognised models of end-of-life care (see figure 20).

These results are very encouraging, but until there is more readily available data on the

delivery of services, we are unable to conclude whether this means that patients with heart failure are receiving the end-of-life care they need.

Effective palliative care relies on a good exchange of knowledge and skills between specialist palliative services and heart failure specialists. Our review also considered the arrangements in place to facilitate this sharing of expertise, although the responses did not contribute to the scored assessment.

Figure 20: Implementation of models of end-of-life care



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT coordinating care forms

* A continuous quality improvement framework for care of the dying, irrespective of diagnosis or place of death.

** A systematic approach to optimising the care delivered by primary care teams for any patient nearing the end of life in the community.

*** This is intended to be a patient-held record that will follow patients through their path of care into various different health and social care settings, which includes patients' thoughts, choices and preferences about their care.

Table 7: Opportunities for transferring knowledge and skills between specialist heart failure and palliative care services

Opportunity	Number of organisations answering 'Yes'	Number of organisations answering 'No'
Joint training initiatives	68.2%	31.8%
Joint projects to develop appropriate symptom management methods	65.5%	35.5%
Joint meetings to discuss individual cases	69.1%	30.9%
Joint meetings to discuss the general care approach	75.4%	24.6%

Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT staffing forms

Table 7 summarises the results for organisations employing specialist heart failure nurses.

Education and support

The guidance from NICE states: "Patients who wish to be involved in monitoring of their condition should be provided with sufficient education and support from their healthcare professional to do this, with clear guidelines as to what to do in the event of deterioration." It also stresses the importance of good communication, comprehensive information and the value of support groups and makes a number of recommendations relating to these issues.

In addition, in response to the consultation undertaken around the *Our health, Our Care, Our Say White Paper*,³⁵ the Department of Health announced in March 2007 that people with long term conditions or who need help from social services will receive 'information prescriptions' to guide them in finding relevant information about their condition.

Our review assessed the content of support and education programmes, the availability of

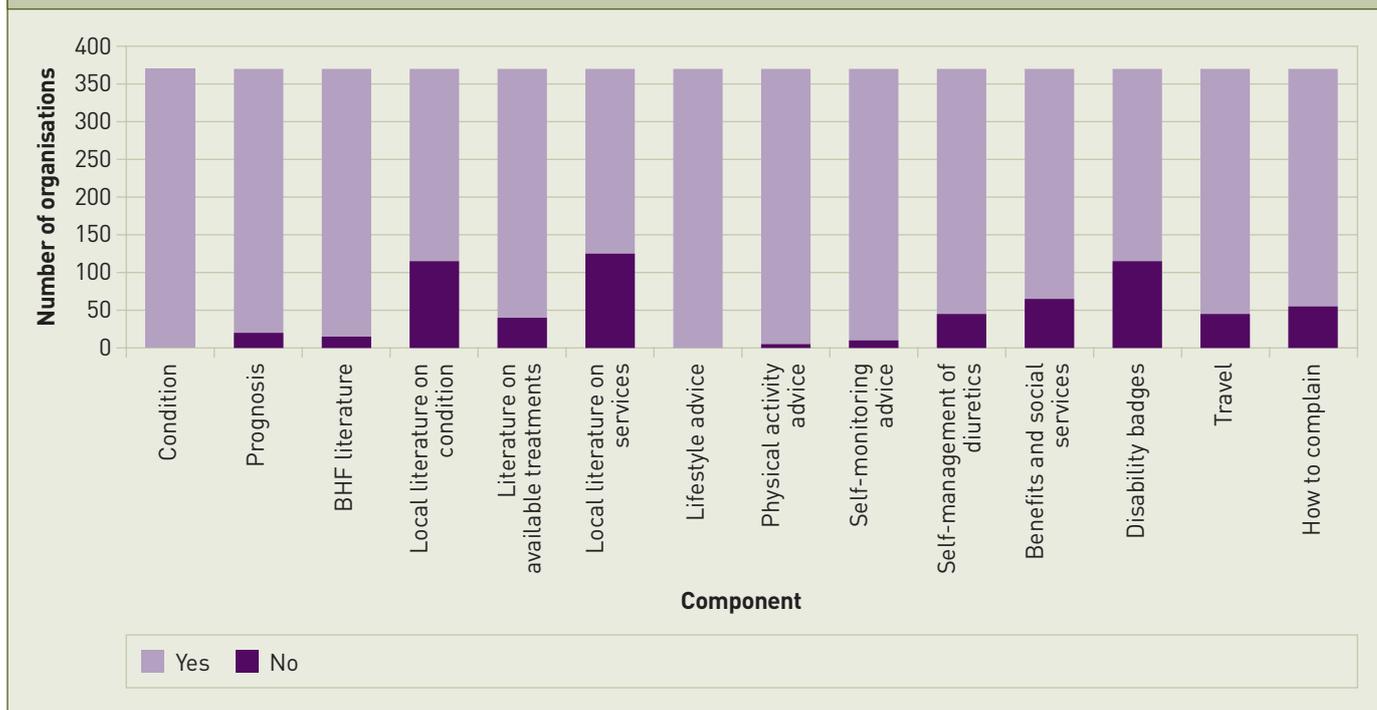
local support groups and whether patients were automatically given contact details for these groups.

We found that 90% of organisations providing services offer some form of education and support programme, and that these are generally very comprehensive, as indicated in figure 21.

However, more could be done to provide information on local services and some of the more pragmatic issues related to living with heart failure such as access to benefits and social services, or obtaining disabled parking permits. In addition, not all services provided information on how to complain (a basic requirement included in the core standards *Standards for Better Health*³⁶). Clearly more needs to be done to meet the commitments made by the Department of Health on information prescriptions.

Ninety-six per cent of organisations who provided services directly to patients with heart failure had some form of locally-accessible patient support group. However, of these, only 51% of organisations automatically

Figure 21: Content of support and education programmes



Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT supporting self care forms

provided contact details to patients. This is something that could easily be rectified.

Having someone to contact to discuss any concerns also featured highly in our consultation with patients during the development stage of the review (see table 3).

We found that 89.8% of organisations providing services to patients with heart failure provided a telephone number so that patients could contact a person who was familiar with their case, if they had any concerns or problems relating to their condition or medication. However, only about 20% of organisations provided any telephone support in the evenings or at weekends. This means that there are long periods when most patients only have access to out-of-hours,

emergency or NHS Direct services for advice.

Telephone support not only helps to alleviate anxiety, but structured programmes of telemonitoring or telephone support have been shown to have a positive effect on clinical outcomes and the quality of life for patients living with heart failure in the community, resulting in reduced rates of admission and death from all causes.³⁷

Involving patients in the development of services

Section 11 of the Health and Social Care Act 2001³⁸ places a duty on the NHS to consult and involve patients and the public in the planning and development of health services and in making decisions affecting the way those services operate. Responses to our review

indicate that 79% of acute trusts and 88% of PCTs had at least one of the following mechanisms in place to actively engage patients with heart failure in the development or evaluation of services:

- a patient representative on a steering or planning group for heart failure services
- patient focus groups
- heart failure or cardiac support group consulted on quality or development of services
- British Heart Foundation 'hearty voices' programme
- other mechanism

While this indicates good progress, all organisations need to ensure that they are meeting their duty in this regard.

Provision of funding

The earlier review of progress on implementing the national service framework, carried out by the Healthcare Commission in 2003/2004, found that there was a lack of funding for specialist heart failure services. As part of this review, we asked organisations whether provision had been made for recurrent funding for all existing and planned heart failure services, as at March 31st 2006. The responses are summarised in table 8.

This indicates that some existing services may be unsustainable, and a third of planned developments may not come to fruition due to lack of funding. Anecdotal feedback suggests that some organisations are disbanding their specialist heart failure services due to financial pressures. This makes it all the more important to be able to demonstrate improved outcomes for patients and cost benefits arising from specialist teams.

Table 8: Had recurrent funding provision been made for all existing and planned heart failure services, as at March 31st 2006?

	Existing services		Planned services	
	Number	Percentage	Number	Percentage
Yes	403	88.6%	215	62.3%
No	52	11.4%	130	37.7%
No development plans in place			110	
Total	455	100	455	100%

Source: Healthcare Commission heart failure service review bespoke data collection 2005/2006: acute and PCT service models and protocols forms

Criterion 4: Are services having a positive impact on hospital admissions, mortality and patient experience?

Seventy per cent of communities scored 'fair' for Criterion 4, and the distribution of results was very similar for each of the two key questions (see figure 22):

- 1 Are services having a positive impact on admissions and mortality?
- 2 Has the national service framework milestone for audit been met?

Outcomes for patients

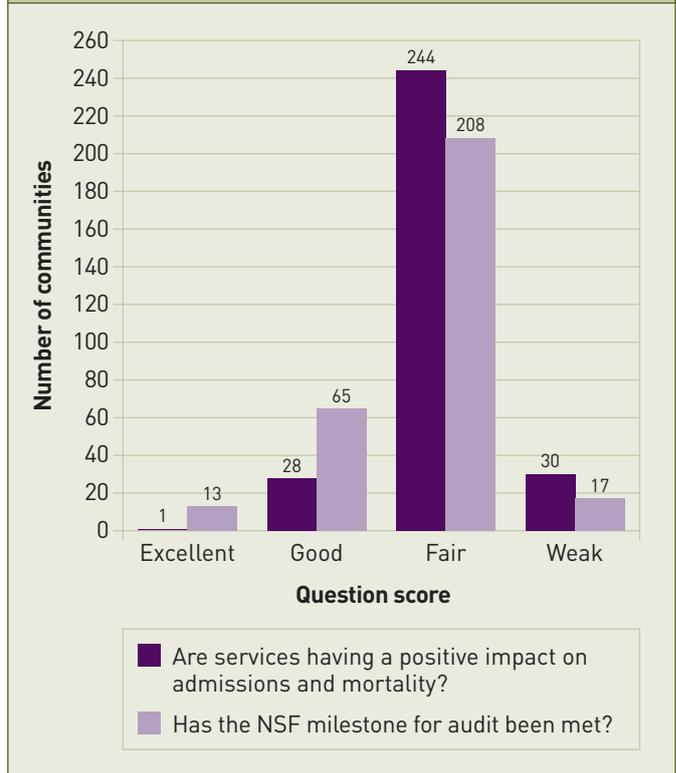
Heart failure accounts for about 5% of all medical admissions to hospital and people with the condition are frequently re-admitted to hospital. Re-admission rates for people with heart failure are among the highest for any common condition in the UK, many of which may be preventable.^{39, 40}

It should be possible to support most patients with heart failure in the community through good multidisciplinary care. A number of studies have demonstrated that effective specialist heart failure services can have a positive impact on rates of admission, re-admission and mortality.⁴¹ If a patient's condition worsens, they may need hospital care, but this can be avoided in many cases by optimal control of symptoms and routine monitoring. Reducing admissions for patients with heart failure, where appropriate, has a great potential to impact on the Public Service Agreement¹⁵ target to reduce emergency bed days by 5% by 2008.

We explored this issue through two key indicators:

- indirectly standardised re-admission within 30 days of admission ratios (2002/2003 to 2004/2005)

Figure 22: Distribution of scores by question in Criterion 4



Source: Healthcare Commission heart failure service review 2005/2006

- indirectly standardised 30-day mortality ratios (2002/2003 to 2004/2005)

Differences in outcomes for patients can be due to age or gender. Standardisation takes account of the variation in age and gender in populations, and allows more reliable comparisons to be made. It allows us to calculate an expected value for an indicator in a given population, which is then compared with the observed value in order to derive a ratio. A ratio of less than one would mean that the observed rate was lower than expected and vice versa.

We found that indirectly standardised ratios for re-admission within 30 days of discharge

varied from 0.39 to 2.16. This shows that the highest ratio is over five times more than the lowest ratio. While only 5% of communities had significantly worse ratios and 3% of communities significantly better ratios when tests of statistical significance were applied, this suggests that more could be done in some communities to reduce the likelihood of re-admission for patients with heart failure.

The variation in indirectly standardised 30-day mortality ratios was less extreme, with a range of 0.70 to 1.4 (twice the difference). In this case, 6% of communities had significantly worse ratios and 7% of communities had significantly better ratios when tests of statistical significance were applied. More detailed research would be required to understand the causal factors resulting in these differential outcomes, but with effective systematic care it should be possible to close the gap between the best and the worst performers.

Clinical audit

Clinical audit is a means of determining whether agreed models of care are being delivered and to inform improvement in the quality of care where necessary. The Government and General Medical Council expect all doctors to participate in clinical audit. The national service framework set milestones for NHS organisations to have an annual audit process for heart failure in place – by April 2002 in hospitals and by April 2003 in primary care teams. It also set out the audit criteria that should be measured. In addition, the NICE guidance listed additional audit criteria to monitor the implementation of its recommendations.

Our review evaluated the extent to which these milestones and criteria had been met. Only 18.5% of PCTs and 19.5% of acute trusts could meet all the criteria for all practices and specialties. Five PCTs and 26 acute trusts could meet none of the audit criteria. This is disappointing, given that it is now four years since the deadline for the second milestone.

There are some good local examples of wide-ranging heart failure audits being undertaken. However, at present, there is no national system for auditing the care of people with heart failure. The British Society for Heart Failure has been developing a minimum data set for acute care, and is working with the Healthcare Commission and the Health and Social Care Information Centre to establish effective data collection systems and an audit programme. The quality and outcomes framework for general practice includes some indicators relating to heart failure, but there is still much work to be done to establish comprehensive audit arrangements across primary and outpatient care.

The experience of patients

Our review considered two indicators in relation to the experience of patients, although these did not contribute to the assessment score:

- 1 Does the local service carry out any evaluation of patient satisfaction through a locally designed survey, discovery interviews* or other mechanisms?
- 2 Does the local service carry out any evaluation of patients' quality of life using local, national or international tools?

* Developed by the former NHS Modernisation Agency as a means to explore the impact of illness on patients' everyday lives during each stage of their journey through the healthcare system.

We found that only 52% of organisations had undertaken an evaluation of patients' satisfaction with specialist heart failure services in 2005/2006 and that only 35.6% of organisations were carrying out a systematic evaluation of the quality of life for patients with heart failure using any of the following tools:

- a locally-defined survey
- the Minnesota Living With Heart Failure Questionnaire
- the Euro Heart Failure Survey
- the Hospital Anxiety and Depression (HAD) scale
- the Short Form 36 questionnaire
- other tool

In addition to better information on audited outcomes for patients, we need to know more about the experiences of patients to ensure that heart failure services are of benefit to them.

Conclusions

This review demonstrates that there have been some very positive steps forward in developing services for patients with heart failure, particularly with regard to access to echocardiography and diagnostic waiting times, the development of specialist services and guidelines, treatment with key evidence-based medicines, frameworks for palliative and end-of-life care and programmes of education and support. Many of the issues identified in the earlier reviews of progress with implementing the *National Service Framework for Coronary Heart Disease* have been addressed.

However, there are still concerns that all patients with heart failure are not being identified, as the recorded prevalence falls short of that predicted from research evidence. The review has also highlighted the need to ensure that all patients with suspected heart failure have access to appropriate investigations to confirm or refute the diagnosis, and that all those with a confirmed diagnosis are provided with the full range of optimal treatments to manage their symptoms and improve their quality of life. This is best achieved through access to specialist services and routine monitoring to prevent deterioration and potentially avoidable admissions to hospital.

While our review demonstrates that most localities have developed clear guidelines and specialist services, these services are not universally accessible. If a previously unidentified demand for diagnosis and care emerges, it could have adverse implications on the capacity of services to deal with extra demand, the costs of prescribing and length of waiting times.

Our review showed that once local services have the basics in place, more attention needs to be given to meeting the needs of patients that go beyond the immediate control of symptoms, such as providing rehabilitation, counselling and psychology services to improve their quality of life. Organisations also need to do more to assess and respond to the experience of patients by evaluating the satisfaction and quality of life of patients.

Research has shown that effective systematic care for patients with heart failure can reduce hospital admissions, re-admissions and mortality. Data pooled for the years 2002/2003 to 2004/2005 demonstrates wide variation in the level of observed re-admission and mortality across PCTs in England when compared with the expected rates (after adjusting for age and sex). This may reflect the capacity and differing levels of maturity of specialist services in different localities. More detailed research using randomised controls would be required to determine the impact of local service models and provision on these outcomes. However, outcomes for patients are more likely to be improved if treatment is optimised and patients are monitored effectively to detect any deterioration.

Clinical audit data relating to heart failure is not widely available in all localities. Many organisations were unable to meet the milestones of the national service framework for the provision of audit data, which should have been achieved by April 2003. In the absence of such information, services will be unable to determine whether all patients are gaining access to relevant systematic care and to demonstrate that they are cost effective. The ability to estimate future need and plan for developing services will also be severely hindered.

Recommendations

Commissioners and service providers in primary and secondary care need to work together within local networks of care to assure themselves and their populations that they are making progress on Standard 11 of the *National Service Framework for Coronary Heart Disease* and in implementing the guidance from NICE on the management of chronic heart failure in adults in primary and secondary care. The following recommendations set out the specific actions that PCTs, acute trusts, strategic health authorities and professional bodies should undertake to ensure that the services provided to patients with heart failure are of high quality.

PCTs and commissioners should:

- review their local recorded prevalence for heart failure against national predicted rates and take action as necessary to address shortfalls to ensure that all patients with symptoms of heart failure are identified and properly investigated
- work together with providers to implement arrangements to ensure that all patients with suspected heart failure have rapid access to the key defining investigations to confirm or refute the diagnosis and its underlying causes in order to determine the most effective course of treatment and care management

- work together with service providers to ensure that all patients with confirmed heart failure have access to the specialist advice and services they require, based on a holistic assessment of their needs. This should be achieved by specifying and commissioning cost effective models of multidisciplinary service delivery which are consistent with the recommendations in the national service framework and NICE guideline. Such a multidisciplinary service should seamlessly encompass both primary and secondary care, with easy and quick access between the two areas. There should also be quick access to specialist clinicians. In the case of hospital-based services, access to specialist clinicians and teams should be given on the basis of need and not related to the ward or specialty of admission
- give more consideration to the psychological and rehabilitation needs of patients with heart failure and commission appropriate specialist services
- ensure that commissioned services participate in the national heart failure clinical audit
- work together with strategic health authorities to ensure that there is a sustainable regional network of services for patients with heart failure

Service providers in primary and secondary care should:

- aim to ensure that diagnostic clinics provide a 'one stop' service, with, as a minimum, access to clinical assessment and echocardiography on the same visit

- ensure that all patients with confirmed heart failure have access to all recommended medication at the optimal dose, in line with the NICE guidelines, in order to effectively manage their symptoms and maximise their outcomes. In particular, providers should aim to achieve prescribing rates for ACE inhibitors that match those of the best performing communities, and seek significant improvements in prescribing rates for beta-blockers
- agree and implement guidelines for monitoring patients, which are consistent with the NICE guidelines for the scope and frequency of monitoring
- develop or adopt methods for evaluating patients' satisfaction and quality of life and act on the findings to improve the quality of services from the patient's perspective
- develop systematic and comprehensive audit arrangements to evaluate whether all people with heart failure are receiving a full package of appropriate investigation and treatment that results in positive outcomes for patients. Commissioners and providers should use this data to evaluate the effectiveness and quality of service delivery and act on the results where necessary

If they have not done so already, boards of trusts can compare their performance with that of other communities and identify areas for improvement. The individual results for each community are available on the Healthcare Commission's website at: www.healthcarecommission.org.uk/improvementreviewheartfailure.

Strategic health authorities should:

- work together with commissioners to ensure that there is a sustainable regional network of services for patients with heart failure
- ensure that each community has an action plan addressing all areas of weakness identified in the Healthcare Commission's individual community assessments

Professional bodies and cardiac networks should:

- use the information provided in this report and other comparative data made available by the Healthcare Commission to press for the improvement of services for patients with heart failure, in line with the above recommendations
- continue to lobby for the development of comprehensive data sets and programmes of audit to evaluate the quality and effectiveness of services delivered to patients with heart failure in all care sectors, and which address the issues identified by this report

Next steps

Work with communities most in need of improvement

The Healthcare Commission has already commenced work with the 26 communities who were assessed as having a score of 'weak' by the review and deemed most in need of improvement. These communities will be required to produce an improvement plan that addresses the key issues that affected their score and to make their plans accessible to the public by publishing them on their local websites. Our regional staff will monitor progress against these plans and performance will be managed by the relevant strategic health authority or, in the case of foundation trusts, by their board. We are working collaboratively with the NHS Heart Improvement Programme and local cardiac networks to support this improvement activity.

Improvement across all communities

This report highlights a number of concerns and we expect all commissioners and providers of services to work together in local communities to ensure that the recommendations are met in full.

The boards of all primary care and acute trusts should develop plans based on the areas of weakness identified in their local community assessment reports and be responsible for ensuring that they are achieved. Boards of foundation trusts are also required to inform Monitor if the trust is at risk of failing to improve in any areas of concern identified by this review. Informal feedback received during and following the review indicates that many organisations have already taken steps to improve local services based on the lessons learned by participating in the review.

Strategic health authorities have a responsibility to hold all organisations (except foundation trusts) to account for improvements. They, with commissioners, will also be expected to lead planning at a regional level.

Our local assessment managers will check that PCTs and acute trusts are addressing poor performance and our regular discussions with strategic health authorities will ensure that our recommendations are accounted for in their systems for managing performance and planning.

Collection of follow-up indicators

We intend to monitor future performance relating to issues in this review, using a small number of indicators selected from the framework of assessment that focus on the areas of most benefit to patients and which have most room for improvement. The specific indicators will be subject to further discussion, but are likely to include those relating to diagnosis, prescribing, re-admission and mortality rates. They will be derived from nationally-available data sources wherever possible, rather than a specific data collection. The process for monitoring performance against these indicators is currently being developed for our other service reviews, which were completed in 2005/2006. This will apply to the heart failure service review once the organisations involved have had an opportunity to make improvements based on the results of their initial assessment. Further details will be released in due course.

A national audit of heart failure in hospital

The general lack of routinely available high quality data relating specifically to patients with heart failure has been an enduring issue for this review. We have been actively promoting the development of a national audit of heart failure by the British Society for Heart Failure and we are sponsoring the supporting programme of work being undertaken by the Health and Social Care Information Centre. Findings from the pilot phase of the audit were reported in May 2007, and are currently being evaluated to inform the national roll-out of the audit, which is planned to commence this year. In time, this will improve our ability to evaluate the quality of care being given to patients with heart failure at a local and national level. However, to be truly effective, any such audit will need to extend its scope to outpatient and primary care settings as well as the acute sector.

We will encourage participation in the audit, once it is rolled out, by including measures of participation in our ongoing process for cross checking trusts' compliance with core standard C05: "Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services". In time, and with the agreement of the relevant parties, indicators from the audit may be used to provide additional assurance that the standards are being met.

References

- 1 Department of Health (2003) *Improvement, Expansion and Reform: the next 3 years, Planning and Priorities Framework 2003-2006*.
- 2 Shah S, Davies M, Cartwright D, Nightingale P (2004) *Management of chronic heart failure in the community: role of a hospital based open access heart failure service*. Heart, July 2004; 90: 755-9.
- 3 Murphy N F, McAlister F A et al. Heart 2004; 90 (Suppl II): P5-6. *The influence of socio-economic deprivation on the primary care burden and treatment of heart failure in Scotland*. See also: McAlister F A et al. *Influence of socioeconomic deprivation on the primary care burden and treatment of patients with a diagnosis of heart failure in general practice in Scotland: population based study*. BMJ, 2004; 328:1110.
- 4 MacIntyre K, Capewell S, Stewart S et al. *Evidence of improving prognosis in heart failure: trends in case fatality in 66,547 patients hospitalized between 1986 and 1995*. Circulation, 2000; 102:126-31.
- 5 Sharpe N, Doughty R (1998) *Epidemiology of heart failure and ventricular dysfunction*. The Lancet;352:suppl 1, 3-7.
- 6 NHS Modernisation Agency (2004), *Coronary Heart Disease Collaborative: Heart Failure Workstream Progress Report*.
- 7 Brown A, Cleland J G F (1998) *Influence of pattern of concomitant disease on patterns of hospitalisation in patients with heart failure discharged from Scottish hospitals in 1995*. European Heart Journal 1998; 19:106-9.
- 8 Reitsma J B, Mosterd A, De Craen A J M, et al (1996), *Increase in hospital admission rates for heart failure in the Netherlands, 1980-1993*. Heart, 1996;76:388-92.
- 9 Krumholz H M, Parent E M, Tu N, et al.(1997) *Re-admission after hospitalization for congestive heart failure among medicare beneficiaries*. Arch Intern Med, 1997;157:99-104.
- 10 Croft J B, Giles W H, Pollard R A, Casper M L, Anda R F, Livengood J R (1997), *National trends in the initial hospitalisation for heart failure*. J Am Geriatrics Society, 1997; 45: 270-75.
- 11 Blue L, Lang E, McMurray J J V, et al. (2001) *Randomised controlled trial of specialist nurse intervention in heart failure*. BMJ 2001;323:715-8.
- 12 Stewart S, Horowitz J D (2002), *Home-based intervention in congestive heart failure: long-term implications on re-admission and survival*. Circulation;105:2861-6.
- 13 McAlister F A, Lawson F M, Teo K K, Armstrong P W (2001), *A systematic review of randomized trials of disease management programs in heart failure*. American Journal of Medicine; 110:378-84.
- 14 Capomolla S (2002), *Cost/utility ratio in chronic heart failure: comparison between heart failure management program delivered by day-hospital and usual care*. Journal of the American College of Cardiology; 40:1259-66.
- 15 Office of the Deputy Prime Minister (2004), *Spending Review Public Services Agreement*.

- 16 Department of Health (2000), *The National Service Framework for Coronary Heart Disease*.
- 17 Department of Health (2003), *The National Service Framework for Coronary Heart Disease: Delivering Better Heart Services: Progress Report 2003*.
- 18 National Institute for Clinical Effectiveness (now NICE) (2003), Clinical Guideline 5: *Chronic heart failure: Management of chronic heart failure in adults in primary and secondary care*.
- 19 Healthcare Commission (2005), *Getting to the heart of it: Coronary heart disease in England: A review of progress towards the national standards*.
- 20 Davies M K, Hobbs, F D R, Davis R C, Kenkre J E, Roalfe A K, Hare R, Wosornu D, Lancashire R J (2001), *Prevalence of left ventricular systolic dysfunction and heart failure in the Echocardiographic Heart of England Screening study: a population based study*. The Lancet 358: 439-44.
- 21 Department of Health (2004), *NHS Improvement Plan*.
- 22 Department of Health (2002), *Guidelines for the appointment of general practitioners with special interests in undertaking procedures: echocardiography*.
- 23 Chambers J, Fuat A, Liddiard S, McDonagh T, Monaghan M, Nihoyannopoulos P, Senior R, Southall E (2005) *Consensus statement: Community Echocardiography for Heart Failure*.
- 24 European Society of Cardiology (2001), *Task Force Report: Guidelines for the diagnosis and treatment of chronic heart failure*. European Heart Journal; 22: 1527-1560.
- 25 Department of Health (2003), *Practitioners with Special Interests in primary care: implementing a scheme for nurses with special interests in primary care: Liberating the talents*.
- 26 Department of Health, Royal College of General Practitioners (2002), *Implementing a scheme for General Practitioners with special interests*.
- 27 Lynn J, Harrell F, Cohn F et al (1997), *Prognoses of seriously ill hospitalised patients on the days before death: implications for patient care and public policy*. New Horizons 1997;5:56-61.
- 28 Rees K, Taylor R S, Singh S, Coats A J S, Ebrahim S (2004), *Exercise based rehabilitation for heart failure*. Art. No.: CD003331. DOI:10.1002/14651858.CD003331. pub2.
- 29 National Institute for Clinical Effectiveness (2004), *Improving supportive and palliative care for adults with cancer*.
- 30 National Council for Palliative Care (2003), Briefing Paper No. 12: *Palliative Care for Adults with Non-Malignant Diseases: Developing a National Policy*.
- 31 Department of Health (not published at time of going to press) *End of Life Care Strategy*.
- 32 Addington-Hall J (1998), *Reaching Out: Specialist Palliative Care for Adults with Non-Malignant Disease*, National Council for Palliative Care.
- 33 The House of Commons Health Select Committee (2004), *Inquiry into Palliative Care*.

- 34 National Council Palliative Care (2005), Briefing Bulletin No.14: The Palliative Care Needs of Older People.
- 35 Department of Health (2006), *Our health, Our Care, Our Say White Paper*.
- 36 Department of Health (2004), *Standards for Better Health*.
- 37 Clark R A, Inglis S C, McAlister F A, Cleland J G F, Stewart S (2007), *Telemonitoring or structured telephone support programmes for patients with chronic heart failure: systematic review and meta-analysis*. British Medical Journal, 10 April 2007.
- 38 Department of Health (2001), Health and Social Care Act 2001.
- 39 Cowie M R, Mosterd A, Wood D et al (1997), *The epidemiology of heart failure*. European Heart Journal;18:208-225.
- 40 Scottish Intercollegiate Guidelines Network (1999), *Diagnosis and Treatment of Heart Failure due to Left Ventricular Systolic Dysfunction*. SIGN Publication number 35, Royal College of Physicians, Edinburgh, Scotland.
- 41 Garg R, Yusuf S for the Collaborative Group on ACE Inhibitor Trials (1995), *Overview of randomised trials of angiotensin-converting enzyme inhibitors on mortality and morbidity in patients with heart failure*. JAMA;273:1450-6.

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ENGLISH

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે. મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

GUJARATI

ਇਹ ਜਾਣਕਾਰੀ ਬਿਨਤੀ ਕਰਨ 'ਤੇ ਹੋਰਨਾਂ ਰੂਪ 'ਚ ਅਤੇ ਜ਼ਬਾਨਾਂ 'ਚ ਮਿਲ ਸਕਦੀ ਹੈ। ਕ੍ਰਿਪਾ ਕਰਕੇ ਟੈਲਿਫੋਨ ਨੰਬਰ 0845 601 3012 'ਤੇ ਫੋਨ ਕਰੋ।

PUNJABI

यह जानकारी बिनती करने पर अन्य रूप में और भाषाओं में मिल सकती है। कृपया टैलिफोन नम्बर 0845 601 3012 पर फ़ोन करें।

HINDI

Akhbaartan waxaa lagu helaa iyadoo siyaabo iyo luqado kale ku qoran haddii la codsado. Fadlan soo wac lambarka telefoon ee ah 0845 601 3012.

SOMALI

Οι παρούσες πληροφορίες διατίθενται και σε άλλες μορφές ή γλώσσες εάν ζητηθεί. Τηλεφωνήστε στο 0845 601 3012

GREEK

المعلومات متاحة أيضاً لدى طلبها بعدد من الأشكال واللغات الأخرى. الرجاء الإتصال بهاتف رقم 0845 601 3012.

ARABIC

یہ معلومات درخواست کرنے پر دوسرے فارمیٹ یعنی شکلوں میں بھی دستیاب کی جاسکتی ہے۔
برائے مہربانی فون کیجئے 0845 601 3012

URDU

如有需要，本信息还有其他格式和语言的版本。请致电 0845 601 3012。

CHINESE-SIMPLIFIED

如有需要，本信息還有其他格式和語言的版本。請致電 0845 601 3012。

CHINESE-TRADITIONAL

অনুরোধ করলে এই তথ্যগুলি অন্য ভাষা ও আকৃতিতে পাওয়া যাবে। অনুগ্রহ করে এই নাম্বারে ফোন করুন 0845 601 3012

BENGALI

Arzu edildiği takdirde bu bilgi değişik formatlarda ve dillerde verilebilir. Lütfen 0845 601 3012 numaralı telefonu arayınız.

TURKISH

Tin tức này có bằng những hình thức và ngôn ngữ khác theo yêu cầu.

Hãy gọi phôn số 0845 601 3012

VIETNAMESE

È possibile richiedere le presenti informazioni su altri supporti o in altre lingue. A tal fine, telefonare allo 0845 6013012.

ITALIAN

Informacje te są dostępne na życzenie w innych formatach i językach.

Prosimy zadzwonić pod numer 0845 601 3012

POLISH

Healthcare Commission

Finsbury Tower
103-105 Bunhill Row
London
EC1Y 8TG

Maid Marian House
56 Hounds Gate
Nottingham
NG1 6BE

Dominions House
Lime Kiln Close
Stoke Gifford
Bristol
BS34 8SR

Kernel House
Killingbeck Drive
Killingbeck
Leeds
LS14 6UF

5th Floor
Peter House
Oxford Street
Manchester
M1 5AX

1st Floor
1 Friarsgate
1011 Stratford Road
Solihull
B90 4AG

Telephone 020 7448 9200

Facsimile 020 7448 9222

Helpline 0845 601 3012

Email feedback@healthcarecommission.org.uk

Website www.healthcarecommission.org.uk

This publication is printed on paper made
from a minimum of 75% recycled fibre

ISBN 978-1-84562-147-6



9 781845 621476



Corporate member of
Plain English Campaign
Committed to clearer communication.

341