CARDIFF AND VALE UNIVERSITY HEALTH BOARD HEART DISEASE LOCAL DELIVERY PLAN 2013 - 2016

FEBRUARY 2014
1. BACKGROUND AND CONTEXT

“Together for Health – a Heart Disease Delivery Plan” was published by the Welsh Government in 2013 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales to prevent avoidable heart disease and plan, secure and deliver high quality person-centred care for anyone affected by heart disease. It focuses on meeting population need, tackling variation in access to services and reducing inequalities in health outcomes across 6 themes.

For each theme it sets out:

- Delivery aspirations for the prevention and treatment of heart disease
- Specific priorities for 2013-2016
- Responsibility to develop and deliver actions to achieve the specific priorities
- Population outcome indicators and NHS assurance measures

The vision:

Our vision for heart care is for:

- People of all ages to have as low as possible a risk of developing heart diseases and, where they do occur, an excellent chance of living a long and healthy life, wherever they live in Wales.
- Wales to have incidence, mortality and survival rates for heart disease which are comparable with the best in Europe

We will use a range of indicators to measure success. These are being developed and will be refined over time and will include indicators such as:

- Coronary disease prevalence rates: % patients under 75 living with coronary heart disease
- Circulatory disease mortality rates under 75 per 100,000 population.
- Survival following out of hospital cardiac arrest
- Cardiovascular death in relation to average life expectancy - potential years of life lost.

The Drivers:

There are good reasons for heart disease to be a key priority area for NHS Wales.

According to the latest figures available from the Welsh Health Survey, 20% of adults are being treated for high blood pressure and 9% for any heart condition, excluding high blood pressure.
The most significant\(^1\) cause of heart-related ill health and death is coronary heart disease (particularly angina and heart attack). Although death rates in Wales have been falling over the last 3 decades, they remain around 15% higher than in England\(^2\). In addition, death rates vary significantly across Wales; the death rate in the most deprived fifth of wards is almost a third higher than in the least deprived fifth\(^3\) - showing the pronounced impact of poverty and the socio-economic determinants of health. While coronary heart disease is a largely preventable cause of ill health and death, the latest figures show that major risk factors remain high:\(^4\):

- 23% of adults report smoking, with 20% of adult non-smokers reporting regular exposure to other people’s tobacco smoke indoors
- 57% of adults were classed as overweight or obese; amongst children the figure was 35% (of whom 19% were obese)
- 43% of adults reported drinking above guidelines on at least one day in the past week
- Only 29% of adults reported being physically active on 5 or more days in the past week

These risk factors highlight the focus on coronary heart disease and promotion of healthy hearts as a theme. Coronary heart disease is, however, just one part of the picture and this Delivery Plan covers heart conditions more broadly. It highlights the importance of providing high quality detection and treatment of all major heart diseases, including:

- Heart failure (predominantly caused by coronary heart disease)
- Arrhythmia management, including management of atrial fibrillation (frequently a consequence of coronary disease)
- Congenital heart disease (in children and adults)
- Inherited or idiopathic cardiac conditions, including cardiomyopathies

**What do we want to achieve?**

The Delivery Plan sets out action to improve outcomes in the following key areas between now and 2016:

- Promotion of healthy hearts
- Timely detection of heart disease
- Fast and effective care
- Living with heart disease
- Improving Information
- Targeting research

2. **ORGANISATIONAL PROFILE**

**Organisational Overview**

The Cardiothoracic Services Directorate is based primarily in the University Hospital of Wales (with additional secondary care outpatient and diagnostic services in the

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\(^1\) Welsh Health Survey 2011, Welsh Government statistics released September 2012
\(^2\) Trends in Coronary Heart Disease 1961-2011, British Heart Foundation, 2011
\(^3\) The Cardiac Disease National Service Framework for Wales, Welsh Government, 2009
\(^4\) Welsh Health Survey 2011, Welsh Government statistics released September 2012
University Hospital, LLandough) and provides outpatient, specialist diagnostic, day case and inpatient services to both the local Cardiff and Vale and also the wider South East Wales populations.

There is a dedicated outpatient and diagnostic department based on the B1-C1 Link corridor at UHW, a dedicated 12 bedded Cardiac Day Case Unit, 3 fully commissioned Cardiac Catheter Laboratories, 3 inpatient wards (including an 8 bedded CCU and 14 bedded Cardiac ICU), and 3 Cardiothoracic theatres within the General Theatre suite.

Overview of Local Health Need and Heart Disease Challenge

Cardiff and Vale University Health Board (UHB) area is the smallest and most densely populated LHB area in Wales, primarily due to Wales’ capital city, Cardiff. The demographic profile of Cardiff differs from Wales due to the high number of young people resident in the area. However, in the Vale of Glamorgan it is similar to the population of Wales. Projections suggest by 2030, the population of over 65 year olds will increase by 44% in Cardiff (19,710 people) and by 53% (12,480 people) in the Vale of Glamorgan. In particular, the numbers of the very elderly (85 yrs +) will increase markedly.

The 2011 Census shows that 15.3% of the population of Cardiff described themselves as non-white. In the Vale of Glamorgan this figure was 3.6%. The Welsh average was 4.4%.

Mapping of the Welsh Index of Multiple Deprivation by area shows higher levels of deprivation around the south of Cardiff and Barry. Deprivation is known to be associated with poorer health outcomes. There are substantial gaps in life expectancy between people living in the most and least deprived areas and even more stark differences in healthy life expectancy and disability-free life expectancy.

In Cardiff and Vale there has been a downward trend on overall circulatory disease mortality, and age standardised rates have been consistently below the Welsh average for both males and females. However it is evident that inequalities exist, with significantly higher rates in our most deprived populations and no evidence that the gap between the most and least deprived is improving.

The Welsh Health Survey (2011+2012) reported that 8% of people surveyed in Cardiff and 7% in the Vale of Glamorgan reported being currently treated for a heart condition.

The percentage of adult smokers in Cardiff and Vale has gradually reduced over time, but currently still remains at 21%. Much remains to be done to achieve the Welsh Government Tier 1 target for the number of smokers to be treated by smoking cessation services and the percentage of treated smokers who have quit at 4 weeks. The proportion of the adult population who are overweight and obese is rising, with most recent estimates suggesting 20% are obese (i.e. BMI of 30 or more). Physical activity trends show low rates and a flat lining trend, with only 26% of adults in Cardiff and the Vale UHB area meeting physical activity guidelines. Trends in reported alcohol consumption are decreasing in Cardiff and Vale, but alcohol related mortality is increasing, with significantly higher rates in more deprived communities.

CHD emergency admission rates in Cardiff and Vale is significantly lower than Wales as a whole. This may reflect underlying incidence and prevalence, but it may also be
a reflection of good quality care in the health system. Emergency admission for stroke is also significantly lower than the Welsh average.

Revascularisation and angiography rates in Cardiff and Vale are similar to the Welsh average. Previous analysis of all Wales data has suggested that there has been inequity of provision of angiography and revascularisation in relation to deprivation. More recent analysis seems to suggest that in Wales in general revascularisation rates increase in proportion to need (CND mortality).

A comprehensive programme of intervention to address lifestyle risk factor is in place, which aim to address inequity, is detailed in the Local Public Health Operational Plan.

3. DEVELOPMENT OF THE CARDIFF AND VALE UNIVERSITY HEALTH BOARD HEART DISEASE LOCAL DELIVERY PLAN

In response to the “Together for Health – A Heart Disease Delivery Plan” (2013), Health Boards are required, together with their partners, to produce and publish a detailed local service delivery plan to demonstrate a systematic approach to progressive implementation of the Cardiac National Service Framework, the Welsh Health Specialised Service Committee Review of Cardiac Services and the Heart Disease Delivery Plan. The LHB Executive Leads for Heart Disease will need to report progress formally to their Boards against milestones in these delivery plans and publish these reports on their websites at least annually.

The Cardiff and Vale UHB Local Delivery Plan was developed following a series of discussions, face-to-face meetings and electronic communication involving a wide spectrum of stake-holders between October 2013 and January 2014. The following professionals have contributed to this document:

- Dr Fiona Kinghorn (Consultant in Public Health, Public Health Wales)
- Dr Tim Kinnaird (Consultant Cardiologist and Interventional Specialist)
- Dr Fong Leong (Consultant Cardiologist and Electrophysiologist)
- Dr Peter O’Callaghan (Consultant Cardiologist and Heart Rhythm Specialist)
- Dr Richard Anderson (Consultant Cardiologist and R+D lead, Cardiothoracic Directorate, UHW)
- Dr Sian Griffiths (Consultant in Public Health Medicine, Public Health Wales)
- Dr Richard Wheeler (Consultant Cardiologist and Imaging Specialist)
- Dr Dirk Wilson (Consultant Paediatric Cardiologist and Adult GUCH Specialist)
- Dr Zaheer Yousef (Consultant Cardiologist and Heart Function Specialist)
- Prof Ulrich Von Oppel (Consultant Cardiac Surgeon)
- Sr Racheal James (Heart Rhythm Specialist Nurse, UHW)
- Sr Cath Owen (Heart Rhythm Specialist Nurse, UHW)
- Sr Rachel Owen (Cardiac Rehabilitation sister, UHW)
- Ms Ceri Abbot (Assistant Directorate Manager, Cardiothoracic Directorate, UHW)
- Mr Chris Coslett (Directorate Manager, Cardiothoracic Directorate, UHW)
- Mr Michael Ware (IT and database manager, UHW)
4. SUMMARY OF THE PLAN – THE PRIORITIES FOR 2013-16

Following the completion of our local population needs assessment, the key findings have been incorporated into our local delivery plan for Heart Disease. This delivery plan includes actions against each of the priorities within the Welsh Government’s Heart Disease Delivery Plan (2013) and actions to implement the Cardiac Disease NSF and the Welsh Health Specialised Services Committee Review of Cardiac Services.

Promotion of healthy hearts

The priorities for 2013 – 16 are:

1. Work with a broad range of partners (including Local Service Boards and the third sector) to:
   - Raise awareness of healthy living
   - Signpost existing sources of information, advice and support relating to lifestyle change
   - Develop and deliver local strategies and services to tackle underlying determinants of health inequality and risk factors for coronary heart disease
   - Target resources in population areas of high risk (such as areas of deprivation) and areas of high impact (including early intervention actions with children to tackle prevention from outset of life)

2. Support and facilitate GPs, practice nurses and community pharmacists to proactively:
   - Use every opportunity in primary care to promote healthy lifestyle choices and smoking cessation
   - Ensure consistent provision of testing and treatment for risk factors such as high blood pressure and cholesterol


This plan outlines the range of actions being delivered by Cardiff and Vale Public Health Team and UHB teams, together with partner organisations, to promote healthy hearts, across the priority areas of reducing smoking, reducing harmful alcohol consumption, increasing physical activity, increasing consumption of fruit and vegetables and tackling obesity. Action is delivered across a range of settings including educational settings, Vale Healthy Communities, Cardiff Healthy City, Public Health practising workplaces, families and healthcare settings.

Action on each of the priority areas includes awareness raising of healthy living and signposting, advice and support, for example through Making Every Contact Counts and brief advice/interventions for smoking cessation and for alcohol.

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5 Including, for example, Stop Smoking Wales, Fresh Start Wales, Change 4 Wales
Some action areas (for example policy) are universally applied across Cardiff and Vale, whilst others are targeted in areas of deprivation within a neighbourhood management partnership approach to delivery. A proactive approach is being taken to work with primary care and community teams to increase evidence-based and consistent delivery of healthy lifestyle advice and support.

A snapshot of focused action for the priority areas are as follows:

Smoking cessation
- Enhanced action to meet the NHS tier 1 target for smoking cessation:
- Increased monitoring and enforcement of the UHB’s No Smoking and Smoke Free Environment policy
- Implementation of a smoking cessation pathway for GP practices

Reducing harmful alcohol consumption:
- Alcohol education and training for teachers and youth workers
- Strengthening the health contribution to consideration of licensing new applications, renewals and amendments
- Increased delivery of alcohol brief interventions by a range of staff, including primary care staff

Increasing physical activity:
- Undertake a health impact assessment of the Deposit Plan of the Local Development Plan in Cardiff
- Promote active travel and access to open spaces within Locality and Neighbourhood Management Teams
- Increase referrals to the National Exercise Referral Scheme in Cardiff and Vale of Glamorgan, particularly in areas of deprivation

Improve healthy nutrition:
- All schools to achieve the Appetite for Life minimum nutritional standards
- Strengthen the focus on food poverty through the development of a food poverty action plan for Cardiff and Vale
- Implement Foodwise for Life in community settings to address level 1 of the Obesity pathway
- Primary care referral of obese patients to community dietetics services where appropriate

In addition, with regard to promoting healthy hearts action area 2 Ensure consistent provision of testing and treatment for risk factors such as high blood pressure and cholesterol, we are starting to develop an approach to tackling identified inequities in access and use of UHB health services, focusing firstly on the pilot area of diabetes. As part of this work we are analysing primary care meeting of QOF targets for the risk factors in diabetes of HbA1c, hypertension, cholesterol, smoking and BMI by fifths of deprivation. Levels of exception reporting by fifths of deprivation for these targets is also captured. Such analysis will help us focus on and improve identified inequities in service provision.

Timely detection of heart disease

The priorities for 2013 – 16 are:

1. Identify and implement ways of raising public awareness of the symptoms of heart disease and the importance of seeking urgent medical advice and raise
awareness of when to ring 999, seek advice from NHS Direct and when to contact their GP
2. Provide GPs with timely access to diagnostic testing and procedures for heart disease, increasing direct access to testing (at the point of care or from a central laboratory), without need for secondary referral, where appropriate
3. Provide rapid access services to meet GP and patient need
4. Provide GPs with timely access to specialist cardiology advice through telephone and email, speeding diagnosis for people who may not need referral to a clinic
5. Ensure adequate access to cardiac catheter laboratories, matched to population need
6. Raise symptom awareness of GPs and ensure through audit that people are referred to secondary and tertiary care in line with national guidance and referral protocols and pathways agreed by the cardia networks
7. Provide specialist cardiology advice within 24 hours for those admitted to hospital with suspected heart disease - reorganising delivery of services to achieve this where necessary
8. Ensure effective collaboration between the All Wales Medical Genetics Service, Cardiac Networks, Hospital Lipid Clinics and GPs to use the Familial Hypercholesterolaemia Cascade Testing service to identify and treat individuals with Familial Hypercholesterolaemia and reduce the high risk of this group developing early onset heart disease
9. Ensure effective use of arrhythmia specialists and the All Wales Medical Genetics Service to ensure patients with inherited heart conditions have appropriate advice and testing and that specialist advice is provided to interpret the results

Cardiff and Vale UHB local priorities:

Cardiff and Vale UHB provides inpatient and outpatient secondary care cardiology spread across two sites (University Hospital of Wales and University Hospital Llandough) and specialist/tertiary services based at the University Hospital of Wales. CAV aims to achieve a referral to treatment (RTT) target of 26 weeks. This will require component waits of 10 weeks for a new cardiology outpatient appointment and component waits of 4 weeks for outpatient imaging tests and 6 weeks for diagnostic angiography.

Cardiology Outpatients

Achieving a 10 week component wait will require a combination of additional new cardiologist clinic slots and a collaborative approach with primary care to agree new referral pathways and alternatives to clinic referral such as electronic access for advise and open access for select patients as well as rapid access physiologist and nurse led clinics.

Imaging and Diagnostic Services

Cardiac imaging services include transthoracic echocardiography, transoesophageal echocardiography, functional imaging including stress echocardiography and myocardial perfusion imaging. The capacity of these services needs to increase significantly in order to investigate outpatients within 4 weeks. Timely investigation of inpatients by performing echocardiography within 48 hours and functional imaging within 1 week is necessary to shorten length of stay and reduce inpatient bed use. Cardiac CT is now recommended as a first line investigation for low risk populations and a minimum provision of 1000 scans per million population is needed, an increase of 300% over current activity levels. For many conditions Cardiac MR is now the gold standard providing safe accurate diagnosis in key areas including congenital
heart disease, aortic disease, cardiomyopathy and coronary artery disease. 1.5 full time scanners (2,275 scans per million population) are required at UHW to provide tertiary services. This will require the development of a new service. Diagnostic angiography needs to be performed within 6 weeks in order to reliably achieve an RTT of 26 weeks.

At present the provision of outpatient and the majority of diagnostic services is physically constrained by cardiology having the same footprint as 15 years ago despite the number of consultant cardiologists increasing from 5 to 13 over that time period. In order to accommodate increased capacity a new Cardiology Diagnostic Department is planned in what was previously the Duthie Library.

Detection of Atrial Fibrillation

The early detection of atrial fibrillation allows stroke risk stratification, initiation of oral anticoagulation and effective stroke prevention. CAV aims to develop links between secondary and primary care in support and educate GPs in the detection and management of atrial fibrillation.

Fast and effective care

The priorities for 2013 – 16 are:

1. Organise services to ensure people admitted because of diagnosis with a heart disease are assessed by a consultant cardiologist\(^6\), within 24 hours of admission to hospital
2. Start definitive treatment in a timely manner, with a focus on driving down waiting times and meeting clinical need. As a minimum treatment must start in line with the 26 week Referral to Treatment waiting times target for cardiac disease
3. Deliver prompt and equitable access to appropriate interventions, including new diagnostic procedures, technologies, treatment and techniques, in line with the latest evidence and guidance and with evidence based policies and priorities agreed by NHS Wales
4. Ensure all complex surgery is undertaken with peri-operative care standards as in the ERAS project
5. Use the 1000 Lives Plus Programme to implement improvements to services for people with acute coronary syndrome, heart failure, atrial fibrillation and in need of anti-coagulation
6. Manage effective transition to quaternary services in England where needed
7. Coordinate effective discharge and timely repatriation of patients to local hospitals as soon as clinically appropriate following treatment in line with discharge plans and the All Wales Repatriation Policy
8. For patients who need it, ensure effective transition to appropriate palliative and end of life care, in line with the Delivering End of Life Care Plan
9. Develop an NHS Wales policy on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, ensuring that this always respects individual patient wishes
10. Review provision of defibrillators in public places and community first responders, within LHB areas, ensuring - in liaison with the WAST and the British Heart

\(^6\) A consultant cardiologist is someone on the General Medical Council’s specialist register with a Certificate of Completion of Training (CCT) or Certificate of Completion of Specialist Training (CCST) in cardiovascular medicine or cardiology, who is employed as a consultant, spends the majority of their direct clinical care programmed activities caring for patients with heart disease and who undertakes regular continuing professional development of relevance to the care of patients with heart disease.
Foundation - that there is adequate provision and training and an effective first responder in place

Cardiff and Vale UHB local priorities:

Cardiff and Vale UHB provides secondary cardiology services for the Cardiff and Vale local population and tertiary services for South East Wales

Cardiac Surgery

A 10 week component wait for cardiac surgery is planned aiming for a cardiac surgical outpatient wait no longer than 4 weeks and a wait of no greater than 6 weeks once listed for cardiac surgery. This will require an increase to 1000 operations per year in 2014-15 rising to 1300 operations in 2015-16 in line with the National Service Framework (NSF 2006).

Percutaneous Coronary Intervention

PCI will increase to achieve NSTEMI revascularisation within 48 hours and increase overall PCI to 1800 cases/M in line with current UK numbers and later increase to 2000/M to achieve the NSF revascularisation target. This will require an increase of approximately 600 PCIs at the University Hospital of Wales.

Acute Heart Failure Services

The development of acute heart failure services is integral to ensuring that people admitted because of a diagnosis of heart disease are assessed by a consultant cardiologist within 24 hours of admission to hospital. Plans are developed to provide one additional heart failure specialist and 3 heart failure nurses. This acute heart failure team will provide daily heart failure rounds in A+E and the acute medical ward and divert select patients to nurse led heart failure optimisation clinics.

Adult Congenital Heart Disease

This is a rapidly expanding area of cardiology due to better treatments in childhood and a significantly larger number of patients surviving into adulthood. A new Grown up congenital heart disease service (GUCH) is starting in South Wales, based at the University Hospital of Wales. The first phase consisting on one GUCH consultant and ancillary staff will start in 2014 and the second phase (2nd consultant) will be phased in 2016.

Ablation Services

Ablation is an effective treatment for patients with symptomatic tachycardia resulting in a significant reduction in acute A+E attendance and acute hospitalisations. Pulmonary vein isolation is being performed with increasing efficacy and lower complication rates and is now standard therapy in the management of highly symptomatic paroxysmal atrial fibrillation.

Device Services

Devices are indicated for the routine management of symptomatic bradycardia, medically refractory heart failure and to treat patient at high risk of future cardiac arrest. An increasing ageing population will result in a year on year increase in device implant for the foreseeable future. A significant increase in new ICD
Implantation is planned to achieve the NSF target of 200 ICDs/M. In addition a significant cohort of patients (approximately 2/3 implants) survive long-term and require ongoing device support (routine box change).

DC Cardioversion Services for Atrial Fibrillation

The success of elective DC cardioversion is dependent on the time from onset of AF to success cardioversion. At present patients experience considerable delays in accessing the elective DC Cardioversion service via the cardiology outpatient clinic route and waiting lists are significantly longer than is desirable. A specialist nurse run open access DC cardioversion service is proposed which will be available to physicians in CAV. Capacity to perform an increased number of elective cardioversions will be provided by developing a multi-functional day case area within the new Duthie Library development suitable for both trans-oesophageal echocardiography and administration of general anaesthesia.

Living with heart disease

The priorities for 2013 – 16 are:

1. Plan and deliver services to meet the on-going needs of people with heart disease as locally as possible to their home and in a manner designed to support self management and independent living. This should include as appropriate:
   - Evidence based follow-up in the community where possible
   - Drug and device management
   - Cardiac rehabilitation (including psychological management and exercise)
   - Exercise programmes (such as the National Exercise Referral Programme)
   - Guidance on healthy lifestyle and self-care to minimise further ill health
2. Assess the clinical and relevant non-clinical needs of people with a diagnosis of a long term heart disease and – in liaison with patients (and where appropriate family/carers) - record relevant clinical and non-clinical needs and wishes as the basis of implementing care in a care plan. This should include adults with congenital heart disease. The care plan should include information on what the diagnosis means for the patient, what to look out for and which service to access should problems occur; it should be reviewed at appropriate points along the pathway
3. Make arrangements to ensure that information in the care plan or GP letter is available both to the patient and recorded on clinical information systems - and is accessible to others who have clinical responsibility for the patient, including out-of-hours GP services, on a 24/7 basis
4. Provide access to expert patient and carer programmes when required
5. Work proactively with third sector services and provide effective signposting to information and support, enabling patients to easily access support services

Cardiff and Vale UHB local priorities:

Cardiac Rehabilitation

Cardiac Rehabilitation enables people with cardiac disease to resume the best possible functioning in society by providing physical, psychological and social support. Despite substantial supporting evidence and national recommendations the multidisciplinary team in Cardiff & Vale is considerably smaller in comparison to the rest of Wales with a total of 5.67 WTE. The number of WTE in Cardiff & Vale is 1.0
WTE per 82,000 in comparison with a range between 1.0 WTE per 39,700 and 23,500 in the other Local Health Boards. As a result the service is not offered to all patient groups who would benefit from rehabilitation and it is planned that rehabilitation will in the future be offered to all patients admitted to hospital with a diagnosis of heart failure.

Despite the challenges the service is run by a small highly trained and dedicated multidisciplinary team who consistently provide high quality patient care which is evaluated through patient satisfaction and audit. The national average uptake of phase 3 Cardiac Rehabilitation 2012 was 43% but the guidelines recommended an uptake of 60%, Cardiff & Vale uptake 2012 was 52%. Plans are being drawn up to increase uptake to 60%.

**Improving Information**

The priorities for 2013 – 16 are:

1. Ensure IT infrastructure supports effective sharing of clinical records/care plans
2. Put effective mechanisms in place for seeking and using patients’ views about their experience of heart services
3. Monitor and record performance against the Cardiac Disease National Service Framework and through annual self-assessment against the Quality Requirements and use the results to inform and improve service planning and delivery
4. Ensure full (100%) participation in mandatory national clinical audits, delivering significant improvements on current low participation rates - to support service improvement and support medical revalidation of clinicians – and ensure that findings are acted on
5. Participate in and act on the outcome of peer review
6. Publish regular and easy to understand information about the effectiveness of heart services

**Cardiff and Vale UHB local priorities:**

Cardiff and Vale participates in the following National Audits:

- National Heart Failure Audit
- National Heart Rhythm Management Audit
- National Adult Cardiac Surgery Audit
- National Angioplasty Audit
- National Congenital Heart Disease Audit
- Myocardial Ischaemia National Audit Project (MINAP)
- The All Wales Coronary Audit
- Central Cardiac Audit Database (CCAD) Percutaneous Coronary Intervention Audit
- CCAD National Congenital Audit
- Familial Hypercholesterolaemia Audit
- The Cardiac Rehabilitation Audit

At present the Cardiothoracic Directorate has 0.5 WTE IT/data manager who oversees the quality, completeness and general accuracy of the National Adult Cardiac Surgery Audit returns. In general data is entered onto the above data bases by clinical and clerical staff. There are a number of significant challenges in gathering complete and accurate data including the admission of significant numbers of patients to specialties other than cardiology (e.g. Heart failure and MINAP audits)
and an inability at present to cross check the validity of data entry. CAV intends to develop its IT systems and support staff to ensure full participation in these audits. It is estimated that this will require an IT support unit staffed with 4 WTE database manager/IT specialists.

At present CAV is one of three pilot catheter ablation sites in the UK participating in a study of Patient Reported Outcome Measures (PROMS). This study is commissioned by NICOR and if proven to be of clinical utility will become incorporated into the National Heart Rhythm Management Audit and may be extended into other areas of cardiology and cardiac surgical practice.

Targeting Research

The priorities for 2013 – 16 are:

1. Support and encourage protected research time for clinically active staff (in primary as well as secondary and tertiary care)
2. Build on and extend academic training schemes to develop a highly skilled workforce
3. Promote collaboration with key research initiatives such as CVRG-C and HBRU
4. Promote public health research, for example to identify the best ways of working with those who are most disadvantaged or to demonstrate how services meet individual and population needs
5. Invest in accurate collection of key clinical data in a format that can be incorporated into the SAIL (Secure Anonymised Information Linkage) database for population-level health and social care research including focus on epidemiology, impact of interventions on outcomes, clinical trial scoping and service delivery modelling and assessment
6. Collaborate effectively with universities and businesses in Wales to enable a speedier introduction of new evidence-based and cost-effective technology into the NHS

Cardiff and Vale UHB local priorities:

1. Support and encourage protected research time for clinically active staff (secondary and tertiary care)
2. Plan to encourage further enrolment of academic training schemes (NISCHR fellowships) to develop a highly skilled workforce
3. Uplift in involvement and enrolment in NISCHR portfolio studies
4. Increase in junior staff involvement in research studies.
5. Increase clinical trial income to the directorates
6. Strengthen and harness existing relationships with Cardiff University

5. PERFORMANCE MEASURES/MANAGEMENT

The Welsh Government’s Heart Disease Delivery Plan (2013) contained an outline description of the national metrics that LHBs and other organisations will publish:

- Outcome indicators which will demonstrate success in delivering positive changes in outcome for the population of Wales.
- NHS assurance measures which will quantify an organisation’s progress with implementing key areas of the delivery plan.

Indicators and assurance measures will be further developed by the All Wales Heart Disease Implementation Group. Progress with these outcome indicators will form the
basis of each LHB’s annual report on heart disease. They will be calculated on behalf of the NHS annually at both a national and LHB population level. LHBs will produce an initial progress report in March 2014 and full annual reports in March 2015 and March 2016.

LHBs will also report progress against the local delivery plan milestones to their Boards at least annually and to the public via their websites. It is expected that Local Delivery Plan and their milestones are reviewed and are updated annually from March 2015.

References and Background Supporting Documentation

1. Cardiff and Vale of Glamorgan Heart Disease Needs Assessment. Dr S Griffiths, Dr F Kinghorn.

2. Strategic Plan for Cardiac Imaging at the University Hospital of Wales. Dr Richard Wheeler


4. Proposed Angiography/Interventional Component of CAV Strategic Services Plan. Dr Tim Kinnaird

5. Proposed Acute Heart Failure Service. Dr Zaheer Yousef

6. Proposed Adult Congenital Heart Disease Service – Dr Dirk Wilson


8. The Cardiac Disease National Service Framework for Wales, Welsh Government, 2009

9. Cardiff and Vale Cardiac Rehabilitation Services. Sr Rachel Owen.

10. British Association for Cardiovascular Prevention and Rehabilitation, The BACPR Standards and Core Components 2012
### Action Plan – 2013 - 2016

#### Promotion of healthy hearts

1. Work with a broad range of partners (including Local Service Boards and the third sector) to:

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<th>Priority</th>
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<td>Raise awareness of healthy living</td>
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<td>Target resources in population areas of high risk (such as areas</td>
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<th>Actions</th>
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<td>Deliver a range of actions in the Local Public Health Operational Plan (LPHOP) (part of Integrated business Plan) for tobacco control, decreasing harmful alcohol consumption, improving physical activity levels, improving healthy eating and decreasing levels of overweight and obesity</td>
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<th>Expected outcome</th>
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<td>The LPHOP includes a range of headline &amp; performance indicators which are monitored regularly, including the headline indicators of:</td>
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<td>% of adult population who smoke daily or occasionally</td>
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<td>% of adults drinking over the recommended levels</td>
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<td>% of adults who achieve the recommended level of 30 minutes of moderate intensity or more on 5 days a week or more</td>
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<td>% of adults reported being obese or overweight</td>
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<th>Risks to delivery</th>
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<tr>
<td>Trajectory planning is underway to determine the levels of service requirement to achieve positive change in population outcomes for priority action areas. There are challenges to meeting the scale of delivery required to impact on these outcomes.</td>
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<th>Timescales / Milestones</th>
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<tr>
<td>A range of detailed timescales are included in each individual action plan for tobacco, alcohol, food and physical activity (refer to LPHOP for detail)</td>
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7 Including, for example, Stop Smoking Wales, Fresh Start Wales, Change 4 Wales
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<th>Use every opportunity to promote healthy lifestyle choices and smoking cessation</th>
<th>Provide 'Making Every Contact Count' training and awareness to UHB staff and partner organisations</th>
<th>Staff able to support clients/colleagues/family to make lifestyle changes resulting in: - Increased physical activity levels and consumption of fruit and vegetables - Reduced alcohol intake and smoking - Increased uptake of smoking cessation services</th>
<th>Limited training provision and uptake</th>
<th>Timescales included in MECC implementation plan</th>
<th>Public Health Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appropriate UHB staff and partner organisations to be offered brief intervention training (alcohol and smoking cessation)</td>
<td>Staff in primary care confident and able to support patients make changes to lifestyle</td>
<td>Limited training provision and uptake</td>
<td>Adherence to pathway</td>
<td>Public Health Team</td>
</tr>
<tr>
<td></td>
<td>Ensure that all patients to be listed</td>
<td>Increase in number of people who access weight management service capacity</td>
<td></td>
<td>Policy to be implemented from 1st December 2013</td>
<td>Clinical Boards</td>
</tr>
</tbody>
</table>
for an elective intervention, that are recorded as a smoker and/or have a BMI over 40, are referred to either smoking cessation services or weight management support as part of the UHB’s Optimising Outcomes Policy statement (OOPs).

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales / Milestones</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use every opportunity in primary care to promote healthy lifestyle choices and smoking cessation</td>
<td>Provide ‘Making Every Contact Count’ training at GP and PN meetings and monitor implementation within practices</td>
<td>Patients supported to make lifestyle changes resulting in - Increased physical activity levels and consumption of fruit and vegetables - Reduced alcohol intake and smoking - Increased uptake of smoking cessation services</td>
<td>Limited training provision and uptake</td>
<td>Review annually as part of QOF</td>
<td>GP Practices for implementation/Primary Care for monitoring</td>
</tr>
<tr>
<td></td>
<td>Offer Brief Intervention Training for smoking cessation and alcohol in primary care</td>
<td>Staff in primary care confident and able to support patients make changes to lifestyle</td>
<td>Limited training provision and uptake</td>
<td>Review annually as part of QOF</td>
<td>Public Health TeamGP Practices for implementation/Primary Care for monitoring</td>
</tr>
</tbody>
</table>

2. Support and facilitate GPs, practice nurses and community pharmacists to proactively:

- Patients supported to make lifestyle changes resulting in increased physical activity levels and consumption of fruit and vegetables, reduced alcohol intake and smoking, increased uptake of smoking cessation services.
- Staff in primary care confident and able to support patients make changes to lifestyle.
- Limited training provision and uptake.
- Review annually as part of QOF.
<table>
<thead>
<tr>
<th>Care</th>
<th>Patients supported to increase physical activity levels</th>
<th>Capacity to undertake assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients supported to increase physical activity levels</td>
<td>Limited provision of community based programmes</td>
</tr>
<tr>
<td></td>
<td>Increased numbers of patients being referred to NERS and completing the programme</td>
<td>Limited information on community based programmes</td>
</tr>
<tr>
<td></td>
<td>Increase in number of patients who have quit smoking</td>
<td>Capacity of NERS programmes to manage demand</td>
</tr>
<tr>
<td></td>
<td>Tier 1 Smoking target achieved</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Ensure that all patients to be listed for an elective intervention, that are recorded as a smoker and/or have a BMI</td>
<td>GP Practices</td>
</tr>
</tbody>
</table>
over 40, are referred to either smoking cessation services or weight management support as part of the UHB’s Optimising Outcomes Policy statement (OOPs).

All patients who smoke must be:
- Recorded as a smoker (over 15 and above) in their lifelong records
- Be offered advice and support which includes providing literature and offering appropriate therapy by following the UHB’s agreed Smoking Cessation Pathway

All GPs who have selected the Smoking Quality Pathway as part of QOF to ensure that all patients who

<table>
<thead>
<tr>
<th>QOF points awarded</th>
<th>Adherence pathway to</th>
<th>Accurate data collection</th>
<th>March 2014</th>
<th>GP Practices</th>
</tr>
</thead>
</table>

Ongoing | GP Practices
| Smoke receive Brief Intervention advice, are referred to smoking cessation services and if providing in-house support, record data as per the template supplied. | Maintain a register of patients aged 16 or over with a BMI ≥ 30. Ensure that patients with a BMI diagnosing them as overweight or obese are given appropriate advice and guidance to have a healthy lifestyle and to lose weight; plus referred on to an enhanced weight management pathway as appropriate. | Patients diagnosed with hypertension are to be given lifestyle advice for: increasing physical activity, reducing BMI to a healthy weight will reduce the risk of cardiovascular disease, diabetes and osteoarthritis. Improvement in levels of healthy behaviour – contribution to achievement of tier 1 smoking cessation. | Capacity of local smoking cessation services. Potential constraints include the capacity of NERS and dietetics; however mitigation includes the exploration of an enhanced weight management pathway with primary care. | Ongoing | Ongoing | GP practices in the main however there is a role for dentists, pharmacists and optometrists regarding the advice and guidance for achieving a healthy weight. |
smoking cessation, safe alcohol consumption and healthy diet.

The Pharmacist and their staff shall, as appropriate, provide advice to people presenting prescriptions, who appear to have diabetes, be at risk of CHD especially those with high blood pressure, smoke or are overweight with the aim of increasing the person’s knowledge and understanding of health issues which are relevant to that person's personal circumstances.

The advice maybe backed up, as appropriate, by the provision of written information, e.g. leaflets; and by referring the person to other sources of information or advice.

<p>| Multi-faceted approach to awareness raising, advice and support for improved health behaviours | Ongoing | Community Pharmacists implementation/Monitored by Community Pharmacy Team |</p>
<table>
<thead>
<tr>
<th>Ensure consistent provision of testing and treatment for risk factors such as high blood pressure and cholesterol</th>
<th>Establish and maintain a register of patients with coronary heart disease</th>
<th>Blood pressure reading is 150/90 mmHg or less. Trials showed that a reduction of 5-6 mmHg in blood pressure sustained over five years reduces coronary events by 20-25 per cent in patients with CHD</th>
<th>Review annually as part of QOF</th>
<th>GP Practices for implementation/Primary Care for monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the request of the LHB pharmacists and their staff shall participate, in a manner reasonable requested by the LHB, in up to six public health campaigns in each year to promote public health messages to users of the pharmacy (including No Smoking Day and the national stroke campaign).</td>
<td>Improved community awareness of how to improve health behaviours and where to get support</td>
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</tbody>
</table>

Heart Disease Local Delivery Plan 22 February 2014
the use of drug therapy.

Establish and maintain a register of patients with peripheral arterial disease.

Where inequities in meeting targets for hypertension and cholesterol control are identified, take action to improve these.

Total cholesterol is 5 mmol/l or less – NICE clinical guideline on lipid modification recommends that an audit level of total cholesterol of 5 mmol/l is used to assess progress in populations or groups of people with CVD

Inequities in risk factor control are lessened

GP Practices for implementation/Primary Care for monitoring

Review annually as part of QOF

Review annually as part of QOF

<table>
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<tr>
<th>Priority</th>
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<th>Timescales / Milestones</th>
<th>Lead</th>
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<tr>
<td></td>
<td>Where inequities in service provision for timely detection exist, take action to improve these</td>
<td>Inequities in identified service provision are improved</td>
<td>Solutions to tackling inequities are often unclear and complex, so tackling these are a challenge</td>
<td>Exploration of inequities by March 2014</td>
<td>Clinical Boards</td>
</tr>
<tr>
<td>Cardiology Out patient access</td>
<td>Collaborate with primary care to look at referral patterns, pathways and alternatives to clinic referral</td>
<td>10 week component wait</td>
<td>OPD component = 10 weeks in order to achieve RTT = 26 weeks by 2014-15.</td>
<td></td>
<td>Cardiothoracic Directorate</td>
</tr>
<tr>
<td>Service</td>
<td>Target Capacity/Year</td>
<td>Routine Outpatient Appointment within 4 Weeks</td>
<td>Urgent Appointment within 1 Week</td>
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<tr>
<td>Transthoracic echocardiography</td>
<td>Increase by 60% to 400 studies per year</td>
<td>Routine outpatient appointment within 4 weeks</td>
<td>Urgent appointment within 1 week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transoesophageal echocardiography</td>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress echocardiography</td>
<td>Increase capacity by 60% to 500 cases</td>
<td>Routine outpatient appointment within 4 weeks</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Myocardial perfusion imaging</td>
<td>Increase capacity by 40% to 500 cases</td>
<td>Routine outpatient appointment within 4 weeks</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cardiac CT imaging</td>
<td>Increase capacity by 300% to 1000/Million</td>
<td>Routine outpatient appointment within 4 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac MRI scans</td>
<td>500 cases/year</td>
<td>Minimum numbers required to run a tertiary service</td>
<td></td>
<td></td>
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<tr>
<td>Diagnostic angiography</td>
<td>Increase capacity</td>
<td>Routine diagnostic angiogram within 6 weeks</td>
<td></td>
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</tbody>
</table>

**1.1 Early detection of Atrial Fibrillation (AF)**

| Develop links with primary care to promote awareness of Atrial Fibrillation |
| Education and Support of practice nurses to offer opportunistic screening of patients >65yrs by manual (radial) pulse check at clinics |
| Education and support with 12 Lead ECG recognition of AF and stroke risk stratification |
| Teaching session/workshops with Cardiff and Vale LHB practice nurses- Annual conference |
| Promote Heart Rhythm Specialist Nurse |
| Increase number of patients diagnosed with AF through opportunistic screening |
| Reduce AF-related strokes and thromoembolism through risk stratification + assessment tools CHADS2 score CHA2DS2-VASc score Calculate AF-stroke risk and initiation of appropriate anticoagulation |
| Improve symptom control through Rate control strategy – advise from HRSN (Local and National Guidelines ECG 2013 + NICE 2014) |
| Improve access and |

**Increased number of AF-related strokes due to undiagnosed patients with AF**

**Annual review**

Sr Rachael James
Heart Rhythm Specialist Nurse

Dr Peter O’Callaghan
Heart Rhythm Consultant
(HRSN) role through Local Cardiac Network and publications (BHF + AFA)

Referral process to tertiary centre for Rhythm control strategy (Local and National Guidelines ECG 2013 + NICE 2014)

Provide practice nurses and GPs with timely access to specialist AF advice through telephone and email contact with HRSN

<table>
<thead>
<tr>
<th>Fast and effective care</th>
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</thead>
<tbody>
<tr>
<td><strong>Priority</strong></td>
</tr>
<tr>
<td>Where inequities in service provision for timely detection exist, take action to improve these</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
</tr>
<tr>
<td>Percutaneous coronary</td>
</tr>
</tbody>
</table>

Heart Disease Local Delivery Plan

February 2014
<table>
<thead>
<tr>
<th>Intervention</th>
<th>Additional 266 cases</th>
<th>Additional 73 ACS sessions</th>
<th>from 1538 to 1800/M in line with UK 2013 2000/M in line with NSF 2006 target NSTEMI revascularisation within 48 hours</th>
<th>one interventional cardiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Heart Failure</td>
<td>3 WTE Heart failure nurses 1 additional WTE heart failure specialist</td>
<td>Daily A+E/MAU heart failure rounds Patients diverted from inpatient to nurse led optimisation clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Congenital Heart Disease Services</td>
<td>WHSCC/CAV plan</td>
<td>Provision of South Wales adult congenital heart disease service</td>
<td>Phase 1 – 2014/15 Includes appointment of 1 consultant + ancillary staff Phase 2 2016/17 Includes appointment of 2nd consultant</td>
<td></td>
</tr>
<tr>
<td>Ablation Services</td>
<td>Conventional Ablations 125/M AF ablation 100/M VT ablation 20/M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Device Services</td>
<td>Pacemakers 700/M</td>
<td>Box changes (ICD 2/3 new implant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICDs (new) 200/M  
CRT (new)  100/M  
rate 5 years ago)  
CRT (1/2 new implant rate 5 years ago)

DC Cardioversion  
Develop open access service for CAV Physicians  
Develop a multi-functional area within the new Duthie library development for both trans-oesophageal echocardiography and DC cardioversion  
Perform DC Cardioversion within 6 weeks of referral and within 3 weeks of achieving a therapeutic INR

Living with heart disease

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions</th>
<th>Expected outcome</th>
<th>Risks to delivery</th>
<th>Timescales / Milestones</th>
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<td></td>
<td>Where inequities in service provision for timely detection exist, take action to improve these</td>
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<td>Exploration of inequities by March 2014</td>
<td>Clinical Boards</td>
</tr>
<tr>
<td></td>
<td>Increase rehabilitation uptake to 60%</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| Evidence based follow-up in the community where possible | To include all patient groups in Cardiac Rehabilitation as outlined by NSF (2009) and BACPR (2012).  
a)provide CR for newly | Reduce hospital admissions  
Reduce demand on cardiology | Unable to deliver Heart Failure cardiac rehabilitation without further investment for staff and accommodation | Review 2015 | Rachel Owen  
Clinical Nurse Specialist Cardiac Rehabilitation  
& Cardiac Rehabilitation Team |
| Drug and device management | Patient hand held record provided to patients attending cardiac rehab which details medication and device therapy  
  a) Cardiac rehab to ensure up-titration of cardioprotective medication during CR programme.  
  b) Involve pharmacy in cardiac rehab to provide patient education targeting compliance issues and polypharmacy. | Achieve >80% compliance with evidence based prescribing- 
  a) conduct audit within cardiac rehab to assess if compliance of evidence-based dosages are being achieved.  
  Pharmacy input only available in Llandough cardiac rehab programme | Lack of resource – hand held records and staff to facilitate support and compliance  
  Pharmacy input has been withdrawn from the education sessions within UHW and Maindy Leisure Centre cardiac rehab programme. No pharmacy staff available to provide education during cardiac rehab. | Annual review  
  Conduct audit 2014 | Rachel Owen  
  Clinical Nurse Specialist  
  Cardiac Rehabilitation  
  & Cardiac Rehabilitation Team |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation (including psychological)</td>
<td>Inequitable service across C&amp;VUHB.</td>
<td>Resolve inequity in cardiac rehab service</td>
<td>Without securing integrated</td>
<td>2014 – 2016</td>
<td></td>
</tr>
</tbody>
</table>
  Heart Disease Local Delivery Plan  
  February 2014 |
| Management and exercise | Physiotherapy, OT & Pharmacy hours reduced which is not inline with national guideline.  
> a) Achieve 80% referral, uptake and adherence.  
> b) Patient evaluation/satisfaction provision. Ensure 100% adherence to BACPR standards and Core Components.  
> a) Continue to audit service on National Audit for Cardiac Rehabilitation.  
> b) Continue monitoring patient satisfaction and introduce patient stories to inform changes in service delivery | Multidisciplinary CR service this will not be achieved.  
> BACPR standards acknowledge psychologist as a member of the CR team - lack of resource to support |  |
| Exercise programmes (such as the National Exercise Referral Programme) | Continue referral process to NERS teams across C&V. Aim to achieve adherence to exercise at 1 year as recommended  
> a) Conduct join audit between cardiac rehab referral to NERS and number of patient attending NERS programmes.  
> b) Achieve 60% return rate in post from 12month NACR postal questionnaire | Availability of patients numbers  
> Patient compliance | Annual review 2014-15/16  
> Rachel Owen, cardiac rehab team & NERS teams |
| Guidance on healthy lifestyle and self-care to minimise further ill health. | Ensure 80% referral to cardiac rehab and the heart failure team. All patients to receive lifestyle advice and self care management advice from time of | Reduction and compliance with cardiovascular risk factors and medication. This will reduce demand on Cardiology and reduce | Lack of staff resource to support 80% referral to service  
> 2014-16  
> Rachel Owen & cardiac rehab team  
> Heart Failure Team |
### Assess the clinical and relevant non-clinical needs of people with a diagnosis of a long-term heart disease and, in liaison with patients (and where appropriate family/carers), record relevant clinical and non-clinical needs and wishes as the basis of implementing care in a care plan. This should include adult with congenital heart disease.

The care plan should include information on what the diagnosis means for the patient, what to look out for and which service to access should problems occur; it should be reviewed at appropriate points along the pathway.

### Develop care plan involving cardiac rehab team, the All Wales cardiac rehab Working group and patient views to ensure consistency and consensus which can be utilised across Wales.

In conjunction to the patient –held self care management plan a detailed letter containing relevant information will be available.

### This will improve communication between primary and secondary care, ensure patient safety, reduce complaints and enhance patient satisfaction with service.

### Lack of staff resource to facilitate

### 2014

### Rachel Owen & Cardiac Rehabilitation Team

### All Wales cardiac rehab Working Group

<table>
<thead>
<tr>
<th>Provide access to expert patient and carer programmes when required</th>
<th>Reacquaint links with Expert Patient Programme.</th>
<th>Cardiac rehab team will have clear direction on appropriate patient referral to EPP.</th>
<th>Time constraint</th>
<th>2014</th>
<th>Rachel Owen &amp; Cardiac rehab team</th>
</tr>
</thead>
</table>

Lack of staff resource to facilitate

### 2014

### Rachel Owen & Cardiac Rehabilitation Team

### All Wales cardiac rehab Working Group

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Heart Disease Local Delivery Plan 31 February 2014
Work proactively with third sector services and provide effective signposting to information and support, enabling patients to easily access support services.

Review current third sector groups and identify those appropriate for Cardiac rehab patients.
Cardiac rehab currently use V.E.S.T to transport patients to Maindy community cardiac rehab programme.

More choice available and improve service for patients

- Review current third sector groups and identify those appropriate for Cardiac rehab patients.
- Cardiac rehab currently use V.E.S.T to transport patients to Maindy community cardiac rehab programme.

2014-15
Rachel Owen & Cardiac rehab team

<table>
<thead>
<tr>
<th>Bereavement Counselling Services</th>
<th>Provide counselling for all families of sudden death victims &lt; 35 years of age.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherited Cardiac Conditions Support Group</td>
<td>Set up by Heart Rhythm Specialist Nurse</td>
</tr>
<tr>
<td></td>
<td>Eventually will be run by inherited cardiac conditions families</td>
</tr>
</tbody>
</table>

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### Improving information

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions</th>
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<th>Timescales / Milestones</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full participation in all National Audits + monitor Directorate performance against NSF quality markers</td>
<td>Appoint four WTE IT/database staff</td>
<td>Internal modification of databases and programming of IT collection systems</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Accuracy and completeness of data confirmed prior to submission</td>
<td>Phase 1 – 2 WTE IT/database staff by 2015</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td>Phase 2 – full complement 4 WTE IT/database staff by 2017</td>
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<td></td>
<td></td>
<td>Clinical Board</td>
<td></td>
</tr>
<tr>
<td>Priority</td>
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</tr>
<tr>
<td>Maximize departmental clinical research to improve patient outcomes</td>
<td>Increase enrolment into NISCHR portfolio clinical studies</td>
<td>Increased departmental NISCHR related research income and patient access to emerging technologies.</td>
<td>Insufficient research nurse provision. UHB R+D administration constraints</td>
<td>Phase 1 - Potential new research nurse appointment by June 2014</td>
<td>Departmental R+D lead and Clinical director</td>
</tr>
</tbody>
</table>