

Do Once and Share – Heart Failure Scope and deliverables.

Scope

1. Production of the deliverables (pathway and dataset definitions and reports) defined below, verifiably based on evidence, national standards and goals, and local and national consultation and consensus of key experts and stakeholders.
2. Ensure that all project outputs are informed by consultation with national as well as local stakeholders. The project's national workshop (in month 5) will precede and influence its end-term deliverables. Prior to the submission of mid-term deliverables, the Clinical Lead will arrange for their review by suitable national referees and the project will agree with the national team during months 1-2 its arrangements for national consultation and consensus.
3. Consider the relationships of the Heart Failure pathway with other overlapping and related care pathways and systems of care, and liaise with DOAS teams which are addressing these. Cooperate, as far as possible, to enable different pathways and their information, data and knowledge and requirements to be defined in forms which are consistent, coordinated and scalable.
4. Establish links with groups working on this field in other clusters to determine similarities in the direction of travel and establish consensus.
5. Liaise with, and feed user interface requirements for this pathway to the NPfIT Common User Interface Project.
6. Identify, recommend and where appropriate prepare the ground for further activities in support of DOAS and NPfIT objectives.
7. In the light of current recommendations on National Clinical Leads, advise the National Programme on the suitability of the current CRS system specification as it applies to heart failure patients.

Out of scope:

1. Exhaustive definition of the knowledge and evidence base for heart failure.
2. Planning, development or promotion of local, interim, or pilot IT solutions for Heart Failure care.
3. Investigation of the road map for progress towards NPfIT-compliant IT solutions within the local clinical community.
4. Determine, assess and advise the current plans of LSPs to implement support for care pathways in the NCRS.

Deliverables

November 2005.

1. A definition of the Heart failure care pathway, covering community, primary, secondary and tertiary care and links to social care. The pathway will embody demonstrable national consensus on best practice. It will identify acceptable variant forms of good practice recognised to be appropriate to particular local resource and structure. (This activity will liaise with Map of Medicine as required by the DOAS Programme.)
2. Report on key issues of safety and risk in the heart failure care pathway which IT systems should be designed to address.

3. Survey of the fitness for purpose of existing (commercially supported and/or widely shared) electronic systems currently being used to collect data on patients with heart failure, with comments on the ease of migration into a national system. Elicit experience from existing implementations on the practicalities of data capture and the specific benefits and limitations of existing systems.
4. Advice to the National Programme on the suitability of the current system specification as it applies to heart failure patients, in the light of current recommendations from the National Clinical Leads. (the activity will liaise as appropriate with the national 'Busy Clinician' and "Confident Patient' projects).

NB Updated versions of the above will be provided where applicable at the end of the project.

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5. A dataset, defined in consultation with the British Society for Heart Failure, for heart failure 'secondary uses' (audit, research resource and operational management), which will be a subset of the direct care dataset. As far as possible the dataset should be capable of collection as a by-product of direct care.
6. A dataset, linked to the care pathway definition, sufficient to support direct care along the pathway, defining requirements for data acquisition, access and sharing and clinical communications along the care pathway. This will be a superset of the 'secondary uses' dataset. The dataset should comprise an agreed mandatory core subset together with a standard set of items whose use will be optional according to local policy, practice and resources.
7. Report on:
 - a. barriers and facilitators to the adoption of a shared electronic care record in heart failure care, including 'cultural' issues and training needs.
 - b. current and anticipated developments in the model of heart failure care which should be provided for in the NCRS.
 - c. opportunities for IT and e-health to enable improved models of heart failure care and/or to mitigate delays, and resource and skill shortages, including their potential contribution to SHA Integrated Service Improvement Plans.
 - d. ways of linking together all relevant information sources, including the reduction or elimination of double data entry.
 - e. training implications for relevant specialties.
 - f. R&D needs and opportunities.
8. A 'how to' guide to defining a local version of the pathway.
9. A clear statement of the benefits of a Heart failure care records system fit for purpose.

For further information contact: Colin Gordon 0207 351 8724 c.gordon@rbht.nhs.uk