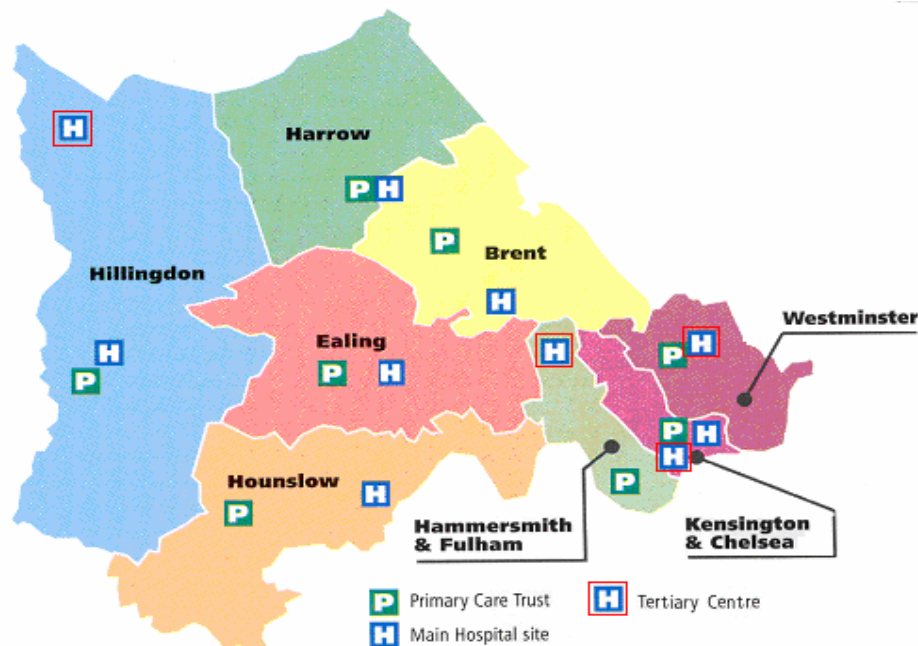




**NHS**

North West London Cardiac Network

## Reviewed Network Strategy & Work Plan 2007 – 2009



Author:	Maria O'Brien – Network Director	Version 1 ratified by NWLCN Board, SHA & CEOs June 2005
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<b>1.</b>	<b>Introduction</b>	
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The original document “Network Strategy & Workplan 2005-2008” was ratified by the Network Board on 6 June 2005 and latterly by the NW London SHA and Chief Executives. This earlier document set out the key plans for the Network over a 3 year period and focused particular emphasis on the work priorities for 2005/06. Since that time, the Network has made substantial progress in all areas of work and this has identified a need to review the original strategy and work plan both in light of these developments and in the context of changing national policy.

A brief summary of progress to date against each of the key areas is provided throughout the document. However, for more detailed information on progress, the Network’s Annual Review should be referred to and is available at [www.nwlc.co.uk](http://www.nwlc.co.uk).

This revised strategy details new and ongoing priorities, milestones and projects for the forthcoming 3 years, placing particular emphasis upon the immediate priorities for 2007. It builds upon the existing firm partnership arrangements already in place across constituent organisations.

Whilst this document has fully focused on cardiac care priorities, the Network is mindful of national developments which may require Cardiac Network’s to progress work within the ‘Stroke’ arena. However, until such time as a ministerial decision is made clarifying requirements around this new area, the Network will continue to focus our existing activity and resources on cardiac care. Should ‘Stroke’ fall within our remit over the coming months, the Network will develop an appropriate work-plan, reprioritising, as necessary, the cardiac work streams detailed in this strategy.

<b>2.</b>	<b>Overview</b>	
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**2.1 The NW London Cardiac Network (NWLCN)**

The Cardiac Network in NW London was initially developed during late 2003 with the support of the former NW London Strategic Health authority and the Chief Executives from each of the constituent organisations. Terms of Reference are detailed within Appendix A.

In line with national guidance (Establishing and Developing Cardiac Networks, Coronary Heart Disease Collaborative March 2004 – [www.modern.nhs.uk/chd](http://www.modern.nhs.uk/chd)), the Network was developed to bring together clinicians, other professionals and managers from all organisations so that they can work together to improve services for patients. The network makes it possible for organisations to develop linkages and consistent approaches across the whole of a patient’s potential experience of services and over a large geographical area.

The Network comprises a Board, chaired by a NW London PCT Chief Executive. The Network is accountable through the Chair to all of the other NW London organisations via the Chief Executive Forum. Previously, the Network Chair, Clinical Lead and Network Director met formally, on an annual basis, with the Strategic Health Authority Chief Executive to present progress. However, with the move to one health authority for London, there is now a need to review this arrangement. It is the Network’s intention to arrange to meet on a bi-annual basis with the identified Lead Executive Director at NHS London to present achievements and progress towards delivering this work plan.

The Network Board consists of both clinical and non-clinical representatives from across NW London covering primary care, secondary care, tertiary care, commissioning, public health, the Strategic Health Authority, patient/carers and London Ambulance Service. Membership of the Network Board has been developed to ensure that local work continues to be supported and that there is a close relationship between the Network and each of the PCTs Cardiac Local Implementation Teams (LITs). This approach aims to focus on delivering work which would benefit from a sector wide approach whilst allowing local services to develop to meet the individual needs of their particular health economy. Each LIT is represented on the Network Board, providing a more effective basis for communication between local organisations and the Network. This supports an approach in which all organisations are involved in agreeing work plans, the priorities of the Network and mechanisms for achieving Local Delivery Plans across each of the centres.

To reflect identified priorities, several Network sub-groups/task groups will take forward specific areas of work. Each of these groups are responsible for reporting progress to the Network Board at regular intervals and for ultimately making recommendations to the Board around specific relevant areas of work.

## 2.2 Geographical Area and Population Profile NWLCN

The Network serves an ethnically and culturally diverse population of over 1.9 million, (Table 1). It has some of the most ethnically diverse wards in the country - around 35% of the local population belong to ethnic minority groups. For example, Brent has the highest "non-white" proportion and Asian communities account for more than a quarter of the population in Ealing, Hounslow, Brent and Harrow NW London is also characterised by areas of great affluence alongside significant deprivation.

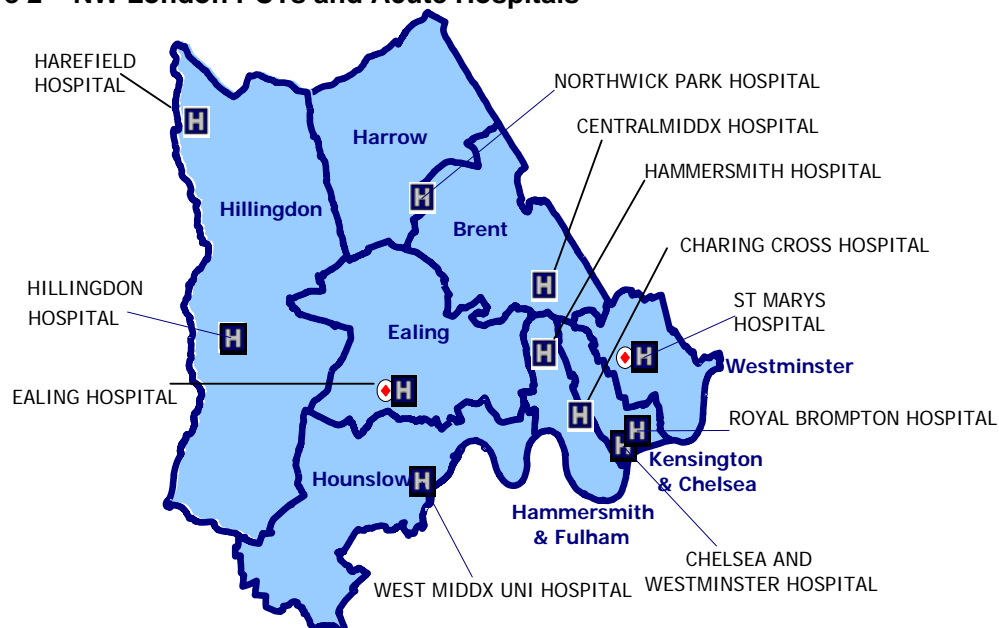
**Table 1 – NW London Demographics**

	Westminster	Kensington & Chelsea	Hammersmith & Fulham	Ealing	Hounslow	Brent	Harrow	Hillingdon
Population 2006*	247,551	186,814	183,733	324,094	214,492	264,339	231,798	273,953
Ethnicity 2006**	31.74	21.62	24.33	43.09	37.87	55.54	40.94	20.65

\*Source: ONS Population Projections 1998, \*\* Source: London Research Centre 1999 Round-based projections (v99 P1)

The Network is characterised by 8 Primary Care Trusts and 8 Acute Hospital Trusts providing cardiac services across 11 hospital sites as detailed in Figure 2. In addition, specialist tertiary cardiac services are provided by three Trusts on four sites. As a leading academic institution, Imperial College is affiliated with many of these organisations, leading the way in education and research.

**Figure 2 – NW London PCTs and Acute Hospitals**



### **2.3 Role of the Network within NW London**

Circulatory Disease still accounts for a significant numbers of deaths. In 2004, cardiovascular disease accounted for more than one in three (37%) deaths in England and Wales. Almost half of these deaths were due to coronary heart disease, which continues to be the largest single cause of death in England and Wales. More than one in five men and one in six women die from coronary heart disease.<sup>1</sup>

Coronary Heart Disease (CHD) is the second largest cause of death in NW London. Whilst significant progress has been made in improving access to meet local need, inequity still exists. For example, three of our PCTs<sup>2</sup> are still to meet the CHD National Service Framework (2000) revascularisation target of 1,500 per million population (pmp)<sup>3</sup>.

Within NW London, eight wards spanning Brent, Ealing, Harrow, Hillingdon, Hounslow and Westminster have standardised mortality ratios (SMRs) for all-age CHD, significantly greater than the average, whilst, some of the lowest SMRs span wards within Kensington and Chelsea and other parts of Westminster. Furthermore, there is also a relationship between ethnicity and predisposition to CHD. South Asians have a 40% higher risk of developing the disease than the rest of the population. Brent, Ealing, Hounslow and Harrow are among the most ethnically diverse boroughs in London.<sup>4</sup>

Whilst many improvements in the delivery of care to people with cardiac disease have been made, there is still much to be achieved. There remain significant variations in service delivery across the Network which must be tackled and cost effective evidence based treatments which provide safe and appropriate care need to be implemented across the sector.

The Network is well placed to work alongside users, clinicians and managers in primary, secondary and tertiary care to reduce inequity and deliver improvements in all aspects of cardiac care.

The Network should add value to the work of the constituent organisations within NW London who remain the statutory bodies through which standards and key actions and targets must be implemented.

Key roles of the Network include:

- Ensuring the delivery of equitable and high quality cardiac services across all Network organisations
- Ensuring that services are patient centred and that care across the Network is safe and appropriate
- Supporting organisations in reducing emergency admissions of patients with cardiac illness, e.g. heart failure admissions, arrhythmias such as Atrial fibrillation etc and in reducing length of in-patient hospital stay for patients with CHD.
- Supporting organisations to enable effective delivery of the CHD National Service Framework and NHS Plan<sup>5,6</sup>

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<sup>1</sup> National Service Framework Report - Getting to the heart of it. Coronary Heart Disease in England: a review of progress towards the national standards, Healthcare Commission, 2005

<sup>2</sup> 'Commissioning for Equity: Inequalities in Access to Revascularisation in the NHS and in the Independent Sector Among London Residents' 2006, London Health Observatory available at <http://www.lho.org.uk>

<sup>3</sup> 'National Service Framework for Coronary Heart Disease', 2000, Department of Health

<sup>4</sup> NWL SHA Public Health Supplement: Annual Review, 2003/04

<sup>5</sup> The NHS Plan: a plan for investment, a plan for reform, Department of Health, July 2000

- Assessing impact and implementation of new guidance across the Network e.g. NICE, Royal College recommendations, new CHD NSF Chapter<sup>7</sup> etc.
- Appraising new technology and assessing impact on care delivery and implementation across the Network
- Developing a strategy for cardiac services across NW London (including decision making/advice on proposed capital investments)
- Supporting organisations to achieve Planning and Priorities Framework (PPF) targets and Local Delivery Plans (LDPs) utilising effective intelligence<sup>8</sup>
- Advising on equitable commissioning issues affecting cardiac service across the Network
- Ensuring effective service improvement activities are spread across all organisations and health communities within NW London
- Leading on national priorities identified by the Department of Health Heart Team e.g. access to diagnostics, delivery of 18 week wait, improved management of inter-hospital transfers, delivery of cardiac choice etc

In order to ensure success of this strategy, the Network must ensure:

- Continued active participation and support from all constituent organisations at both a clinical and managerial level
- Support from the London Strategic Health Authority at different levels including –
  - Information and performance
  - Public health
  - Strategy and planning
  - Workforce
  - Modernisation
- Protection of existing funding stream to support Network activities beyond July 2007

<b>3.</b>	<b>Network Infrastructure</b>	
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### **3.1 Internal Infrastructure**

The current structure of the Network's core team is detailed as follows:

- Chair
- Director
- Clinical lead (2 sessions per week)
- Public Health Lead (4 sessions per week)
- Assistant Director (Network Lead for Service Improvement)
- Network Administrator
- 3 Service Improvement Project Managers
- Patient & Public Involvement Service Improvement Lead
- 3 Senior Project Managers (workforce, 18 week wait delivery, Heart Failure/Rehab & Primary Care)
- IHT Co-ordinator for non-elective cardiac care across NW London
- Chair Heart2Heart User Forum (unpaid)

<sup>6</sup> The NHS Improvement Plan: putting people at the heart of public services. Department of Health, June 2004

<sup>7</sup> Chapter Eight: Arrhythmias and Sudden Cardiac Death. Department of Health. March 2005

<sup>8</sup> National Standards Local Action: health and social care standards and planning framework, Department of Health, 2005/06 – 2007/08

Short term secondments/consultancies will be recruited into the core team, where appropriate, to draw on specialist expertise, not available within the team.

### **3.2 External Infrastructure**

- Heart Improvement Programme
- Heart2Heart User Forum

<b>4.</b>	<b>Key Stakeholders</b>	
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### **4.1 Internal NW London Stakeholders**

Internal stakeholders include:

- NHS London
- Imperial College
- Primary Care Clinical Teams
- Chief Executives, CHD PCT Leads, Commissioners and clinical teams in PCTs
- Chief Executives, Senior Managers, Consultants and clinical teams in Acute Trusts
- Local Implementation Teams (incorporating social care and local boroughs)
- Practice Based Commissioning Groups
- Patient / carer representatives (individuals and specific NWL patient groups)
- Specialist Commissioning Team (hosted via Hillingdon PCT)
- London Ambulance Service
- Other NW London Networks e.g. Diabetes, Emergency Care, Palliative Care, Cancer etc

### **4.2 External Stakeholders**

There are a large number of external stakeholders, these include:

- Cardiovascular Team – Department of Health
- Heart Improvement Programme
- National Institute for Clinical Excellence (NICE)
- Health Care Commission
- Public
- Media
- Other Cardiac Networks (particularly London and the South East)
- Specialist Commissioning Group (SCG)
- Voluntary organisations e.g. British Heart Foundation (BHF)
- Royal Colleges & Societies: Royal Society of Medicine (RSM), British Cardiovascular Society (BCS), British Cardiovascular Intervention Society (BCIS), Society of Cardiothoracic Surgeons (SCTS), British Association of Cardiac Rehabilitation and other affiliated groups.
- Independent sector
- Industry

<b>5.</b>	<b>Work Plan 2007/08</b>	
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The work plan for 2007-09 focuses on a number of key areas. An overarching principle of the Network strategy will be to identify and reduce inequities in access and treatment as well as to monitor and support local health economies in effectively delivering the CHD NSF standards. The NWLCN will also be working with organisations to support initiatives which will enable reductions in emergency hospital admissions and which will allow a reduction in in-patient hospital stays across all areas of coronary heart disease and stroke. Areas identified as requiring particular focus by the Network have been developed into specific pieces of work for 2007-09.

In addition, the Network has an important role to play in ensuring that all organisations across NW London have support which will enable them to meet targets identified nationally as part of the PPF targets and locally as part of the LDP process. The Network will feed into local planning with PCTs and Practice Based Commissioning (PbR) groups to ensure that priorities, funding and service improvement activities are targeted appropriately to support delivery of national and local CHD objectives.

Finally, the Network will also take the lead in reviewing any relevant NICE guidance and will assess the impact of this across NW London. The Network has a responsibility for ensuring the delivery of evidence based practice and equity across the sector; it will therefore advise organisations appropriately on the implementation of such guidance.

In addition to the above overarching areas, the following specific areas of work have been identified:

## **SECTION A - CORE NETWORK WORK STREAMS**

### **5.1 Service Improvement**

#### **Priority: High**

Service improvement underpins almost all aspects of the Network's activities. In keeping with NHS Modernisation methodology, the service improvement approach serves to promote the re-design and improvement of services ahead of any adjustments made to Trusts' commissioning arrangements. The Service Improvement team of project managers work across the patient pathway to ensure that resources for new developments are appropriately directed only after a full evaluation of the potential benefits. The Service Improvement team of project managers are all skilled in the application of the modernisation techniques, which are pivotal to the delivery of service improvements and redesign. Service Improvement Project Managers are based within local health economies, taking forward service improvement initiatives identified locally, as well as leading on agreed Network initiatives on a sector-wide basis.

In addition, the Service Improvement team support specific sector wide projects including in particular, the delivery of the 18 week wait within individual health economies. In the main, these larger projects are led by Senior Project Managers to drive forward particular areas of work including 18-week target, Workforce & education, and Primary care.

Pressure on future resources will require the team to purely focus on the key areas identified in this work plan, ensuring effective integrated working with colleagues to deliver the specified milestones. There will be a continued need to identify local champions to lead on key pieces of work within their particular organisations, supported by the Network core team.

Exit strategies will need to be developed to deliver ongoing sustainability for all projects undertaken by the Network.

All service improvement activities will need thorough evaluation upon completion supported by written evidence demonstrating 'added value' against investment.

Key objectives are to:

- Drive forward Service Improvement projects within local health economies in response to national and local priorities within agreed timescales and with regular reporting mechanisms.
- Identify sector-wide lead roles against agreed Network priorities e.g. Inter-hospital transfers, primary angioplasty, heart failure, rehabilitation etc, and report regularly on progress, outcomes and issues specific to agreed and local projects.
- Involve patient's voice and patient's needs at the heart of the projects by the use of techniques and methodology, such as discovery interviews and digital voices (a mechanism of sharing patient's experiences through succinct electronic moving image files).
- Integrate clinical perspective and clinical staff into all project work, as appropriate.
- Facilitate the collection, analysis, synthesis, and presentation of appropriate quantitative and qualitative data, as required in line with the NWLCN datasets and local initiatives.
- Support communication across the sector, in adherence to existing strategies, to ensure dissemination of information and opportunities for discussion are accessible and relevant to target audiences, and enabling sharing of good practice and knowledge.
- Assessment of services using techniques including: demand and capacity, scoping and mapping of services, surveys and evaluation of service improvements/redesigns etc.
- All service improvement projects will require exit strategy as part of the project plan and full evaluation on completion to demonstrate 'added value' against investment.

**Milestone 1:** 07/08 Continued co-ordinated approach and spread of service improvement activities across the sector in response to nationally and locally identified priorities.

**Milestone 2:** 07/08 Established work plans within local health economies spanning the patient pathway and facilitating shared knowledge and best practice across the sector and beyond – in particular in joint initiatives with neighbouring Networks.

**Milestone 3:** 07/08 Implementation and evaluation of sustainable service improvements across the patient pathway to underpin delivery of the 18-week patient pathway.

**Key Performance**

**Indicator 1:** 07/09 Consistent delivery of information to all stakeholders & embedding of service methodology and service redesign within all local organisations

**Key Performance**

**Indicator 2:** 07/09 Implemented service improvements with improved patient flows through cardiac centres e.g. Echo departments.

**Key Performance**

**Indicator 3:** 07/09 End-to-end patient pathways free from lengthy waits.

## **Key Performance**

**Indicator 4:** 07/09 Successful integration of service improvement initiatives within clinical teams towards achievement of interim milestones and national targets.

## **Key Performance**

**Indicator 5:** Early 2007 - the production of detailed local health intelligence information for all local health economies across NW London.

## **Risks 1:**

Uncertain funding levels: baseline budgets not yet agreed beyond July 2007. Changes to levels of funding may require re-prioritisation of this work plan.

Likelihood of occurrence - high

Impact on business – if inadequate funding available to employ current staffing levels, some work streams within this document will need to be reviewed based on an agreed re-prioritisation against available funds.

Management of risk – Added value of the Network requires demonstration to continue to gain financial support from PCTs beyond March 2008

## **Risk 2:**

Inability to promote spread and embed service improvement methodology to all organisations in 07/08 due to high vacancy rates due to uncertain funding stream beyond July 2007.

Likelihood of occurrence – high

Impact on business – Reduces Network ability to achieve a number of its objectives – may impact upon the support available to local organisations to enable achievement of national and local targets

Management of risk – clear communications to promote Network agenda and joint working on locally agreed priorities. Increased use of secondments for specific projects to be implemented

## **Resource Implication:**

Ring fenced resources accounted for in recurrent 07/08 funding.

## **Network Lead:**

Jinty Wilson, Assistant Director

## **5.2 Patient and Public Involvement**

### **Priority: High**

The Network is committed to developing patient centred services designed around individual need. The Network will support and encourage all organisations to consult with the public and patients in the planning and development of services. The Network's User Involvement Strategy, completed in November 2004 has been mainly implemented with some aspects needing further focus over the forthcoming year.

The Network has aimed to get effective user involvement at all levels of the Network utilising a variety of tools; at Board level, the Network Heart2Heart Forum, Trust PPI Forums, local cardiac patient support groups, Discovery Interviews, Surveys, Focus Groups, formal linkages with local Cardiac groups, PALS teams etc.

To date the Network has been successful in recruiting a large number of patients/carers from different geographical locations and ethnic backgrounds to the Heart2Heart User Forum and this progress will need to be sustained in the coming years.

Supported by the Network's PPI lead, the Heart2Heart Forum has taken forward a variety of streams of work including: patient surveys, development of home-care packs, educational literature for patients printed in different languages, health awareness events/fairs etc. The success of events aimed specifically at ethnic groups such as the September 2006

Heart2Heart World Heart Day Event has provided the impetus for further investment in these areas. Over the forthcoming 2 years, the Network will concentrate on developing more effective engagement with ethnic community groups, charities and local media to promote preventative aspects of cardiovascular disease.

- Milestone 1:** Q1 2007 - Formal linkages established supported by a detailed database of key leads for all community groups, voluntary organisations and charities such as. Asian Network, local mosques/temples, Age Concern, MENCAP, British Heart Foundation etc
- Milestone 2:** Q1 2007 - Identification of specific areas of mutual working with existing patient forums and services including PALS, PPI Forums (or their successors), Local Implementation Group patient leads etc.
- Milestone 3:** Q1 2007 - Delivery to time of the British Heart Foundation pilot for “Hearty Voices” training for South Asians.
- Milestone 4:** Q2 2007 - Establishment of a full autonomous training programme for discovery interviews pan-London with all NW London Network project managers trained in this technique and demonstrating application in practice.
- Milestone 5:** Q2 2007 – Roll out of the home care pack across all NW London acute hospitals supported by patient ward visits.
- Milestone 6:** Q4 2007 – Development of buddy system linked with individual rehabilitation teams – this will involve the development of a resource of appropriately trained patients who can be called upon and ‘matched’ to support patients undergoing cardiac rehabilitation. All such ‘buddies’ would require local training, completion of an Expert Patient Programme and relevant personnel checks from local Human Resource Departments.
- Milestone 7:** Q3 – Establishment of patient led health awareness campaigns via a variety of means including literature, local media, the Network website and use of events with the aim of hosting a minimum of 1 large event annually.
- Milestone 8:** Ongoing - Demonstration of continued recruitment of patients/carers to the Heart2Heart User Forum. Evidence of the continued use of patient surveys, focus groups, attendance at local health fairs, development of patient information and active engagement in all aspects of the Network’s activities.
- Milestone 9:** Current identified patient surveys to be completed by Q1 with further surveys identified by Q2.

**Key Performance Indicator 1:**

Effective user representation evident at all levels of the Network with evidence of joint working across local community groups and charities such as the British Heart Foundation. Delivery of the BHF “Hearty Voices” training programme for South Asians and implementation of other patient led initiatives including ward visits, the ‘buddy’ scheme for rehabilitation services and health awareness events.

**Risks:**

Inability to retain adequate patient/carer numbers to support the above Network activities  
Likelihood – medium  
Impact on business – will prevent implementation of some of the above initiatives and will reduce patient involvement in key Network wide activities.

Management of risk – Need to widely promote work of the Network, use variety of techniques for recruitment of patients/carers and establish effective early formal linkages with established local groups

**Resource Implication:** Funding required to support ongoing PPI activities e.g. travel expenses, catering costs, room hire etc) – estimated 10k annually (to be funded out of the annual Network budget allocation).  
Funding to support a PPI service improvement project manager lead 0.5wte (to be funded out of the annual Network budget allocation).

**Network Lead:** Joanna Gardner, Service Improvement Project Manager  
Maria O'Brien, Director

### **5.3 Network Communication**

#### **Priority: High**

Communication with our internal and external stakeholders remains an important and ongoing area for focus. Implementation of the Network's Communication Strategy during 2005 played a major role in engaging key groups and publicising the work of the Network.

A variety of different communication methods have been used since the launch of the Communications Strategy ranging from newsletters, communication cards, flyers, general promotional material, education & training events, local media and the Network's website. Whilst successful, the methods of communication will need to remain varied and fluid in order to meet the continued and changing needs of our different stakeholders.

From a clinical perspective, it is essential that the Network is able to reach all professional groups across NW London so that they can inform priority areas of our work and engage fully in our activities. The Success of educational events including our first NW London Cardiac Network Conference, "At the Heart of it – leading the way in cardiac care" held in October 2005 and subsequent education sessions developed for specialist nurses and primary care clinicians serve to support this objective.

On a wider basis, it is essential that the work of the Network continues to be effectively shared and communicated; demonstrating the 'added value' which the Network brings to all stakeholder groups. During 2006, the Network produced a comprehensive review document detailing achievements to date. The production of an Annual Report will therefore continue to remain a priority area as part of our Communication Strategy.

From a patient perspective, the Network needs to ensure that information produced is readily accessible, informative and patient centred. The Network needs to build upon the success of initiatives including the "Healthy Living" brochures, such that they are available to different sections of the English and non-English speaking population. Information needs to continue to be developed in conjunction with cardiac patients, via a variety of mediums to ensure that it is accessible to all sections of the diverse NW London population, e.g. elderly patients/carers, non-English speaking patients/carers, learning disability patient/carers, mental health patients/carers etc.

In addition to sustaining the progress already made to date, the priority for the forthcoming two years will be to develop a communications marketing strategy focusing around the creation of new and innovative methods of communication with our stakeholders. Provision of more specific information covering areas of interest such as delivery of the 18 week wait, medicines management, commissioning etc. will also be developed. The Network's

engagement with primary care has been identified as high priority and appropriate communication tools will need to be established to support this.

**Milestone 1:** Q1 2007 – Development of a formal evaluation tool to complement existing evaluation mechanisms aimed at assessing effectiveness of the Network’s existing Communication Strategy and to identify areas requiring further development.

**Milestone 2:** Q1 2007 – Development of a communications marketing strategy to highlight new information needs and to identify original and innovative methods of communication across the various different stakeholder groups. This will include development of an annual project plan detailing planned communication initiatives throughout the year.

**Milestone 3:** Programme of priority educational events identified and developed during Q1 for 2007/09.

**Key Performance**

**Indicator 1:** Assessment tool developed and used to evaluate communication strategy during 2007, Q1

**Key Performance**

**Indicator 2:** Marketing strategy developed in conjunction with key stakeholders and project plan in place highlighting all planned communication initiatives. Q1

**Key Performance**

**Indicator 3:** Programme of planned educational activities for 2007/09 developed during Q1.

**Risk 1:** Uncertainty of future funding levels may impact upon some of this work. This risk will be reduced by seeking sponsorship from industry in line with the Network’s “Working with Industry Policy” (2006).

**Resource Implication:** Funding required from ring-fenced allocation to support the various aspects including a) ongoing website support, development & maintenance, b) Events, conferences, workshops, c) communication literature etc circa 50K.

**Network Lead:** Jinty Wilson, Assistant Network Director

**5.4 Information Strategy and Performance Monitoring**

**Priority: High**

Over the last 2 years, the Network has been successful in developing a core CHD dataset to monitor performance of organisations in delivering the standards of the CHD NSF. This has been supported by the availability of additional information sources including a) access to MINAP/QMAS via Rapport (service improvement tool), b) drug prescribing via the Strategic Health Authority, c) clinical and waiting time data via the NW London IHT web-based transfer system and d) provision of outcome and performance data from each of the Network’s 3 primary angioplasty centres.

In order for the Network to continue to operate effectively, it needs access to high quality robust information to inform work priorities and to enable required service improvement activities to be appropriately targeted to support the various organisations. Information is required to support all stages of the patient pathway, including prevention, primary care,

ambulance services, secondary care including rapid access chest pain clinics, tertiary care, heart failure services and rehabilitation. Robust information is also required to support expert advice to commissioners, clinical governance, performance management and planning. Delivery of the 18 week patient pathway during 2008 requires the ability to access information from referral through to first definitive treatment. As such, the Network needs to continue to work closely with local organisations, NHS London, Department of Health, London Health Observatory and other sources to ensure continued and improved access to high quality information.

The Network will continue to play a key role in performance monitoring and will adapt service improvement activities and work priorities to those areas highlighted as requiring additional support to meet the required standards. In the changing NHS landscape, the Network will need to develop integrated links with NHS London in relation to the performance monitoring of key national and locally agreed cardiovascular milestones across NW London.

- Milestone 1:** Agreed ongoing data support and performance monitoring arrangements in place with NHS London by Q1.
- Milestone 2:** To have in place a) rehab data set (York) across all NW London organisations, b) agreed common data set for primary angioplasty and c) widespread use of Rapport by Q1.
- Milestone 3:** To commence work on the implementation of the national heart failure data set Q4 onwards.
- Milestone 4:** To access RTT information from across relevant Trusts and produce regular benchmarking information on key cardiac areas; quarterly.
- Milestone 5:** To explore during Q1 other sources of potentially rich information including Dr Fosters.
- Milestone 6:** To establish a process of 'peer review' across organisations and the London Networks by Q4.

#### **Key Performance**

**Indicator 1:** Arrangements in place for regular performance information and monitoring with NHS London

#### **Key Performance**

**Indicator 2:** National rehabilitation data collection in place across all NW London with quarterly audit data & benchmarking data produced across the Network

#### **Key Performance**

**Indicator 3:** Agreed process in place to establish 'peer review' within and external to NW London

**Risk 1:** Future relationship with NHS London unclear which may impact upon performance monitoring across organisations.

Likelihood of occurrence – High

Impact upon business – will reduce inability of the network to effectively assess organisational performance against key quality cardiovascular milestones.

Management of risk – need to consider other sources of information including Dr Fosters

**Risk 2:** Financial constraints within organisations may impede implementation of national data sets including, rehabilitation and heart failure.

Likelihood of occurrence – High

Impact on business – Will prevent data completion, will impact upon ability for either the SHA or Network to assess NSF implementation across the sector, will reduce ability to identify areas for development/support

Management of risk – will need active support of both the SHA and CEO's of respective organisations to gain prioritisation and 'buy-in' from all organisations

**Resource Implication:** May require investment (0.5wte) data analyst pending available support from NHS London

**Network Lead:** Maria O'Brien, Director

**NHS London Lead:** To be confirmed

## **5.5 Clinical Governance**

### **Priority: High**

Although statutory organisations have responsibility for clinical governance within each of their organisations, the Network also has a responsibility to highlight areas of concern and to make recommendation on required improvements. Cardiac services across the Network support audit, clinical governance and continuing professional development. The Network needs to develop an appropriate clinical governance strategy which will have the capacity to assess the equity of all interventions undertaken, clinical outcomes and the degree to which individuals have access to comparable treatments. Within the changing landscape of the NHS, the Network will need to review its current governance arrangements and develop a new strategy aligned to new structures being created across London.

**Milestone 1:** Draft Governance Strategy to be developed by Q2 & circulated to key stakeholders for consultation

**Milestone 2:** Final draft to be presented to Network Board & Chief Executive Forum for ratification and action plan for implementation developed by Q3

### **Key Performance**

**Indicator 1:** Ratified Clinical Governance Strategy in place by Q3

**Risk 1:** Current uncertain arrangements for Networks at a National and Local level; future structure and function. Governance strategy cannot be developed until national and local structures have been clarified and agreed.

Likelihood – high

Impact on business – lack of clarity will impact upon delivery of some aspects within this work plan and ability to revise governance arrangements.

Management of risk – work closely with the Heart Improvement Programme, DH vascular programme, NHS London, NW London CEOs and the other London Cardiac Network to develop a consistent approach for the future configuration and remit of Cardiac Networks across London.

**Resource Implication:** Not known at this time.

**Network Lead:** Network Clinical Lead  
Maria O'Brien, Network Director

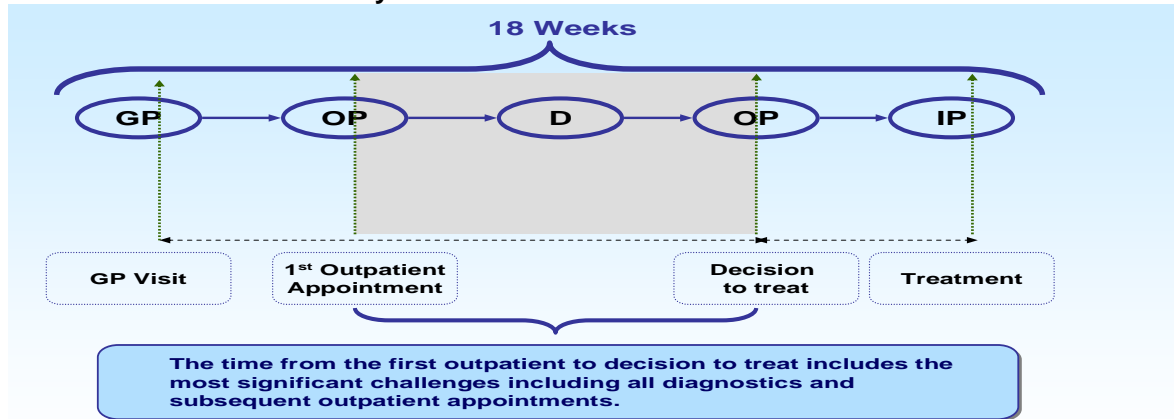
## SECTION B - SPECIFIC NETWORK WIDE WORK STREAMS

### 5.6 Delivering the 18-week Patient Pathway

#### Priority: High

The Government has set a national target of ensuring that by December 2008, no-one will wait more than 18 weeks from GP referral to hospital treatment.<sup>9</sup> As an interim target, the Department of Health has stated that 85% of admitted patients and 90% of non-admitted patients should be meeting the 18 week standard by March 2008. Implementation of this target is proving challenging for all areas of the NHS; cardiac services are no exception.

#### The 18 week Patient Pathway



Over the last year, the Network has mapped, patient pathways for angiography, angioplasty, electrophysiology/device implants, coronary artery bypass grafting (CABG) and valve repair/replacement across every NW London organisation. The waiting times at each stage of the patient pathway have been measured. An analysis has been made of where delays are occurring in order to target specific service improvement activities to facilitate the required improvements to support achievement of the target.

As a result of this work, a number of service redesign projects were identified across each of the organisations; focusing on different aspects of the patient pathway. A number of these pilot projects have focused around diagnostic services, ensuring that organisations are meeting the requirements of Choice of Scan Phase 3<sup>10</sup>. Over the coming months, the learning from each of these pilot projects will be spread across the Network to enable accelerated progress to be made in different areas of the patient pathway.

During the forthcoming year, further service improvement activities will be targeted to support organisations make required service redesign aimed at eliminating delays and supporting long term sustainability. In addition, concentrated effort will be placed upon measuring and costing existing “backlog” to support commissioners in targeting resources effectively. Another main strand of work will centre on the required information flows and processes to enable accurate measurement of waiting times both within and across different organisations. The Network will establish a sector wide strategy group to oversee implementation of this work stream. It is envisaged that the strategy group would look at common issues across the network e.g. agreeing pathways across the secondary/tertiary care interface, duplication of diagnostics, RTT measurement etc.

<sup>9</sup> Commissioning an 18 week Patient Pathway, Department of Health, 2006

<sup>10</sup> Choice of Scan: Phase 3: Guidance. Department of Health, August 2006.

It will be essential to support all aspects of this work through frequent and effective communication to stakeholders across the Network.

<b>Milestone 1:</b>	All pilot projects completed and evaluated with action plan in place, detailing recommended pathways and to support spread of learning across the entire Network by Q1.
<b>Milestone 2:</b>	Accurate analysis and costing of “backlog” completed for all organisations and report tabled to commissioners. This will include assessment of true capacity and demand within key service areas across the Network by Q1.
<b>Milestone 3:</b>	Information processes established across each organisation to support collection of data and measurement of waiting times at each stage by Q2.
<b>Milestone 4:</b>	Further service redesign projects implemented to support innovative practice and longer-term sustainability by Q2.
<b>Key Performance Indicator 1:</b>	Network wide project steering group established with evidence of spread of service improvement activities across the Network.
<b>Key Performance Indicator 2:</b>	Agreed Network wide pathway established and implemented spanning secondary and tertiary care referrals
<b>Key Performance Indicator 3:</b>	Agreed processes in place across organisations to support RTT measurement.
<b>Key Performance Indicator 4:</b>	“Backlog” quantified and agreed commissioning/acute Trust plans in place to eliminate backlog and maintain “steady state”.
<b>Key Performance Indicator 5:</b>	Organisations demonstrate achievement in meeting the interim milestones identified as part of the 18 week-wait pathway.
<b>Risk 1:</b>	Financial organisational constraints may impact upon delivery of target particularly in relation to costs associated with treating the “backlog” Likelihood – high Impact on business – inability for some organisations to deliver 18 week patient pathway on time. Management of risk – Network to undertake detailed analysis of the backlog and provide report to commissioners to enable effective planning and decision making.
<b>Risk 2:</b>	Sustaining service redesign projects once direct support of Network project managers +/- specific short-term funding has been withdrawn Likelihood – high Impact on business – inability to deliver sustained improvements in some organisations to meet 18 week patient pathway. Management of risk – Exit strategies to be developed as part of all planned projects. Local “buy-in” and leadership obtained at the start of any projects with “sign-off” for sustained improvement gained from relevant senior manager prior to commencement.
<b>Resource Implication:</b>	Service redesign will be supported by existing Network project managers. Cost of sustainability and treatment of “backlog” is not fully understood at this time.
<b>Network Lead:</b>	Jennifer Johnson, Senior Project Manager, 18 week-wait

## **5.7 Reducing Length of Stay: Improved Effective Management of inter-hospital Transfers**

### **Priority: High**

Over the past two years, the Network has made enormous progress in improving the waiting times for patients admitted as an emergency with an acute cardiac condition who subsequently require transfer to another provider, as part of the same admission for either Angiography, Angioplasty, Device Implantation, Electrophysiology or Cardiac Surgery. Some of the key measures implemented included: setting a 48-hour target from admission to transfer, developing a standardised risk assessment/referral system, appointment of a NW London Inter-hospital transfer co-ordinator, implementation of an electronic web-based referral and audit system linked to all NW London Acute Trust's and their feeder organisations external to NW London.

The effectiveness of all the initiatives implemented by the Network to improve this area was demonstrated in the results of a national audit, developed by the Heart Improvement Programme, during October 2005 which highlighted NW London as being amongst the top performing Networks nationally. Further, an analysis taken from the *Dr Foster Shared Intelligence Hospital Acute Tracker* (HAT), in early 2006 highlighted that despite rises in emergency admissions across NW London (increase of 14%), there was a corresponding reduction in emergency bed days (down by 8%). Additional analysis of this data by the SHA confirmed that cardiac activity was the major contributing speciality for this improvement.

Whilst the improvements to date have been impressive, particularly in relation to Angiography and Angioplasty, further change is required across the other cardiac pathways. This area of work therefore requires continued focus to drive further improvements across the Network which will enhance the patient experience, eliminate excess bed days and release further capacity to support organisations in meeting the 18-week patient pathway.

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| <b>Milestone 1:</b> | Development of regular performance monitoring and benchmarking reports for all NW London organisations – in progress  |
| <b>Milestone 2:</b> | Continued development of the IHT web-based referral system to support use for cardiac surgery, electrophysiology and device implantation – in progress  |
| <b>Milestone 3:</b> | Improve data entry across all NW London organisations through ongoing monitoring and training – in progress   |
| <b>Milestone 4:</b> | Agree an effective model across all NW London organisations to facilitate patients being “diverted” to the centre with the shortest waiting times – in progress   |
| <b>Milestone 5:</b> | Agree standardised pathway's of care for all surgical referrals including implementation of programmes to support 'home discharge' with early surgical re-admission dates, standardised 'work-up'/optimisation pre-transfer and repatriation processes, (where appropriate) |
| <b>Milestone 6:</b> | Improve local access at either the DGH or tertiary centres to pre-surgery diagnostic tests e.g. lung function, echocardiography, carotid Doppler etc as part of the overall work plan for delivery of the 18-week patient pathway.  |

### **Key Performance**

**Indicator 1:** Continued demonstrable improvements in waiting times across all cardiac pathways

### **Key Performance**

**Indicator 2:** IHT system developed to support electrophysiology, device implant and surgical referrals and rolled-out to all Trusts by Q1.

## **Key Performance**

<b>Indicator 3:</b>	Improvements in the surgical patient pathway implemented demonstrating reduced waiting times and improved patient experience.
<b>Risk 1:</b>	Uncertain funding arrangements post July 2007 leading to concern in relation to ongoing sustainability, specifically a) funding of the NW London Inter-hospital Co-ordinator role and b) future upgrades/maintenance of the IHT web-based system. Impact on business – lack of sustainability with potential deterioration in waiting times Management of risk – exit strategy needs to be developed in conjunction with providers to support ongoing work, particularly in relation to funding for the NW London Inter-hospital Co-ordinator role.
<b>Resource Implication:</b>	Ongoing funding of the NW London Inter-hospital Co-ordinator role circa 40K inclusive of 'on-costs'. System maintenance/development circa 15k annually
<b>Network Lead:</b>	Dr Iqbal Malik, Consultant Cardiologist St Mary's NHS Trust Maria O'Brien, Network Director

### **5.8 Primary Angioplasty & Clinical Research to advance Improvements in Care Delivery**

#### **Priority: High**

Since 2005, an integrated NW London model for the delivery of Primary Angioplasty services has been implemented such that any NW London patient now presenting with an ST elevated Myocardial Infarction (STEMI) is taken direct by the London Ambulance Service to either St Mary's or Hammersmith Hospitals (for inner NW London) or Harefield Hospital (for outer NW London) where they receive primary angioplasty instead of thrombolysis. This agreed Network wide model has been in place on a 24 hour, 7 day per week basis for all NW London residents since October 2005. Evaluation to date has shown that 30 day mortality rates have fallen significantly from 11.5% - 3% since implementation of primary angioplasty. Cost benefits have also been identified, particularly in relation to bed-days, with an average saving noted of 8.7 bed-days per case.

The agreed Network model is also part of a national Department of Health pilot evaluating the feasibility of providing such services across other parts of the country.

Ongoing evaluation, quality monitoring and audit of our primary angioplasty service is therefore required to continue to deliver improvements for heart attack patients in NW London. The Network will lead on developing appropriate tools to support the monitoring and benchmarking of services across our organisations.

Of equal importance is our commitment to supporting clinical research activities across the Network to enhance the provision of care to patients. The Faculty of Medicine at Imperial is one of Europe's largest medical institutions with an annual research income approaching £100million. The university has close collaboration with many of NW London's major teaching Trusts enabling the translation of research into clinical practice. All the tertiary sites across NW London have joint academic appointments with the university. The wealth of expertise across NW London in terms of research is therefore immense. As such, it is important that the Network supports local research initiatives linked to clinical practice. In relation to primary angioplasty, two Network wide projects have been identified: 1) Gender

analysis of patient receiving Primary Angioplasty and 2) Target vessel versus total revascularisation.

Both projects serve to address important questions relating to a) potential inequities in access/treatment and b) the most effective form of intervention for patients presenting with STEMI. The outcome of such research is likely to have a direct impact upon future care for patients.

- Milestone 1:** Agreed data set developed to monitor quality of Primary Angioplasty services – in progress
- Milestone 2:** Established mechanism in place to support the quarterly production of benchmarked information across all Primary Angioplasty centres – by Q1.
- Milestone 3:** Research proposals agreed with all stakeholders for both research projects – in progress
- Milestone 4:** Ethical approval obtained for both research projects by Q1.
- Milestone 5:** Funding secured from external sources to support both research projects alongside individual Trust approval by Q1
- Milestone 6:** Research projects commence by Q2/Q3

**Key Performance**

**Indicator 1:** Demonstrable ongoing improvement in key performance measures including ‘call to balloon times’, ‘door to balloon times’, ‘length of stay’ and mortality.

**Key Performance**

**Indicator 2:** Initiation of the multi-centre gender analysis and ‘target versus total’ revascularisation research proposals.

**Risk1:** Inability to secure required funding.  
Likelihood of occurrence - low  
Impact on business – inability to undertake either research proposal  
Management of risk – other sources of funding will be investigated and evaluated.

**Risk 2:** Sustainability of the Primary Angioplasty service due to changes to tariff arrangement penalising Trust’s over-performing on other aspects of emergency activity  
Likelihood of occurrence – medium  
Impact on business – a) inequity in service provision to some residents of NW London, b) increase in emergency activity at some DGH sites, c) increase in length of stay for this patient group across the Network  
Management of risk – work with commissioners to reach a local agreement on tariff arrangements for Primary Angioplasty  
Seek national resolution via the Department of Health Vascular Programme and Payment by Results Team

**Resource Implication:** 1) Tariff arrangements require resolution  
2) Research costs unknown at this time.

**Sub Group Chair:** Professor Ken Taylor, Clinical Director, Hammersmith Hospitals Trust

**Network Lead:** Professor Ken Taylor, Clinical Director Cardiovascular Services, Hammersmith Hospitals NHS Trust  
Maria O'Brien, Network Director

## **5.9 Heart Failure Services**

### **Priority: High**

Heart failure accounts for approximately 5% of all medical admissions to hospital in the over 65 age group. It accounts for 1% of the total UK health expenditure. With improvements in cardiac invasive techniques and increased survival of patients post Myocardial Infarction, this number is continuing to increase. As such, it was identified as an important area of care in Chapter 6 of the CHD NSF.

It is common for patients with this condition to have frequent hospital re-admissions placing additional burdens on health care and social services. Heart failure has been identified by the Health Care Commission in their report "Getting to the heart of it"<sup>11</sup> as an area which requires further work to progress towards the recommendations detailed within the CHD NSF and NICE guidance<sup>12</sup>. Following this report, the Healthcare Commission implemented an Improvement Review of Heart Failure services during 2006; the results of which are due to be published during 2007. The Network will work alongside organisations to support implementation of any recommendations made by the Healthcare Commission in this report.

A key part of the Network's role is to develop and support the implementation of evidence based care models which facilitate a reduction in emergency hospital admissions and improvement in the quality of care provided to patients with heart failure within each of the local health economies. Over the past year, considerable progress has been made in improving heart failure services across the Network and in benchmarking performance between different organisations. However, despite this progress, inequalities in care provision still exist across the Network and it is therefore important that services continue to be developed in a coherent manner across the patient pathway so that a high standard of care can be provided across all of our local health economies.

In late 2006, the Heart Failure group produced and circulated a comprehensive 'Blueprint'<sup>13</sup> for the diagnosis and management of patients presenting with heart failure. This document covers all aspects of the patient pathway, detailing standards required across NW London. Over the coming year, the Network will work closely with local health economies to facilitate implementation and to monitor compliance with the recommended standards. A key part of this strategy will be the development of effective community heart failure services and the introduction of B-type Natriuretic Peptide (BNP) testing within each local health economy. This will both enable improvements in the diagnosis and management of patients with heart failure as well as supporting delivery of the 18 week wait patient pathway by reducing a) emergency hospital admissions and b) demand for Echocardiography.

As part of our work stream around heart failure, the views of our patients will continue to play an essential part of service development. Their views will actively be sought through the use of a variety of techniques including questionnaires and discovery interviews.

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| <b>Milestone 1:</b> | Action plan developed across each local health economy to assess implementation of the "blueprint" recommendations along with a timeframe for delivery by Q1.                  |
| <b>Milestone 2:</b> | Action plan established to support implementation of a Network wide accessible service for BNP testing by Q1.  |
| <b>Milestone 3:</b> | Service improvements initiatives identified to support delivery of any recommendations detailed by the Healthcare Commission as a result of the 2006 Improvement Review by Q1. |

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<sup>11</sup>"Getting to the Heart of it" Coronary heart disease in England: A review of progress towards the national standards, Commission for Healthcare Audit and Inspection, London, 2005.

<sup>12</sup> Chronic Heart Failure: Management of chronic heart failure in adults in primary and secondary care. National Institute of Health and Clinical Excellence. July 2003.

<sup>13</sup>Blueprint for Excellence in Heart Failure Services in North West London. NW London Cardiac Network; Heart Failure Group. November 2006.

<b>Milestone 4:</b>	Completion of patient evaluation via survey and discovery interviews by Q1 with action plans developed to address any concerns raised.
<b>Milestone 5:</b>	Evaluation plan developed to enable assessment of performance of organisations against “Blueprint” during 2007. This will include the need to develop benchmarking data, scoping service levels, monitoring readmission rates, reductions in length of hospital stay and repeating the public health analysis used as benchmark in the development of the “Blueprint” by Q2.
<b>Milestone 6:</b>	Development of an optimum recommended model for the delivery of heart failure services based upon best practice nationally alongside an evaluation of services already in place across the Network by Q1. This should incorporate the learning from the “Do once and share” heart failure programme completed earlier in 2006.
<b>Milestone 7:</b>	Supporting organisations to implement the national heart failure dataset by Q4.
<b>Milestone 8:</b>	Assessing the use of rolling out new technologies to support ‘care at home’. This will include utilising the findings and recommendations from the current NW London Imperial telemedicine research trial underway as well as other available sources to support service users and commissioners develop heart failure care in the most effective way.
<b>Key Performance Indicator 1:</b>	Agreed plans in place with timescales for implementation of the “Blueprint” recommendations including availability of BNP across the Network
<b>Key Performance Indicator 2:</b>	Demonstrable reduction in length of stay and emergency readmission rates for heart failure patients across NW London as evidenced by local data collection and public health analysis.
<b>Key Performance Indicator 3:</b>	Production of regular benchmarking data for services across the Network with roll-out of the national heart failure dataset underway utilised to inform further service improvement.
<b>Key Performance Indicator 4:</b>	Evaluation of new technologies completed with written recommendations presented to commissioners.
<b>Risk 1:</b>	Financial constraints may limit roll-out of “Blueprint” recommendations resulting in continued inequity across the Network. Likelihood of occurrence – Moderate Impact on Business – will impact on ability to deliver the “Blueprint” recommendations and will impact on achievement of reductions in lengths of stay and emergency hospital admissions. Management of Risk – ensuring involvement of commissioning leads and service lead from all organisations. Provision of high quality accurate information to support decision making and planning.

**Resource Implication:** There may be a financial impact upon some of the PCTs and Acute Trusts where heart failure services are under developed. This will need to be quantified across each local health economy.

**Network Lead:** Professor Martin Cowie & Dr Mark Dancy, Co-Chairs, of the NW London Heart Failure Group  
Temo Donovan, Senior Project Manager

## **5.10 'End of Life' Care**

### **Priority: High**

Improving 'end of life' care for patients with heart failure remains an important goal and forms part of the "Blueprint" recommendations. The Network need to work with organisations to ensure that the necessary facilities and support are in place to ensure that whether a patient dies in hospital, a hospice or at home, they receive a high standard of care and are treated with dignity. From a national perspective, the 'End of Life Care Programme',<sup>14</sup> aims to improve the care for patients from all disease areas at the end of their life and a number of tools have been developed to support this initiative. Specifically, Anticipatory Care Pathways, including the 'Gold Standards Framework', (GSF),<sup>15</sup> Care of the Dying Pathways including the 'Liverpool Care Pathway' (LCP)<sup>16</sup> and Advanced Care Planning including 'Preferred Place of Care' (PPC)<sup>17</sup>

During 2006, the Network launched a work stream to take forward this important area of work. To support this initiative the Network seconded a Palliative Care Nurse Specialist, one day per week to work directly with the Network on this project. The NW London Heart Failure Group will act as the steering group to oversee this work stream.

To date, a baseline assessment has been completed across all NW London organisations utilising the 'Supportive and Palliative Care' toolkit<sup>18</sup>. This has demonstrated considerable inequity in service provision and has enabled formation of an action plan to focus service improvements at key stages of the patient pathway. Some areas of good practice were highlighted which the Network will concentrate on spreading across organisations.

During 2007, a number of initiatives will be implemented to support improvements in current service provision and implementation of 'end of life' tools. The creation of a web-based service directory will be launched to support teams involved in 'end of life' care. Intensive work will be undertaken with local hospices and palliative care teams to facilitate access for heart failure patients.

**Milestone 1:** Directory of services developed by Q1.

**Milestone 2:** Pilot commenced within Hillingdon utilising PPC to empower patients in choosing the preferred place in which to die and linking this with the use of the GSF and LPC for cardiac patients. Learning from this pilot will enable roll-out of these tools for cardiac patients across NW London by Q3.

**Milestone 3:** Establish training needs, (particularly around the need for advanced communication skills) and link with appropriate training programmes including: a module from the "Principles of

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<sup>14</sup> NHS End of Life Care Programme: <http://eolc.cbcl.co.uk/eolc>

<sup>15</sup> Gold Standards Framework: [www.goldstandardsframework.nhs.uk](http://www.goldstandardsframework.nhs.uk)

<sup>16</sup> Liverpool Care Pathway: [http://www.mcpcil.org.uk/liverpool\\_care\\_pathway](http://www.mcpcil.org.uk/liverpool_care_pathway)

<sup>17</sup> Preferred Place of Care: [www.cancerlancashire.org.uk](http://www.cancerlancashire.org.uk)

<sup>18</sup> Supportive and Palliative Care in Heart Failure: A resource kit for cardiac networks. Heart Improvement Programme. Available at: <http://www.heart.nhs.uk/endoflifecare/index.htm>

<b>Milestone 4:</b>	Palliative Care – Breaking and supporting patients receiving bad news’ training programme delivered at Michael Sobell House. Strategy developed to support engagement with key stakeholders across NW London including: Palliative care teams, Hospices, London Ambulance Service, GP out of hours services, A&E leads, bereavement/counselling services, complimentary therapy services, heart failure clinical teams, social services.
<b>Key Performance Indicator 1:</b>	Service directory developed.
<b>Key Performance Indicator 2:</b>	Increase in the number of patients with end stage heart failure dying at home or in hospices as evidenced by widespread use of ‘end of life’ tools
<b>Key Performance Indicator 3:</b>	Improved service provision as demonstrated in the repeated analysis of services utilising the Supportive and palliative care toolkit
<b>Risk 1:</b>	Financial constraints may limit prioritisation of palliative care services across the Network. Likelihood of occurrence – Moderate Impact on Business – will impact on ability to deliver required national standards. Management of Risk – ensuring involvement of key stakeholders from all organisations and providing high quality accurate information to support decision making and planning.
<b>Resource Implication:</b>	There may be a financial impact upon some of the PCTs and Acute Trusts where palliative care/end of life services are under developed. This will need to be quantified across each local health economy.
<b>Network Lead:</b>	Dr Daryl Francis, Consultant Cardiologist, St Mary’s Hospital Debbie O’Hanlon, Specialist Palliative Care Nurse, Trinity Hospice Temo Donovan, Senior Project Manager

## **5.11 Rehabilitation**

### **Priority: High**

A baseline assessment of rehabilitation services conducted by the Network during 2005 served as an important factor in supporting the improved delivery of services during 2005/06, in line with the recommendations of Chapter 12 of the CHD NSF. However, it still remains an area where further progress is required to enable the sustained provision of a seamless service for patients across all areas of the Network. Nationally, just like heart failure, rehabilitation services were highlighted as an area of the CHD NSF requiring more concentrated improvement, as outlined in the Healthcare Commission’s report “Getting to the heart of it.”

Over the past 18 months, the NW London Rehabilitation group have a) implemented a generic referral form across the Network, improving information flows between services, b) developed a unified risk stratification protocol and c) produced a “healthy living“ brochure, in

a variety of languages, advising patients on various lifestyle topics and detailing all the rehabilitation team contact details from across NW London.

The Network is committed to ensuring that there is continued improvement in this area and will work with organisations over the coming year to take forward further initiatives. The support and views of patients continue to focus our priorities for this work stream. The results of a patient survey, conducted in late 2006, have highlighted areas of good practice and a number of areas requiring further work.

<b>Milestone 1:</b>	Roll-out of the national rehabilitation dataset to all NW London rehabilitation services by Q1.
<b>Milestone 2:</b>	Review of rehabilitation services for heart failure patients with Network wide recommendations to support consistent and equitable delivery to this group by Q2.
<b>Milestone 3:</b>	Agreed project plan to support the electronic referral of patients across NW London to rehabilitation services by Q3.
<b>Milestone 4:</b>	Evaluation of “phase 4” programmes, with Network wide recommendations for future service provision by Q2
<b>Milestone 5:</b>	Review of rehabilitation services available to patients post ‘device implantation’ with Network wide recommendations made for future service delivery by Q2.
<b>Key Performance Indicator 1:</b>	Robust benchmarking data available and regularly reviewed for all NW London rehabilitation services.
<b>Key Performance Indicator 2:</b>	Models of service delivery evaluated, developed and implemented for a) provision of “phase 4”, b) heart failure patients c) patients post device implantation.
<b>Key Performance Indicator 3:</b>	IT solution developed and implemented by Q4 to support referral across services.
<b>Risk 1:</b>	Financial constraints may limit prioritisation of rehabilitation services across the Network. Likelihood of occurrence – Moderate Impact on Business – will impact on ability to deliver required national standards. Management of Risk – ensuring involvement of key stakeholders from all organisations and providing high quality accurate information to support decision making and planning.
<b>Resource Implication:</b>	There may be a financial impact upon some of the PCTs and Acute Trusts where rehabilitation services are under developed. This will need to be quantified across each local health economy.
<b>Network Lead:</b>	Dr Amarjit Sethi, Consultant Cardiologist Ealing NHS Trust & Co-chair of the Rehabilitation Group Judith Edwards, Cardiac Nurse Specialist, Westminster PCT & Co-chair of the Rehabilitation Group Temo Donovan, Senior Project Manager

## **5.12 Public Health**

### **Priority: High**

Public health includes ensuring health improvement, surveillance and protection to reduce inequalities and promote population health, as well as supporting service improvement initiatives to deliver better services for patients. There is considerable potential to help NHS and partner agencies support healthier lifestyle choices in line with 'Choosing Health'<sup>19</sup>. Implementation of the fully engaged, upstream scenario proposed by the Wanless II report<sup>20</sup> will reduce the increasing burden on the NHS by £30 billion by 2022.

The Network is committed to working with local organisations to support sector wide initiatives aimed at improving the health of our local population. To support this work stream, the Network appointed a Public Health Consultant in late 2006 to advise and drive forward progress on appropriate aspects of this agenda. Public health and prevention will form an increasingly important aspect of our overall agenda over the coming years.

Some early priority areas include:

- Establishing information flows about PCT populations, primary care, relevant acute trust data
- Tackling inequalities; mapping data by ethnicity & gender to ensure services match need, (starting with revascularisation).
- Establishing connections with other groups, e.g. Directors of Public Health, Health Promotion Leads, Smoke free/Tobacco Alliances, Obesity groups, Sports/Physical Activity Partnerships
- Reviewing and responding to relevant NICE consultations and advising on implementation of published guidance
- Pilot work to support action by primary care on patients 'at-risk' of cardiovascular disease
- Providing specialist advice to providers and commissioners on appropriate aspects of cardiovascular prevention, diagnosis and treatment

<b>Milestone 1:</b>	Map CVD information flows by Dec 2007.
<b>Milestone 2:</b>	Follow up on LHO revascularisation & ethnicities report with acute trusts & PCTs by Mar 2007.
<b>Milestone 3:</b>	Monitor revascularisation rates by ethnicity & gender annually.
<b>Milestone 4:</b>	Promote HEA with relevant commissioners by Dec 2007.
<b>Milestone 5:</b>	Survey NW London Smoke Free leads and Smoking Cessation leads by Dec 2006
<b>Milestone 6:</b>	Secure connections with Smoke Free London by Dec 2006
<b>Milestone 7:</b>	Agree sector action plan to support launch of Smoke Free public places by Mar 2007
<b>Milestone 8:</b>	Re-launch NW London PCT Obesity leads group Dec 2006. Agree sector action plan, if needed, by Q3 2007.
<b>Milestone 9:</b>	Establish links with Sport England and any Physical Activity leads in the sector to share good practice on Physical Activity promotion.

### **Key Performance**

**Indicator 1:** CVD Information database & framework in place 2007/08

<sup>19</sup> Choosing Health: making healthy choices easy. Department of Health. 2004

<sup>20</sup> Wanless, D., "Securing our Future Health: taking a long-term view". Final Report, London, HM Treasury. 2002.

<b>Key Performance Indicator 2:</b>	Document reduction in inequalities in revascularisation rates by ethnicity & gender by 2008/09
<b>Key Performance Indicator 3:</b>	Smoke free NWL Sector action plan developed & successful local implementation of Smoke free
<b>Key Performance Indicator 4:</b>	Responses to relevant NICE consultation received & ratified by Network Board
<b>Risk 1:</b>	Due to re-organisation many PCT & SHA employed partners are undergoing transition and staff may find engagement with the Network difficult at least until future jobs are confirmed. Likelihood of occurrence – High Impact on Business – will impact on ability to deliver the information and action plans Management of Risk – ensuring involvement with the key leads to ensure we are linked in early to new staff or data flows
<b>Network Lead</b>	Dr Bal Kaur, Public Health Consultant Anna Kilpin, Senior Project Manager

### **5.13 Primary Care**

#### **Priority: High**

Primary care is pivotal in delivering a significant element of the NSF. The Network needs to develop more effective links across primary care, supporting PCTs to meet key targets and to focus on developing more effective pathways of care within the community.

Work in this area will focus on:

- Evaluating existing local initiatives already in place and implementing mechanisms for spreading good practice and sharing community based models of care across the sector, for example, re-establishment of primary care sub-group.
- Development of standardised care pathways across the Network spanning primary and hospital services
- Supporting the shift of care from secondary to primary care settings, where appropriate, particularly around the development of community diagnostics e.g. Echocardiography, 24 BP monitoring, Event recorders etc
- Assessing impact of primary care data and CHD registers in delivering improvements in health
- Comparison of Quality and Outcomes Framework (QoF) data across the sector alongside national benchmarking to enable assessment in relation to prevalence of CHD, Heart Failure and Hypertension. This will enable work to be targeted to enable PCTs to meet targets around e.g. control of blood pressure, control of cholesterol and smoking cessation
- Supporting development and implementation of programmes which will improve the management of Atrial Fibrillation and anticoagulation within primary care
- Developing education and training initiatives across primary care disciplines.
- Supporting the implementation of appropriate guidance including NICE, cardiovascular risk assessment etc.
- Enabling primary care to develop robust mechanisms for identifying, risk stratifying and treating patients 'at-risk' of developing cardiovascular disease through the development of primary prevention registers.

<b>Milestone 1:</b>	Pilot of software to support the establishment of primary prevention registers across primary care by Q1.
<b>Milestone 2:</b>	Action plan to evaluate effectiveness of pilot including full business case to support subsequent roll-out across NW London, related costs and funding streams
<b>Milestone 3:</b>	Roll out of 'best practice' standardised care pathways across the Network spanning key areas of cardiac care, (commencing with heart failure and arrhythmia management) by Q2.
<b>Milestone 4:</b>	Production and circulation of regular benchmarked QoF data with action plans developed to support identified areas of concern.
<b>Milestone 5:</b>	Education plans established to support primary care practitioners in the acquisition of additional skills to improve cardiovascular care. To include further roll-out of the Certificate in Cardiovascular Medicine, GP seminars and a Practice Nurse Training Programme by Q2.
<b>Milestone 6:</b>	Production of targeted communications with primary care focusing on priority areas of interest as identified by PCT leads and primary care clinicians by Q1.
<b>Key Performance Indicator 1:</b>	Establishment of primary prevention risk registers across primary care with demonstrable evidence of improvements to patient management
<b>Key Performance Indicator 2:</b>	Practice nurse training programme established and Cohort 3 of Certificate in Cardiovascular Medicine commence.
<b>Key Performance Indicator 3:</b>	Improvement in the performance of key primary care targets e.g. blood pressure control, cholesterol management, smoking cessation by Q4.
<b>Risk 1:</b>	Due to re-organisation many PCT & SHA employed partners are undergoing transition and staff may find engagement with the Network difficult at least until future jobs are confirmed. Likelihood of occurrence – High Impact on Business – will impact on ability to deliver the information and action plans Management of Risk – ensuring involvement with the key leads to ensure we are linked in early to new staff or data flows
<b>Risk 2:</b>	Engagement from primary care clinicians difficult to achieve Likelihood of occurrence – medium Impact on business – lack of 'buy-in' by primary care will hinder implementation Management of risk – Benefits of work clearly identified. Champions within primary care identified. PCT CHD leads kept engaged in process and responsible for nominating appropriate practitioners from primary care to input into the process
<b>Resource Implication:</b>	Sustainable funding stream will need to be identified to support ongoing educational initiatives and roll-out of primary prevention registers across the Network.
<b>Network Lead:</b>	Anna Kilpin, Senior Project Manager Dr Bal Kaur, Public Health Consultant

## **5.14 Medicines Management**

### **Priority: High**

Ensuring consistent, standardised cost effective prescribing across the Network is an increasingly important area of our work. Prescribing leads had highlighted various examples of inappropriate prescribing within their local PCTs alongside variation in practice across secondary care providers. Over the past 18 months, the Network has worked with prescribing leads and clinicians to develop standardised guidelines for key cardiac drugs including Clopidogrel and Statins.

Over the coming year, the Network will build on this work to monitor compliance and to assist organisations in delivering agreed changes to prescribing. Other opportunities for joint working with prescribing leads will be sought e.g. use of ACE inhibitors, evaluation, impact and roll-out of new drugs including Rimonabant, Omega 3 fish oils etc.

Where appropriate, the Network will also explore options for joint working with Industry on stakeholder agreed projects of proven mutual benefit to both parties. All such work will be clearly defined and in line with the Network's "Working with Industry" policy<sup>21</sup>

**Milestone 1:** Effective roll-out and implementation of Network wide prescribing guidelines covering Clopidogrel and Statins.

**Milestone 2:** Audit of Clopidogrel use in primary care across NW London completed, analysed and evaluated by Q1 with an action plan formulated to address any areas of concern identified.

**Milestone 3:** Action plan developed in conjunction with prescribing leads to support the switch to Simvastatin as the first line recommended statin in accordance with the Network guidelines and where clinically appropriate.

**Milestone 4:** Production and circulation of regular benchmarked information on prescribing across NW London organisations

**Milestone 5:** Agreed process in place across the Network for supporting the introduction of new cardiac drugs by Q2.

**Milestone 6:** Opportunities for joint working with industry identified and agreed by all NW London stakeholders by Q3.

### **Key Performance**

**Indicator 1:** Evidence of improved compliance with Network wide prescribing guidelines.

### **Key Performance**

**Indicator 2:** Increased use of generic products, where clinically appropriate, with corresponding improved management of patients in clinical practice. Evidenced by improved QoF performance for key areas including blood pressure control, cholesterol control etc.

### **Key Performance**

**Indicator 3:** New drugs introduced across the Network in an agreed, consistent and planned manner across primary and secondary care.

### **Risk 1:**

Inability to reach agreement on some areas of prescribing between primary and secondary care  
Likelihood of occurrence – moderate  
Impact on business – inability to deliver consistent, standardised and cost effective prescribing.

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<sup>21</sup> Working with Industry. North West London Cardiac Network. October 2006. Available at: <http://www.nwlc.n.co.uk/pdfs/workingwithindustrypolicyoct06finalx.pdf>

Management of risk – Full engagement with key stakeholders throughout development of guidelines. Establishment of a multidisciplinary group to review published evidence during development of guidelines, particularly where controversy is more likely to occur.

**Resource Implication:** Significant cost savings could be realised through more consistent prescribing across the Network allowing reinvestment of resources to support other areas of cardiovascular care.

**Network Lead:** Maria O'Brien, Director  
Dr Bal Kaur, Public Health Consultant

## **5.15 Supporting Commissioning and Service Planning**

### **Priority: High**

The Network has a key role to play in informing commissioning decisions and priorities for both specialist and non specialist cardiac services. In the changing NHS landscape, this aspect of the Network's role is likely to take on a more prominent role in coming months. It is therefore important for the Network to develop more formalised links with the Directors of Commissioning, Specialist Commissioning Group and the emerging Practice based Commissioning Cluster Groups.

A further aspect of the Network's role in this area is to inform decision making around the strategic planning of cardiovascular services. Both at a London level and Network level, there is a need to develop appropriate strategies to support future health needs around areas including revascularisation, electrophysiology, Grown up Congenital Heart Disease, Paediatric Cardiology and emergency service provision for the acute management of stroke.

The Network is appropriately placed to advise on the appropriate service configurations of such services to meet population needs and national changes to cardiovascular care delivery. The Network will continue to work with colleagues at the Department of Health on related projects such as the SE Stocktake,<sup>22</sup> to inform future planning priorities and with the newly formed NHS London.

**Milestone 1:** Established links in place with all NW London Practice based Commissioning (PbC) cluster group leads by Q1.

**Milestone 2:** Identification of PbC planning priorities for 07/08 for all PbC groups, with action plans in place to support any planning around cardiovascular priorities by Q1.

**Milestone 3:** Project plan identifying and ensuring attendance at all appropriate (i.e. those with cardiac focus) NW London commissioning forums/meetings with a strategy in place for ensuring, where appropriate, that service improvement informs future commissioning decisions by Q1.

**Milestone 4:** Development of a formal mechanism with PbC leads, Directors of Commissioning, Specialist Commissioning Group and NHS London to inform commissioning decisions and strategic planning by Q2.

**Milestone 5:** Appropriate work streams established with key stakeholders at Network and pan-London level to inform work around the planning and configuration of services by Q2.

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<sup>22</sup> Stocktake of Cardiac Care (South East). Final Report. Department of Health. 2006

<b>Key Performance Indicator 1:</b>	Commissioning decisions will be informed by Network advice and recommendations with service improvement activities incorporated as part of the process ahead of any planned significant changes
<b>Key Performance Indicator 2:</b>	Work streams established with PbC groups on cardiovascular priorities.
<b>Key Performance Indicator 3:</b>	The Network informs decision making at a Network wide and pan-London level on the strategic development of key cardiovascular services.
<b>Risk 1:</b>	<p>The re-organisation of NHS services in London and future uncertainty about the defined role of Networks in the new NHS may impact on ability to deliver key milestone in the specified timescales, (particularly where key jobs are yet to be confirmed).</p> <p>Likelihood of risk – high</p> <p>Impact on business – Network will not be able to deliver agreed work plan</p> <p>Management of risk – ensuring involvement with key leads already in place to ensure linkages are established when new staff arrive. The Network will feed in and inform both the national Network review underway and the concurrent London wide review; linked to the London Commissioning Review.</p>
<b>Resource Implication:</b>	Nil of note.
<b>Network Lead:</b>	<p>Maria O'Brien, Director</p> <p>Anna Kilpin, Senior Project Manager</p> <p>Dr Bal Kaur, Public Health Consultant</p>

## **5.16 Chapter 8: Arrhythmia & Sudden Cardiac Death**

### **Priority: High**

Chapter 8<sup>23</sup>, the new chapter of the CHD NSF, was launched by the Secretary of State for Health on 4 March 2005. The new chapter extends the scope of the previous chapters, covering arrhythmias and sudden cardiac death:

*“Cardiac arrhythmia affects more than 700,000 people in England and is consistently in the top ten reasons for hospital admission with Atrial Fibrillation (AF), the most common arrhythmia, affecting up to 1% of the population and accounting for almost 1% of the entire budget of the NHS. The overall incidence of stroke is about 5% per year in people with AF so it is a significant cause of mortality in England. Implantable Cardioverter Defibrillators (ICDs), advanced pacing devices and catheter ablation have provided many more treatment options.*

*There are approximately 100,000 sudden cardiac deaths each year in the UK of which the majority which occur in people under 30 years old are caused by inherited cardiomyopathies and arrhythmias. An estimate 400 sudden cardiac deaths each year are unexplained and the majority of these have a genetic basis.”*

<sup>23</sup> Chapter Eight: Arrhythmias and Sudden Cardiac Death. Department of Health. March 2005.

The chapter sets out three quality requirements and 20 markers of good practice for the prevention and treatment of patients with cardiac arrhythmias and people who may be at risk of sudden cardiac death. It identifies areas of good practice to enable the identification of people who are at increased risk alongside the assessment of family members to reduce their risk of sudden death.

During 2006, the Network commissioned the Cardiac Networks Device Survey Group to undertake a review of pacemaker and ICD implantation rates across NW London as part of a national project. The results of this survey indicated significant variation in practice and implantation rates across the Network. As a result of this work, the Network will take forward a number of varying work streams including a) a scoping exercise and analysis of admissions to determine current referral patterns/capacity, existing resources, service provision and any future organisations plans/investments to implement the standards of Chapter 8, b) an analysis of device implant referral patterns and existing commissioning arrangements in conjunction with Specialist Commissioning, c) the development of appropriate Network wide pathways to support the identification, triage and treatment of patients presenting with a suspected arrhythmia d) the development and piloting of a model of care to support improved diagnosis, management and referral from within primary care, e) the hosting of a number of educational initiatives and events, commencing with primary care.

The Network Director will also continue to work with colleagues at the Department of Health on the national device taskforce group, developing appropriate national recommendations, models and commissioning guides to support effective implementation of Chapter 8.

- Milestone 1:** Scoping exercise commenced during Q1
- Milestone 2:** 2005 device implant data completed and presented by the National Networks Device Survey Group to enable development of plans to tackle variation by Q1.
- Milestone 3:** Pathways development commenced covering various aspects of the patient journey across all care interfaces commencing with Atrial Fibrillation by Q2
- Milestone 4:** Educational initiatives agreed and planned to target key stakeholders across the Network by Q2.
- Milestone 5:** Model developed to support appropriate identification, triage and management of patients presenting with arrhythmia within primary care by Q2.
- Milestone 6:** To develop recommendations for commissioners on appropriate and planned levels of device implants by Q3.

- Key Performance Indicator 1:** Action plan formulated following analysis of completed scoping exercise by Q1.
- Key Performance Indicator 2:** Pathways of care in place across the Network spanning, primary, secondary and tertiary care by Q2.
- Key Performance Indicator 3:** Education events held and evaluated positively by clinicians by Q3.
- Key Performance Indicator 4:** Primary care model piloted during Q3 and evaluated by Q4 with action plan to support sustainability and roll-out across the Network as appropriate.
- Key Performance Indicator 5:** Reduction in variation for device implants across the Network by Q4 with agreed sector wide commissioning arrangements in place for ICD.

**Risk 1:** Financial risk: may be significant resource implications for individual PCTs particularly around increasing use of technologies to meet NSF good practice guidance e.g. development of local arrhythmia clinics, appointment of more specialist arrhythmia practitioners, increase rates of: ICDs, complex pacing, electrophysiology procedures and genetic testing  
Likelihood of occurrence: High  
Impact on business: lack of additional resources to implement these recommendations will impact upon ability to deliver the full new NSF chapter  
Management of risk – Work streams to be prioritised, clear access criteria developed consistently across NW London in line with NICE guidance to ensure equity and transparency of clinical decision making, evidence base and service improvement methodology incorporated in any decision making process around new service delivery models, involvement of PCT leads and Specialist commissioning group in relevant streams of work

**Resource Implications:** These will need to be identified as work progresses

**Network Lead:** Professor Nicholas Peters, Consultant Cardiologist, St Mary's NHS Trust  
Maria O'Brien, Director  
Katie Marsh, Senior Project Manager

### **5.17 Non-invasive Imaging**

#### **Priority: High**

The use of specialist non-invasive cardiac imaging techniques plays an important role in the diagnosis and management of patients with confirmed or suspected cardiac disease. Such modalities include, for example:

- Echocardiography (Transthoracic, Transoesophageal and Stress)
- Positron Emission Tomography (PET)
- Cardiac Magnetic Resonance Imaging (CMRI)
- Myocardial Perfusion Scintigraphy (MPS)
- Cardiac 64 slice CT

Considerable variation exists across the Network both in terms of access to these varying modalities and waiting times following referral. In the future, there is likely to be an increasing reliance upon existing and new forms of non-invasive imaging modalities, and the Network will need to be able to plan and anticipate the impact of these areas on service delivery.

To take forward this area of work, the Network convened an Imaging working group during 2006. Since then, the Network has completed a detailed analysis of all non-invasive imaging modalities in operation across NW London including current referral patterns, activity levels and waiting times. Where available, a review against NICE recommendations was undertaken. As part of this work stream, the use of non-invasive imaging was benchmarked against other diagnostics including Angiography and assessed against conversion rates for Angioplasty and Coronary Artery Bypass Grafting. The analysis indicated considerable variation across the Network. During 2007, the Network will concentrate on the development of agreed referral pathways and a guide to support commissioners in procuring appropriate services across the patient pathway.

<b>Milestone 1:</b>	Draft report on service provision completed by Q1.
<b>Milestone 2:</b>	Commissioning recommendations completed by Q2.
<b>Milestone 3:</b>	Agreed referral pathways developed during Q2.
<b>Key Performance Indicator 1:</b>	Draft report presented to the Network Board during Q2
<b>Key Performance Indicator 2:</b>	Recommendations agreed by Commissioners by Q3.
<b>Key Performance Indicator 3:</b>	Referral pathways in operation throughout the Network by Q3 with corresponding improved access to all clinical teams.
<b>Risk 1:</b>	<p>Commissioners will need to consider increased investment in non-invasive imaging and potential decrease in investment for coronary angiography. This may not prove possible to achieve in the current changing NHS structures.</p> <p>Likelihood of occurrence: High</p> <p>Impact on business: inability to reduce variation and achieve appropriate levels of non-invasive imaging tests across the Network</p> <p>Management of risk – Need to ensure clear, evidence based, unambiguous information to influence change and inform commissioning decisions.</p>
<b>Resource Implications:</b>	These will need to be identified as part of the groups commissioning recommendations
<b>Network Lead:</b>	<p>Professor Richard Underwood, Professor of Cardiac Imaging, Royal Brompton &amp; Harefield NHS Trust</p> <p>Jinty Wilson, Assistant Director</p>

## **5.18 Workforce and Education**

### **Priority: High**

Having a thorough understanding of the cardiac workforce requirements across the Network is essential in enabling both effective planning to meet future service needs and in retaining a skilled workforce. Such understanding requires knowledge of all staff groups including:

Cardiologists and Cardiac Surgeons  
 Nursing (including Nurse Specialists)  
 Cardiac Radiologists/Radiographers  
 Cardiac Physiologists  
 GPs with Special Interest in Cardiology

It is only through gaining this knowledge that the Network can support organisations to work collectively in order to develop effective strategies to support recruitment and retention, create appropriate educational programmes and develop new and enhanced roles.

As a first step, during 2006, the Network undertook a comprehensive review of the workforce across NW London. A draft report with recommendations has been compiled and will be presented to the Network Board during 2007. Once ratified, the Network will then concentrate on taking forward the report's key recommendations with our stakeholders.

From an educational perspective, the Network has supported a number of training initiatives including:

Seminars for primary care clinicians  
Certificate of Cardiovascular Medicine for primary care practitioners  
Network wide Conference "At the Heart of it" in October 2005  
London wide Learning Event in September 2006  
Workshops covering a variety of topics e.g. cardiac choice initiative, motivational skills workshop for specialist nurses etc

During 2006, the Network will continue to build on this important area of our work and develop programmes in response to key national drivers and local need.

The Network will be appointing a Regional Advisor to the British Cardiovascular Society & Royal College of Physicians early in 2007. It will be essential for the Network to work closely with this role to ensure appropriate strategies are developed in relation to medical staffing.

The Network will continue to support the development of new and innovative roles e.g. Generic Catheter Lab Practitioner and will closely with partner organisations such as 'Skills for Health'<sup>24</sup> to formulate required competencies to support development of new roles.

<b>Milestone 1:</b>	Draft report approved by Cardiac Network Board January 2007.
<b>Milestone 2:</b>	Workforce strategy group established by Q1 to take forward key recommendations of the report.
<b>Milestone 3:</b>	Action plans agreed across the Network to take forward work on priority areas of recruitment and retention by Q2.
<b>Milestone 4:</b>	Regional Advisor appointed by Q1 to support medical action ; plan in relation to medical staffing.
<b>Milestone 5:</b>	Programme of educational events planned for 2007/08 year by Q1

**Key Performance**

<b>Indicator 1:</b>	Strategy in place to addresses gaps identified by the Network Workforce report by Q4.
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**Key Performance**

<b>Indicator 2:</b>	New roles identified with work commenced on development by Q4.
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**Key Performance**

<b>Indicator 3:</b>	Educational events delivered according to agreed programme including additional cohort: Certificate in Cardiovascular Medicine, Practice Nurse Training Programme, Network Conference and Chapter 8: Seminars
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<b>Risk 1:</b>	Central investment for workforce and education initiatives significantly reduced which will impact upon ability to deliver some initiatives.
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Likelihood of occurrence: High

Impact on business: inability to recruit and retain the necessary workforce to deliver on key targets including the 18 week-wait patient pathway.

Management of risk – Need to identify other streams of funding external to the NHS. Will need to concentrate on collective working across organisations to deliver Network wide solutions which will reduce financial impact of individual organisations trying to address this issue in isolation.

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<sup>24</sup>Coronary Heart Disease National Competence Framework Guide: Version 2. Skills for Health, March 2005

**Resource Implications:** Not known at this stage

**Network Lead:** Maria O'Brien, Director  
Clinical lead

### **5.19 Grown up Congenital Heart Disease**

#### **Priority: High**

There are around 135,000 young people and adults currently living in England with congenital heart disease. With the enormous advances in treatment over the last twenty years, many more children with congenital heart disease are now surviving into adulthood. This aspect of cardiac care was not addressed in the original CHD National Service Framework. Therefore, in 2005, a guide<sup>25</sup> was produced providing recommendations for adult congenital heart disease services and for the transition from paediatric to adult services. The guide covers services for people with congenital heart disease age 16 and over and covers all types of congenital conditions.

This important area of work covers a number of specialist services and the Network will therefore take this work forward on a pan-London basis during 2007.

**Milestone 1:** Pan-London specialist/commissioning group convened by Q1.  
**Milestone 2:** Review of existing pathways for GUCH services and assessment against standards detailed in the GUCH guide completed pan-London by Q3.  
**Milestone 3:** Action plan agreed to formalise pathways across GUCH centres, secondary care providers and primary care by Q4.

#### **Key Performance**

**Indicator 1:** Scoping document produced indicating current performance against standards on a pan-London basis by Q3.

#### **Key Performance**

**Indicator 2:** Agreed pathways in place supporting secondary and primary care providers, linked with the relevant GUCH centre by 2008.

**Risk 1:** Nil of note

**Resource Implications:** Not known at this stage

**Network Lead:** Maria O'Brien, Director

### **5.20 New Technologies: Percutaneous Valve Implantation**

#### **Priority: Medium**

Medical technology continues to progress at a rapid pace and the arena of cardiology and cardiac surgery are no exceptions. A key function of the Network should be to advise on such new technologies and to make recommendations on appropriate implementation across the Network. Such new technologies require close and careful monitoring to ensure safety and quality with implementation thoughtfully planned to prevent uncontrolled proliferation of

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<sup>25</sup> A commissioning guide for services for young people and Grown Ups with Congenital Heart Disease (GUCH)' 2006, Department of Health

such developing technologies across multiple centres. Any recommendations will also need to consider clinical and cost effectiveness to enable commissioners to make informed choices for their local populations.

Percutaneous valve technologies provide an example of an emerging technology which the Network intends to support work on over the coming year.

**Milestone 1:** Working group convened to consider new technologies with terms of reference and priority areas for review identified by Q2.

**Milestone 2:** Workplan in place with one technology (percutaneous valve technologies) reviewed in detail and Network-wide recommendations made by Q4.

**Key Performance**

**Indicator 1:** Report produced detailing main emerging technologies by Q3.

**Key Performance**

**Indicator 2:** Document produced detailing the outcome of the review of percutaneous valve technologies including Network-wide recommendations and any related costs by 2008.

**Risk 1:** Nil of note

**Resource Implications:** Nil of note

**Network Lead:** Neil Moat, Cardiac Surgeon, Royal Brompton & Harefield NHS Trust

<b>6.</b>	<b>Future Developments</b>	
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As the future role of Networks within the new NHS is clarified over the coming months, it is anticipated that the Network will need to review this work plan, potentially reprioritising some areas detailed above. It is envisaged that there will be a need to evolve and adapt to changing structures both nationally and across London which may impact upon some of the priority areas contained within this document.

With the expanded role of the National Director for Heart Disease, now encompassing both Heart Disease and Stroke, it is likely that a stroke work stream will need to commence, initially in relation to the diagnosis and management of stroke in the acute phase.

Any changes to this strategy and work plan will be discussed and agreed with our local stakeholders in advance.

<b>Appendix A</b>	<b>Terms of Reference</b>	
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The Cardiac Network has the following key objectives –

- a) to ensure that cardiac services develop to meet the standards in the National Service Framework, comply with NICE guidelines and generally improve the health of the people in NW London and the services available to them:
- b) to establish support for a sector-wide approach to planning, commissioning and assessing the performance of coronary heart disease services and to develop robust mechanisms for involving local people, PCTs and trusts in this approach.

The role of the Cardiac Network for NW London is to -

[Planning]

- develop plans for specialist heart services in line with the existing strategy, including developing modern capacity for providing revascularisation and heart surgery in line with national targets for providing treatment and responding to patient choice:
- plan the coherent development of the full range of CHD services, linking specialist and local services for preventing, diagnosing and managing the treatment of acute and chronic heart disease:

[Service development]

- plan the development of coherent, locally supported, evidence-based clinical strategies for treating heart disease across the entire patient journey, ensuring that agreed changes in clinical practice are implemented and shared throughout the Network:
- embed service improvement activities at all levels across the Network to maximise the benefits of the service development methodology it employs in improving services:
- establish clinical advisory and other project groups to review and make recommendations on specific areas of work or developments, ensuring representation from across the sector:
- oversee the implementation of Network wide elements of the NSF, NICE guidance and other National CHD policies:

[Links]

- establish links with other Clinical Networks, for example, the Diabetes Clinical Network, to discuss areas of common concern, including disease prevention and treatment. This will include the early identification and treatment of diabetes and coronary heart disease, with local mechanisms for monitoring patients with diabetes who may develop heart disease:
- establish links with health communities outside NW London which currently refer patients to specialist cardiac services in the sector, to take account of their needs and strategies in planning future services:

[Monitoring]

- monitor the development of local cardiac networks whose functions are to develop linked local services across primary, community – including local authority - and secondary care and into specialist centres for the prevention, diagnosis and treatment of heart disease:
- agree an effective means for agreeing an integrated system for quality assessment and improvement:
- develop a network wide clinical governance strategy, quality assurance and peer review mechanism for cardiac services:

[Commissioning]

- develop appropriate sector-wide commissioning arrangements, starting with specialist heart services, and then agree development priorities across the whole spectrum of CHD services in NWL, seeking the agreement of the Directors of Commissioning to improve service capacities consistent with those priorities:

[Workforce]

- develop a modern, skill workforce able to provide high quality, effective coronary heart disease services and address particular problem areas for recruitment and retention of staff, working closely with the Workforce Directorate at NHS London.

The Chair of the Cardiac Network Board is accountable to the Chief Executives of the acute Trusts, Primary Care Trusts and the Strategic Health Authority for the work of the Network and will report back to this community at regular intervals about progress in achieving the agreed objectives. The Chief Executive will also, when necessary, bring specific proposals to the group of Chief Executives for agreement by the wider community.

**Figure 3 – Network Links**

