Secondary Prevention

North Trent CHD Collaborative

Modernisation Agency

1. Before and After

Shared Risk Assessment pre-cardiac surgery

Before

- Patient would have risk factors identified when placed on waiting list for surgery and advice given but there was no formalisation of this process with either the patient or their Primary Care team
- Patients had potentially long waits for surgery with no structured follow up of their modifiable risk factors
- Patients often presented at pre-assessment clinic one week prior to surgery without having made any progress in addressing such things as smoking or obesity and sometimes their operations had to be cancelled at short notice

After

- Specialist nurse sees patient directly after they see the Consultant and completes a proforma with the patient detailing the lifestyle changes advised and agreeing targets
- The patient is given a copy and a copy is forwarded directly to a named practice nurse or GP
- Practice nurse can use information to update practice CHD register and is able to continue to support the patient and manage identified risk factors via their CHD clinic while the patient waits for surgery
- The specialist nurses in Secondary will also act as a point of contact offering support to Practice Nurses and will enable earlier referral back to the hospital team if the Primary Care team have concerns about the patient achieving their targets

Direct booking into smoking cessation service

Before

- Patients who had smoking identified as a risk factor when placed on the waiting list for cardiac surgery were given details of smoking cessation service but left to follow it up themselves
- As the patient had usually been advised that they would have to wait in excess of 6 months for their surgery there was often perceived to be no sense of urgency in contacting smoking cessation services and patients were often still smoking when presenting for operation

After

- Small numbers of nurses are working in collaboration with the smoking cessation service and Trust Smoking Cessation facilitators to assess patients appropriateness for referral and directly book an appointment at a smoking cessation session within two weeks of their hospital attendance. This information is also communicated to the Primary Care team as part of the risk assessment above.
- Patient begins cessation cycle earlier and is able to have more than one attempt if necessary prior to their surgery.
- Audit data is currently being collected to evaluate the initiative and direct booking into smoking cessation is being expanded to include post PCI and MI patients

Black and Ethnic Minority Support Worker

Before

- Practice with high black and ethnic minority population was struggling to identify CHD patients
- Practice nurse was trying to establish CHD clinic but was unable to communicate effectively with her patients
- Was not cost effective or practical to use traditional interpretation services due to the numbers of patients involved

After

- Funding identified via PCT and CHD Collaborative to place a multi-lingual black and ethnic minority support worker in the practice for an initial 6 month pilot period to improve accuracy of ethnicity registers and identification of patients, provide interpretation support to practice nurse and reception staff, and generally support cultural awareness within the practice
- As the role develops support will also be offered to two other small local practices with significant black and ethnic minority populations

2. Patient & Carer Experience

Patient and carer interviews have continued in both Doncaster and Sheffield. It is important to state that most interviews generally contain a lot of highly complementary remarks about the staff and service, however there are some key issues which have emerged. These have been grouped into three broad areas.

Accessing services

Several patients reported some difficulty in gaining access to the services that should be available to them.

'No not really...well I am struggling to stop smoking...I have cut down... I did ask [the practice nurse]...a few months since now...and she actually gave me these tablets... but they didn't suit me at all...I felt ill after I took them...I took 'em for about a week and I felt ill so I stopped taking them...[Did you get any follow up from the nurse?] No...I just thought I'm not having them...but actually I've read or heard since that people have died who been taking these tablets who've got heart conditions...some people have died...so I thought...but I'm going to have a word with her next week ...she did say if they're no good we can get you patches...these...whether they work or not I don't know...obviously I've got to want to stop...'

'... I suppose if I really wanted to I could sort of go round there and ask them about it [practice CHD clinic], but I've sort of had no communication from the doctor themselves.'

'...when I gets up to the doctors I says can I see a doctor I'm not well and then I were white and sweating. "No she says, no we're busy", so I said I am poorly and she said "we are busy but if you want to wait while half past six..."'

Communication

Issues were raised by both patients and their carers around failure in communication in particular across the Primary / Secondary care interface

'I think if I had had more guidance at the time, obviously if you think you're cured completely, which I perhaps did, because all the symptoms had sort of gone away and I was OK again...Perhaps my lifestyle would have altered... if I'd have known this was a continuous thing, which I could have done something about and slowed it down through diet...'

'I was actually given a letter to bring home and I took that in and I went to my GP a week later to get a repeat prescription and he didn't know what sort of tablets I was on...I think the actual information was in the letter but for some reason it hadn't actually got from his secretaries desk onto his computer...When you're sitting with him all he's got is his computer on his desk and he punched it in and I'm still on all my old tablets that are obviously completely different to the ones that I came home on...luckily I had the list with me of all the different tablets I'd got, and should have been on'

Isolation

Patients and carers often reported a sense of isolation.

'I'm sure they didn't believe I was poorly. I don't know why...they don't believe I'm badly but I'm not one to act.'

'No idea [if the practice has a CHD register], nobody's followed up from there [the GP practice], nobody...I thought they might have ...first fortnight when you come out it would have been nice if they'd have popped in to have seen how I was...'

'Well, every time I get an appointment there's a phone number on it ' if you need any help phone this number'...but you just feel a bit of a nuisance...'

Working for the patient and carer

The secondary prevention project team is trying to tackle some of the issues raised through patient and carer experiences.

Lack of access to follow up care

Work continues in collaboration with Sheffield Health Authority, Primary Care Collaborative and PRIMIS to develop and improve practice CHD registers to enable more accurate identification and follow up of CHD patients.

Communication

Improving communication across the Primary / Secondary care interface is being addressed by several initiatives such as work on a computerised discharge summary, shared risk assessment documentation pre-surgery, and the compilation of a city-wide directory of Primary Care CHD lead GP's and Practice Nurses to facilitate referral to named health professionals.

Isolation

Work is being undertaken to reconfigure Rehabilitation and Secondary Prevention services in Sheffield to enable the provision of seamless, more patient focussed care, which should ensure that patients are actively followed up in Primary Care when discharged from hospital.

3. Run charts

Work carried out by Sheffield Health Authority and via a British Heart Foundation funded project had ensured that GP practices in North Sheffield had already made significant progress in establishing Coronary Heart Disease (CHD) registers. In order to ensure that similar standards of care were being met across all North Sheffield practices a data collection form was devised and used to validate the information contained in these practice registers. 18 of the 21 practices have now had their registers validated, and problems and issues identified around how information is being recorded and used are now being addressed by the CHD Collaborative in partnership with Sheffield Health Authority's CIRC project, PRIMIS, and the Primary Care Collaborative. Better recording and accuracy of data has allowed more patients requiring follow up at practice secondary prevention clinics to be identified and treated.