The National Institute for Cardiovascular Outcomes Research

National Heart Failure Audit

(Troubleshooting Session - Q&A's)

Category	No.	Question	Response
Additional dataset changes	1	Would it be possible to have a N/A option for Warfarin, DOAC, DM drugs and Ivabradine as these are often not indicated-	Clicking 'no' is acceptable. These fields are not analysed in the same way as the other therapies for HFrEF.
	2	Is it possible to have N/A for all the discharge and referral fields as these are not applicable if the patient is RIP?	If a patient does not survive to discharge, all the discharge fields will be hidden, and the tab greyed out.
	3	Height – Unnecessary – Can it be removed?	It is necessary if and where BMI is required in analysis.
	4	U&E's – Can the order be changed to reflect the normal order that results are received?	Unfortunately, this is how the database was set up.
	5	CKD used to be included as core but has been removed; it is extremely relevant please can it be re-instated?	The admission creatinine provides a prognostic indicator and a measure of CKD. We can also derive eGFR.
	6	Echo – Primary Pulmonary Hypertension is not included can it be added?	Please use the 'Other' tab.
	7	The palliative care option should be core.	This is on the proforma and will be reconsidered as a

			core mandatory.
	8	Would you be able to add an option for the 'LVEF' for an 'unknown' or 'unable to measure' for patients that have a recent Echo but they have been unable to record or estimate the LVEF?	This is now addressed with new LVEF fields. This will appear as follows: LVEF (Most recent, either measured or visually estimated): 1. ≥50% (normal/low normal) 2. >40% and <50% (mild) 3. >35% and ≤40% (moderate) 4. ≤35% (severe) 9. Unknown You can put an eyeball estimate in the Dropbox options.
	9	Would it be possible to have a N/A option for Warfarin, DOAC, DM drugs and Ivabradine as these are often not indicated?	Please select 'No'.
Definitions/help improvements (dataset spreadsheet)	10	CVA – the description is poor and ambiguous.	This is not our decision.
QReg5 (changes to functionality)	11	Would it be possible for RIP patient to have all the d/c drug and follow-up fields hidden if death in hospital 'yes' is entered?	If a patient does not survive to discharge, all the discharge fields will be hidden, and the tab greyed out.
	12	On your email within the dataset changes transplant, palliative, surgery and date of follow up are mandatory, but when you go to enter onto the database these fields are within the non-core section, yet you cannot save the record without completing the follow-up date. Can this be clarified please?	This is correct, you cannot save the record as complete if you do not have a date of review appointment, but there is the option to select 'Unknown' for any of the referral fields.

	13	Discharge Planning – There is no ability to select not applicable? Also, can this be ghosted out if the patient is RIP or not HF? When would discharge planning be not applicable?	If a patient does not survive to discharge, all the discharge fields will be hidden, and the tab greyed out. If the patient does not have HF then they should not be submitted to the HF audit.
	14	How long can we submit the previous dataset?	Until 31st March 2022. Direct data entry users do not have a choice – all new records will be in v5 dataset, but they can edit v4 as well. Those who import can import either dataset.
	15	There is no ability to select a particular date range in the search section and the search disappears after each patient, so you have to re-search each time.	There is no date range search at the moment, but the filter wizard will allow a search for records in the last year/month/week/day (under Period).
	16	Can the past medical history (PMH) not be saved so we do not have to repeatedly complete it for the same patient?	PMH can change over time therefore will need to be able to update.
	17	Please provide details of how we can send data that does not use the NICOR website, as other trusts are doing, e.g. can we send data using excel spread sheet from data extracted from our epr?	Files submitted must be in a csv format, we currently do not accept excel spreadsheets for import, but this is in the pipeline. There is a guide to HF Imports and Exports available on the website here: https://www.nicor.org.uk/national-cardiac-audit-programme/datasets/
	18	Are there any planned upgrades to improve the data inputting?	No planned upgrades, other than to implement a fix to allow a field value to be blanked.
	19	What are the inclusion criteria for the "Data Submission	Data submission timeliness is calculated by getting

		Timeliness" reports?	the difference between discharge date and creation date – no other inclusion criteria is looked at.
	20	What information is included in the "Compliance level" dashboard?	This dashboard shows the % of records submitted within 7 days of discharge (soon to be changed to 90 days) in the last 7 days/30 days/90 days/120 days. If you have achieved 85% (soon to be 90%) of records within the set time, the bar goes green.
Data entry clarifications & guidance	21	With regards to the ECHO findings the dataset now asks for significant LVSD (EF<40%). There is no option for those with an EF >40% who still have LVSD and the only way for the other EF options to appear is if you “tick” the <40% box so how do we enter those with an EF of >40%?	This is now addressed with new LVEF fields. This will appear as follows: LVEF (Most recent, either measured or visually estimated): 1. ≥50% (normal/low normal) 2. >40% and <50% (mild) 3. >35% and ≤40% (moderate) 4. ≤35% (severe) 9. Unknown
	22	Hb – The reference range is incorrect.	This has been corrected. It is currently 50-200.
	23	Atrial fibrillation – The question is unclear, if they are in AF on admission they may not have before, so it isn’t a past medical history.	This was debated at length partly due to the possible paroxysmal nature. The responses are there to capture present and history. If they have AF on admission, they have come in with it and it may be unknown how long they have been in AF, or it is known and they are still in AF, either way the answer is 1. Yes, if they have a history of AF but are not in AF on admission the answer is 0.
	24	ECG – If no ECG it still requires a QRS which obviously we will not have.	If an ECG was performed, then please respond to the QRS field. If an ECG is unknown, record as 0.

	25	In some cases, an EF is not given on the Echo but you have not given an option to say unknown.	You can include an eyeball estimate in the Drop box buckets that are given. We have also now incorporated an option 'Unknown'. See above.
	26	Medications – The dose does not allow you to include the unit of dose measurement or medications with twice a day doses so this is ambiguous and in many cases factually incorrect.	We know that medications are given in different time patterns and doses according to patient tolerance. It is not possible to capture all the different possibilities; therefore, the total daily dose in mg is required.
	27	Digoxin – It comes up with incorrect dose when I try and input – the range is incorrect.	The range allows for an mg dose to the 3rd decimal point. This means for digoxin 62.5 micrograms has to be entered as 0.063mg (the 3rd decimal point is rounded up from 0.0625) 1.25micrograms will be entered as 0.125mg.
	28	Ivabradine – There is no choice for contra-indicated.	We know it is only given in SR when HR control remains an issue with or without betablockers. Contra-indicated is not necessary for analysis.
	29	ARNI – It does not allow you to complete the correct dose as there are two drugs so two doses a total dose is incorrect.	We know that when prescribing the 2 components, both should be written separately. For the audit please give the total combined daily mg dose, by adding total of the 2 components and multiplying by the frequency: For example, 24mg/26mg = 50mg and if given twice daily = 100mg per day.
	30	The 2-week date may not be known at the time of discharge but may still achieve, there is no way of reflecting this.	It is possible to save as a draft and add the date at a later stage when known.
	31	LVEF – the British Society of Echocardiography have changed their guidance on how LVEF should be recorded as follows: A new 'borderline low LV ejection	36%-49% is a large range. If the EF is more accurately given, please use this to tick the appropriate field.

		fraction' group of 50-54%. Patients with an LV ejection fraction of 36-49% are defined as 'impaired LV ejection fraction'. The Society no longer advocates division into 'mild' or 'moderate' LV impairment. However, your database will still be using the old Mild and Moderate categories. As our echo cardiographers are using the new guidance more and more, we don't always know where in the 36-49% range the patient is and so don't know if they are mild or moderate for your purposes. Can we have some guidance as to how to deal with that? For example, do we put them all as Mild, all as Moderate, or all as Unknown (which doesn't really seem appropriate as it has been measured, just not in the format you want).	This was discussed at the last meeting and the consensus was to continue using a 'mild' 'moderate' and 'severe' breakdown of EF. These will appear as outlined under question 21 above. We cannot change our dataset every time the BSE change terminology. Our cut points are based on treatment options rather that echo minutiae and designed to align with evidence based clinical guidance.
	32	ECHO **-** Now have the option of 6. Cor Pulmonale/Right HF due to lung disease. Can we have some guidance as to when this should be used? We have always previously excluded any Cor Pulmonale patients from the report as this is a Respiratory problem. Has the criteria now changed and we should include **true** Cor Pulmonale patients or is this just for an indication of any heart failure patients who also have Cor Pulmonale?	If patients are coded as Cor Pulmonale (rather than any of the ICD-10 codes used for the audit) ideally, they should not be submitted to the HF audit. However, we know many are coded as HF and included in the HES denominator. This then requires inputting and the new option 6. allows them to be captured more accurately. If HF team members are uncertain your local HF lead may be able to help.
	33	When asked if confirmed HF? Does it mean HFrEF or any type of HF?	Any.
	34	Will SGLT2i be included within medications?	Yes, it will be unlinked and stand alone.
	35	If a patient is transferred over as an urgent referral for treatment would these be excluded from the dataset?	In the early days of the audit, it was the discharging Trust that was required to enter the whole of the patients' inpatient stay. However, the HES data per hospital did not recognise that, so we have added a

			field indicating transferred to other hospital which allows each hospital to enter their data towards achieving the minimum 70% case ascertainment.
	36	Is there a list of mandatory fields that need completing without which we cannot submit data?	The core mandatory fields are on the v5 proforma. These are listed in column 'C' of the dataset spreadsheet in the 'procedure' tab.
	37	Should date entered (referral/review appointment date) be after discharge date? Or can it be any date from admission date? Cardiac rehab etc. Sometimes see when patient IP-should this date be entered?	No, it should be a post discharge date, but excellent service if you are getting Rehab to see HF patients as inpatients.
	38	Could you advise on how we can proceed completing the audit for cardiomyopathy sections to ensure we are submitting data and completing forms accurately?	We are unsure what the exact query or issue you are raising is. Could you therefore please contact us directly if this Q&A summary hasn't helped (see other queries)?
	39	Could you advise on what should be recorded for the SGLT2 inhibitors (discharge) section where a patient is not on medication? Currently, there are 3 options and "Other".	This field is being expanded to reflect the new evidence base for use of SGLT2i in HF.
	40	Do patients admitted onto a day case ward (IV diuretics, GP assessment unit) need to be included in NICOR data and entered?	Are they included in the HES data for your hospital? If so yes, but not otherwise. It will be looked at for analysis of outcomes however we recognise many fields will not be relevant.
	41	Is it ok to enter HF patients who don't have to be entered onto NICOR, onto the database if they have been reviewed and managed by the HF team during their admission?	If you feel that their primary diagnosis and problem during the admission was HF, then yes. However, many of us are called to give input to patients with known HF who are inpatients for another reason. These should not be added as they do not have HF in the primary position on discharge.

	42	If observations are out of limit, what should we do i.e. BP of 220 weights of 150kg?	We will look at changing the ranges. For now, please just put in the maximum options, where less than actual value.
	43	Was a referral to HF cardiologist follow-up made- How would we know if a GP has a specialisation in HF, do You have a list of GPs?	It would be likely that your HF lead consultant is aware of any GP's who have carried out specialist training in HF within the surrounding CCG/PCN. Failing that, every Trust has a person who communicates with GP's and/or CCG leads across their CCG/PCN's. You could ask them to send out a communication asking if there are any GPWSI in HF. NICOR do not have access to this information.
	44	There is no field for LVSD if the EF is >40% - what do we enter these as?	Historically you are right but this has now been addressed as outlined under question 21 above (and this revision will shortly be available).
	45	Ambulatory care and elective admission have been added. Please can it be conformed urgently that the audit does not include anyone with a 0 day stay so we can remove them from our audit list please and if so, can these other options be removed as they are superfluous.	The audit is not designed to monitor elective admissions. However, some Trusts record Ambulatory care/day units as emergency admissions which therefore do count towards the HES denominator. Others record them as planned/elective on HES. This means some Trusts must include these admissions to meet the required case ascertainment. NICOR will want to capture those admissions to Ambulatory care to be able to ascertain if outcomes such as re-admission and mortality are any worse or better than for a normal admission. We are also considering reducing the fields required for HES coded admissions of <24 hrs, with an update in due course.

	46	If a patient is transferred from another hospital (but still within the same Trust) should this admission be recorded under both hospital codes with the relevant dates or just under one?	If your hospitals have separate HES discharge codes, you will have to capture the information for both episodes. Check if previous NHFA reports have reported separately for each hospital.
	47	Are all the new medications in the dataset?	Yes, the SGLT2i will be unlinked from diabetic therapy as a stand-alone medication for HF in line with latest evidence.
	48	Can data entry be done by an audit person, or does it have to be a nurse?	It can be done by an audit person/admin and many Trusts employ admin to enter data. However, it is usually a HF Nurse or someone with a good degree of clinical knowledge to gather the information ready for admin to enter.
	49	If a patient is seen by another provider e.g. community, is this date to be entered? There may be a delay in entering that date, what is the position on this?	If a patient is seen first post discharge by a community HFNS, for example, this is the date to enter. Cases can be saved as draft and incomplete fields entered at a later stage if needed.
	50	Short stay patients, overnight - are they included?	Yes, if HF is the primary diagnosis. Please also see earlier queries and comments.
Justification for future changes	51	Elective Admissions are not included in the audit so why has this been added? Diuretic lounge attendances/ ambulatory care attendances are not admissions.	We agree, however some trusts are including these episodes as emergency admissions on their HES data, in which case they are required to be entered. It will allow an assessment of the outcomes compared to a usual admission. It is also another control check that the Audit is monitoring emergency HF admissions, and we will remove elective admissions from the analysis.

	52	Date of Echo. Is this necessary?	The echo field is based on an echo in the last 12 months, otherwise tick 10. No echo. The date adds validity. Also needed for NICE compliance-echo needed for new patients. (The field does allow dates from >12 months to be entered.)
	53	On the new NICOR forms, the cardiomyopathy section does not include an option for “Ischaemic Cardiomyopathy” (See Below). This is the most common type of cardiomyopathy and makes up a large number of our patient’s aetiology. Subsequently, the Heart Failure team are unsure on what options should be recorded on these forms in the meantime as there isn’t an appropriate substitute for this such as “other cardiomyopathy”, whilst “other inherited” wouldn’t be accurate.	Ischaemic Cardiomyopathy is a confusing term. The new fields were to capture the inherited cardiomyopathies, and other aetiologies due to toxins and/or viral rather than the most common cause of HF which is ischaemia. (Coronary artery disease) If the cause of someone’s HF is ischaemia, then the ‘Ischaemic Heart Disease’ field on the Medical History tab should be ticked and NOT one of the cardiomyopathies. I have copied and pasted a quote from the cardiomyopathy website below and highlighted the key phrase: ‘DCM is usually defined as a dysfunction in the contraction of the heart muscle, associated with enlargement of the ventricle of the heart (usually the left ventricle, and giving it the term ‘dilated’) in the absence of other conditions (such as high blood pressure or coronary artery disease). However, this presentation is variable, and not always clear. In addition, the causes of DCM can vary widely, from genetic causes to toxins and viral infection of the heart (myocarditis).’ If the aetiology is IHD or hypertension, then we should not be calling it cardiomyopathy. To clarify: put NO for cardiomyopathy and YES to IHD. IHD is not a

			cardiomyopathy.
	54	If a patient does not require any HF follow up-i.e., to be followed up on catchment area or in out trust we don't follow up mild LV, so we discharge the patient to the care of the GP, is there a possibility that a NOT applicable can be added as an option? As answering "NO" seems to look a bit negative, as if the patient will not be followed up.	One could argue that those patients with mild LV impairment should have some cardiology f/u as their heart function is not quite normal and could progress. The audit is there to reflect what actually happens - don't worry about it looking negative. NICE guidance recommends HF follow up with all patients admitted to hospital within two weeks of leaving hospital.
	55	Meds such DM, Ivabradine, anti Coags & Warfarin- They do not have the option of NOT applicable, just like the rest of the meds. Ischaemic Cardiomyopathy-there is no option for this on the Database.	See responses above.
	56	Sometimes LVEF cannot be quantified due to poor images, fast HR and this field has been left blank because of this. Are there any plans to adjust/record this more accurately?	Often there is an impression of function given and the LVEF fields are to have descriptive terms added to help when a precise EF is not known. An 'Unknown' option is also going to be added. Please also see earlier comments.
	57	Will the new dataset include mental health as part of the past medical history? Evidenced link between anxiety and depression in HF however this doesn't seem to be collected or reported on within NICOR.	You are correct – it is not currently captured. It has been discussed in the past and may be considered in the future. It is a huge additional piece of work, although very significant.
Communication & support	58	Very poor communication from the NICOR team, we hear from them once or twice a year, they take a long time to reply if at all and when I had an urgent issue. I discovered they were on annual leave at the same time. The communication around the deadlines dates is not	Thank you, your comments will be taken on board. We aim to provide updates when significant changes happen at NICOR i.e. dataset changes, Scottish centres no longer submitting, moving to QReg5, but we will aim to improve our communication.

		existent, yes, I can go and search around for it on the website but surely they should be communicating this clearly to us.	It would also help us improve our communication if centres would notify us as soon as possible whenever there are changes to the contacts we have listed. Thank you.
	59	This year has been very stressful, and they have taken until the week before the deadline to communicate the extended date to us, this is completely unacceptable when I have been working well over my hours to try and get it done to the point of physical exhaustion! This shows a complete lack of support or respect to those of us completing the audit.	We apologise for adding to an incredibly stressful year and really appreciate all the effort that has been put in to adhere to requirements. Has discussion with senior management been considered to discuss Trust level expectations given the year we have all had? It would not be unreasonable for the Trust to accept a lower than usual case ascertainment. We do take your frustrations onboard, and we aim to improve upon this, whenever possible. However, some decisions regarding extensions to deadlines must be cleared by Barts, HQIP and NHSE, lest this delays the programme timelines. This, in turn, means we may not be able to give you as much warning as we, and you would like, for which we are sorry.
	60	We are not given any opportunity to comment on input on dataset changes, they have been lots of issues with the dataset, some being quite clear serious clinical errors is the dataset not checked by someone clinical before it is released? As the clinical leads we are best placed to reflect what would be most useful for our services to collect as well as reflecting relevant targets.	Thank you for your comments. Please be reassured that the database is reviewed by senior clinicians whose priority it is to provide useful robust data which demonstrates key priorities for improving care and outcomes for our patient group. That is what our DEG is for, with good representation from doctors, nurses, pharmacists, coders and others.
	61	The question and answer session although much appreciated, has been set up with minimal notice for us to be able to attend and one session was never going to fit all, they should be prepared to put more than one	Thank you for your comments; we agree that this format may be the way forward to provide better communication. Prior to Covid, NICOR held regular ‘roadshows’ around the country, the last being March

		session on and they should occur throughout the year.	2020. We will be reassessing the format of the meeting to inform future sessions.
	62	Please can we have a proforma for V5 which is not 4 pages long? Please provide comprehensive guidance for new datasets?	These are being updated and we will aim to make the Excel proforma as succinct as possible whilst ensuring all relevant fields are included.
	63	What support is available regards submitting data?	Your Trust's clinical audit department may be able to support. In some Trusts the IT departments can also be very helpful.
	64	When will the new dataset and documents (proformas etc.) be available on the NICOR website?	They will be available soon.
	65	Although we are one team we cover two hospitals so have to enter data separately for both. When they send the reports for us to check prior to publication they only sent us 1 site and not both and again no response when asking for the other one or to queries about any issues. So, my point is they are not sending accurate or complete data out.	We can investigate this but it would be helpful to specify which Trust this relates to. Would you contact us directly if you would like us to explore this further, please?
Process, timing and implementation of dataset changes	66	The Dataset update was done mid-year which is completely in appropriate and cause a great deal of additional stress. It has always been done in line with the new audit year and I am unsure why this was not kept to.	The aim is to update the datasets at least 6 months before implementation, but in recent times we have changed platforms, and moved to QReg5, which did impact our timing. Our apologies for any unintended inconvenience.
	67	When do we have to move over to the new dataset?	From the reporting year 2021/22. Any discharges with HF in the primary position from 1st April 2021 to 31st March 2022.
	68	Are there any more changes to the NICOR data in the	In response to feedback there are some minor

		immediate future?	adjustments to improve the process, some of which have been flagged in this document. Thereafter, the dataset will not change substantially for at least another 3 years.
	69	Just making contact following on from your post in the Pumping Marvellous Group about NICOR issues. Our biggest difficulty at present is the lack of communication between NICOR and HD clinical (who manage Solus, which is how we submit our data). It seems obvious to me that in the new dataset if the patient has not had an echo, the fields asking for date of echo and LVEF should not be mandatory. Likewise, if HF diagnosis is absent or unknown, the field asking if this is a new diagnosis or known diagnosis should not be mandatory. However, it has been coming up 8 weeks that we have been trying to resolve this and I am tearing my hair out!! HD clinical need an explicit instruction to make those fields only mandatory if positive response, however NICOR are skirting around it and just tell me they are looking into it (I am not sure what needs looking in to!) and will be in touch. I initially assumed this would be a very easy fix, but it's not turning out to be. I think we are in the minority in using solus. Ordinarily we are happy with solus as it gives us monthly data that we can use to check our performance against and lets us add in locally relevant fields for reports, so very keen to continue with it. Echo is a key QI-it has to be mandatory. There is an option to include another imaging modality. HF diagnosis needs to be confirmed-it is a HF Audit. We remove cases without this being checked.	We have kept 'date of echo' mandatory, but the key information can be taken from an MRI and we are modifying the dataset so that this is clear. The LVEF remains mandatory since this influences optimal care. Please also see earlier comments (Q21) and elsewhere.
NICOR audit	70	The data reporting is now so behind it almost makes the	This is the aim of the National Cardiac Audit

reporting		information irrelevant, we need more regular reporting otherwise we are putting in hours of work for nothing …that is being addressed.	Programme (NCAP) and the online tools are to help encourage more contemporaneous reporting and ongoing validation.
	71	Are admissions <24hrs still excluded from the national/public reports? And does this apply to records marked as 'elective' as well?	Correct, but it is used for case ascertainment. Please also see earlier Q&As on this/similar subject.
	72	Want to learn more about heart failure KPIs?	You can find the KPI's in the NHFA annual summary reports here: https://www.nicor.org.uk/national-cardiac-audit-programme/heart-failure-heart-failure-audit/
	73	How is outlier analysis addressed?	None done yet as we are developing risk models.
	74	How frequently are data shared with regions?	Annually through our aggregate and summary reports.
	75	How can the new data be accessed /fed back to Health Boards more promptly?	All centres can export their own data to share feedback to or share with Health Boards.
	76	Do you use the HES data as an independent benchmark for the number of patients any individual hospital should be submitting for the NICOR datasets? You look at your own HES data we just look at the aggregate data.	We compare the HES data each hospital/Trust sends to NHS digital with the numbers submitted to the Audit, to work out the percentage of submissions for participating institutions. This is of interest to CQC, BPT and others, and we hope to you. The cumulative numbers across HES & the NHFA, ensure the reports reflect actual practice.
Other (Covid-19, Opt-outs, BPT, future plans):	77	With the national data opt out I think there needs to be a system to account for drop in data entry if a Trust/site has a lot of patients who have opted out of having their data entered as numbers will clearly be down. How will this be reflected in the national reports as otherwise it will	We only expect a small % of opt out which we hope will not impact participation rates, but we will have to wait and see once it is implemented.

		look like the Trust simply hasn't achieved as high a %? WE suspect that during COVID, targets will not be applied.	
	78	How will reduced data submission due to COVID pandemic redeployment affect the validity of data?	Redeployment is one of several factors which may have influenced the numbers submitted. The next annual report reflecting the COVID year will endeavour to highlight the issues faced by HF teams and its impact on services.
	79	How will reduced data submission due to COVID pandemic redeployment be reflected in comparison of year-to-year performance for individual trusts?	As above.
	80	On the database- there is a data submission timeliness- we do not audit on the dot. Our cases get coded a month after the patient has been discharged. Will this affect our performance as a trust?	This is a recommended target for data submission, but there are no repercussions if targets are not met. This is being changed to 90 days.
	81	Does the 90 days mean the quarterly targets are now removed?	Not that I am aware of. The current quarterly submission deadlines still stand.
	82	What are the plans for shortening time frames for data to be uploaded?	This is yet to be discussed.
	83	Are there plans to roll out to community services?	This has been discussed at NICOR over the years; however, it is extremely complex due to data sharing agreements. It is something we are still reviewing but it will not be in the immediate future.
	84	A lot of services gained data support through business cases using BPT – without this, Trusts will struggle to finance data inputting support, any thoughts around this?	Unfortunately, we have no control over BPT and agree this is difficult. However, all trusts are mandated to provide data to National audits, and this is reviewed

			by CQC. It may be useful to highlight this to your trust if you need support.
	85	Elective admissions are coded HF will they be included in the HES numbers?	No.
Teams chat facility – troubleshooting session	86	Please clarify the target for echo time, 6/12 or 12/12?	Within 12 months is the limit.
	87	If a patient is a planned admission for offloading is this recorded as elective or emergency?	If a patient is planned TCI requiring admission to offload, they should be included. Code them as an emergency admission.
	88	If a patient is elective, if this is not included on the analysis, can this be classed as exclusion?	Elective patients are not included in HES. See also other Q & As on this subject
	89	Can I clarify are you saying that by us choosing Elective that the data does not taken into account?	That is correct.
	90	Some patients coded as HF do not have HF, so we put those on as HF diagnosis absent if we are unable to get the coding changed. This is to make sure we add sufficient numbers against HES target. Completely understand these are excluded from analysis, but confirming they are "counted" for BPT target?	Only HF patients with a confirmed diagnosis in the primary position are included in the audit and count towards the BPT. In most hospitals, there are other patients who have not been coded as HF, but who have been admitted with HF, and their data should be entered into the Audit, and will contribute towards the BPT.
	91	Re echocardiogram. If an echo has not been done for good reason (palliative) then how do we record these. Diagnosis may have been confirmed previously or may not be appropriate for that patient (e.g. other terminal disease). If we put 10. No echo then we will appear to have failed that metric. If we put previous echo result but	Just put a note in-not appropriate.

		a date longer than 6 months ago or 12 months ago, we will have failed according to the audit metric.	
	92	Can a Not indicated or Not applicable be added on the option of ECHO?	Echo (field 9.23) has option 9, which is 'Unknown' in the Heart Failure dataset v5.0.
	93	We would not necessarily be repeating further Echo within a year if they already have a diagnosis of LVSD/Heart Failure it seems wrong that you are limiting it to a year if the diagnosis is clear, it encourages unnecessary Echoes.	Column 'M' in the Heart Failure dataset states: Results of echocardiography, or other gold standard test (including MRI, nuclear scan, angiogram, and CT scan), from which LVEF measured or estimated, recorded during this admission or in the 12 months prior to admission.'
	94	The use of ambulatory care is similarly an urgent event, with the aim of preventing an emergency inpatient admission - should this not be treated the same as an elective admission for off-loading then? Many of our decompensations who would have been inpatient admissions previously are managed via ambulatory pathway - including new diagnoses HF.	Elective patients would still not be included in the NHFA. Please also see earlier comments.
	95	When the patient is transferred to another hospital, can we put the associated questions unknown?	If the patient has been transferred to another hospital, then you can tick 'No/Unknown' for the subsequent core mandatory fields if this information is unavailable.
	96	Can we have the shorter proforma sent around please?	We do have an Excel proforma to circulate.
	97	RE. Date of follow-up with HF MDT. The audit system wants a date entered when we say that there is a FU with HF team. If we don't know that date and have answered No to the "Is the first HF FU apt within 2 weeks" but we indicate that they are having FU with community HFN or HF consultant, the system still wants a date (this date	Column 'M' in the Heart Failure dataset spreadsheet states the following: This should not be speculative, and yes should only be selected if the date of the appointment is decided. This field is only mandatory if you respond 'yes' to any other referrals, otherwise, leave blank. You can save the record as draft, and

		may not be known but will happen).	subsequently, when this appointment has taken place within 2 weeks of discharge, enter the date.
	98	Re: Import.	You can save an excel sheet as a csv file, if you speak to your admin or IT team, they should be able to help.
	99	A lesson learnt.	Just make sure any sheets go through your own hospital's governance process.
	100	Why is there no option to choose for patients who refuse or decline the heart failure service support offered?	It is not uncommon for patients to decline and all we can answer is no on the audit. It still reflects what happened.
	101	What are trusts doing about 'data opt out' and what if this negatively affects our submissions? Any advice?	Data opt out is at Trust Level - you should not be submitting the data on patients who have opted out to us. Ensure you are aware of any local guidance and see answer to Q108.
	102	If a patient is admitted because of a fall but treated for HF during the admission is this an emergency admission for HF?	Yes.
	103	Question re follow up with HF specialist nurse, if patient lives out of our area for our HF nurses and is referred to a neighbouring team there is no option for answering to reflect this- only no / unknown. They will have a referral, but we are unable to currently reflect this as we do not see the follow up appointments to record the date.	There is no way to reflect this scenario in detail in the current dataset.
	104	Also, for medications like Ivabradine, Warfarin & Anti Coags, why is there no option of Not indicated or not applicable? Answering a NO is like we haven't given it to	This field currently aims to capture prescribed medications. The option 'No' also captures the scenario where it might not have been applicable.

		a patient, when it is not really needed.	
	105	Please define 'procedure?'	Any device (therapeutic or monitoring) implantation, ablation or surgery but not tapping of ascites or pleural effusion. Devices include pacemaker, ICD, CRT, ILR, Mitraclip, TAVI ETC.
	106	Is the Data set change coming on Monday 14/6/21 the final data set change?	That was the aim, but due to feedback from the centres, we have been making further clarifications, but this will be available soon.
	107	It may sound basic but please can I have some clarity on which patients you want the data on? If HFpEF EF >50% for example are these counted?	Field LVEF (9.24) has an option for patients with ≥50%, which are counted in the NHFA. Please submit data on all patients admitted to hospital with HF. Please also see earlier comments on changes to recording LVEF (for example, answer to Q21).
	108	Data opt out - we've built in the comparison against HES, % opted out and adjusted %. When NICOR pull the HES they should exclude opt-outs as NHS Digital provide that option.	NICOR should not receive any patients that have opted out; this should take place before data is submitted. Please see further information here: https://www.nicor.org.uk/for-hospital-clinical-and-audit-teams/national-data-opt-out/
	109	As I understand it, NICOR is expecting centres to have extracted the opt outs has this changed?	That is correct. Please see above.
	110	Please can you advise what option should be selected in the cardiomyopathy section on NICOR where a patient has Ischaemic Cardiomyopathy? Currently there isn't an option there apart from 'No' to reflect this. Thanks.	The term 'ischaemic cardiomyopathy' seems to have emerged over the last few years and adds to confusion as far as I can see. If the cause of someone's HF is ischaemia, then the 'Ischaemic Heart Disease (IHD)' field on the Medical History tab should be ticked and NOT one of the cardiomyopathies.

	111	Regarding patients coming in with other problems but have treatment for HF during admission, they may still have HF in a primary diagnosis position. If you do not submit data for these, then your case ascertainment % will drop and you may miss BPT target.	Please see above.
	112	Ischaemic Cardiomyopathy is a type of dilated cardiomyopathy, so I have been using that option.	Please see above.
	113	For ivabradine and warfarin-ticking no is fine, they are not mandatory for all. If you also tick AF and HR, we will work it out downstream re applicability.	Good.
	114	Ischaemic cardiomyopathy is not classified as a cardiomyopathy, it is bad language. For LVSD, if the patient has IHD, tick that -tick no to the CM box.	Correct and as above.
	115	The field type for ECG and ECHO are listed as Text (single value) however multiple options can be chosen, Should this field be Text (multivalue; separated)?	This will be changed to Text (multivalue; separated) in the updated dataset.
	116	Re confirmed diagnosis box. If the patient is known LVSD but has not had an echocardiogram on that admission or within 56 or 12 months, what should be recorded in the confirmed diagnosis box? The system seems to want you to record NO, but in fact it is YES.	Agree.
	117	In that instance, wouldn't the ECHO be "No" but the confirmed diagnosis be "Previously confirmed"?	Agree.
	118	Is there a reason why you chose not give % compliance against the questions/standards as a standard report? After all that is what will show you where QI is required.	The Data Completeness reporting tool can be used to determine field completeness by month/year. It is still being tested and is due to be released, once we have

			completed the testing.
	119	Does everyone have access to the "User Reports" at present? Or is this set up available for selected users? On looking to my account I only get as far as "Data Submission Timeliness" Tab	This will be rolled out in the coming months.
	120	Why were the changes made halfway through the year?	The timing of implementing the dataset changes was impacted by the move from Lotus Notes to the new QReg5 platform.
	121	What happens if the patient is a long admission?	The HF Audit is designed to monitor the care of patients admitted to hospital with heart failure, and one hopes will be appropriately HES coded accordingly. Data should be entered into the audit, in the usual way. This should be no different for patients who have prolonged HF admissions than those with shorter admissions.
	122	Is it 90 days from dc?	The "procedure" in the HF Audit is the DC date, so yes, it is 90 days from that date.
	123	Where do we put that the patient was not a HF diagnosis on HES?	The NHFA only includes patients with a diagnosis of HF. See also earlier comments on this subject.
	124	There are some strict coding rules, so there will be patients not primary coded as HF. If you are asking for these to be added it skews compliance figures with HES. This is not advised from an audit point of view.	Please see earlier comments on HF coding and audit submission above.
	125	Will you do a follow up presentation especially when reporting comes online?	Yes.

	126	Could an option for self-discharge be added into the discharge planning, follow up questions as if patient self-discharges we cannot answer accurately.	Self-discharged patients are a small cohort of people, however for the purposes of the audit please select 'Unknown' if the patient self-discharges.
	127	I am concerned that your speaker said we can put non HES primary diagnosis patients in. I thought the whole idea was for consistency and only patients on official diagnosis coded lists would be included. If you are able to add others this will skew the data and mean that there is not an even playing field. E.g. if a patient has an admission for MI and has LVSD, in my trust this would not be put onto the HF audit as MI is the primary diagnosis and HF secondary. They may have had excellent HF care, investigation and medicines and FU on discharge. If a different trust includes all of these, then they will appear to have a higher % of LVSD patients with a primary diagnosis of HF getting optimal care.	The use of HES was just to provide a benchmark to provide people with targets beyond the confines of their own practice. It's not an audit of HES. The aim of the Audit was to collect information on a large representative sample. The Best Practice requirement is there to ensure people are engaging with the Audit, but recognises coding is not perfect. It is an all or nothing %, so a Trust either meets the 70%, of HES submissions, or not - but once at that cut-point no additional merit, in terms of the Audit, even if the Trust were to submit 150% of the HES coding. We should of course all aspire to submitting all our patients admitted with HF, but difficult to achieve. If a patient is admitted to hospital with heart failure, and this aspect of their care dominates the admission, their data should be submitted to the Audit, even where local coding has mistakenly not reflected this with a HES code of HF in the primary position.