MODULE SPECIFICATION – POSTGRADUATE PROGRAMMES

KEY FACTS

<table>
<thead>
<tr>
<th>Module name</th>
<th>Chronic Heart Disease Management in Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module code</td>
<td>TBC</td>
</tr>
<tr>
<td>School</td>
<td>School of Health Sciences</td>
</tr>
<tr>
<td>Department or equivalent</td>
<td>Division of Health Services Research &amp; Management</td>
</tr>
<tr>
<td>UK credits</td>
<td>15</td>
</tr>
<tr>
<td>ECTS</td>
<td>7.5</td>
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<tr>
<td>Level</td>
<td>7</td>
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MODULE SUMMARY

The National Service Framework [NSF] for Coronary Heart Disease [CHD] was published in 2000. The NSF identified a number of principles and a range of measures to improve quality of care for people with CHD. These included:

- setting out formal standards of care that local health communities are expected to achieve
- assisting NHS organisations to focus on treatments that have been proven to be the most clinically effective and that represent the best value for money
- promoting regional networking across health communities and encourages health professionals (such as general practitioners, nurses, hospital doctors and social care professionals) to work more collaboratively

Additionally, NSFs for Diabetes Mellitus (DH 2001) and Older People (DH 2001) and Long Term Conditions (DH, 2005) include targets directly relevant to the management of CHD.

It has been suggested in the Department of Health’s paper *GP contract changes 2014/15. Equality Analysis* that “general practices act as both the gateway to and coordinator of patient access throughout their care journey” (DHa 2014: 4)

The new General Medical Services [nGMS] contract (2004) provided new mechanisms to allow general practices greater flexibility to determine the range of services they wish to provide, including through opting out of additional services and out-of-hours care.

The nGMS contract provided a major focus on quality and outcomes. The new quality and framework [QoF] would reward practices for delivering quality care with extra incentives to encourage even higher standards. The quality framework has four main components focusing on:

- clinical standards, covering CHD, stroke or transient ischaemic attacks, hypertension, diabetes, chronic obstructive pulmonary disease, epilepsy, cancer, mental health, hypothyroidism and asthma
- organisational standards covering records and information about patients,
information for patients, education and training, practice management and medicines management

- experience of patients covering the services provided, how they are provided and their involvement in service development plans
- additional services

The changes to the general practice contract in 2004 with modifications thereafter in the ensuing years have been the driver for the publication of the Department of Health’s (2014b) paper *Transforming Primary Care. Safe, proactive, personalised care for those who need it most.* This aforementioned document set out the actions needed to take a more personalised and proactive approach to keeping the population healthy, independent and out of hospital. A key factor cited as needing to change is the rate of emergency admissions and that at least 1/5 of these admissions are preventable:

*Every preventable admission represents a failure of the system to care for the people it service – and can trigger further health problems.*” (DH, 2014b: 15).

The development of the module - *Chronic Heart Disease Management in Primary care* is a way of supporting and enabling health professionals (in particular practice nurses and specialist heart failure nurses) to have a contemporary evidence base to meet this new quality agenda. This is especially pertinent for practice nurses and their role in the delivery and management of clients with Long Term Conditions [LTC] in the general practice setting, where the provision of LTC is one of the essential services that all general practices must provide. Therefore, it is crucial that health professionals, such as practice nurses, who care for and manage clients with LTC have a robust contemporary evidence base to guide these clients’ care and management.

This module will be delivered by academics and practitioners in the School of Health Sciences, who have a wealth of expertise in cardiac and primary care. Additionally, clinical specialists will have input into the teaching of this module.

**Module outline and aims**

This module aims to provide nurses working across care sectors [i.e. primary care and the acute setting] with the requisite knowledge and skills to manage clients CHD and Heart Failure [New York Classification 1 and 2] effectively.

**Content outline**

The content of your module will include:

- Spectrum of CHD and Heart Failure: Age, ethnicity & risk factor assessment
- Assessing and reviewing the patient with CHD and Heart Failure
• Understanding renal insufficiency related to CHD and Heart Failure

• Polypharmacy including medications relevant to CHD (e.g. Statins, Aspirin, Beta-Blockers, Angiotensin-converting enzyme inhibitors, Nicotine replacement and hypotensives)

• Dealing with concordance

• Behaviour change: principles and practice. Dealing with ways to promote cessation in smoking, promoting healthy eating and exercise in an area of cultural diversity

WHAT WILL I BE EXPECTED TO ACHIEVE?

On successful completion of this module, you will be expected to be able to:

Knowledge and understanding:

• Critically evaluate and review the impact of variables within the wider environment that may affect the care and management of your client with CHD or Heart Failure

• Critically appraise how recent changes in health policy have impacted on the care delivered to CHD or Heart Failure clients within your practice area.

• Critically review knowledge of pharmacology and audit in clinical decision making

Skills:

• Critically evaluate and appraise the impact of your health promotion activities on clients and communities

• Work effectively with the interprofessional team to design and critically justify holistic care provided to patients

• Critically evaluate how evidence based practice can be utilised to ensure that the public can make informed choices with respect to lifestyle choices

• Act as a catalyst for practice development in the management of CHD and/or
Heart Failure by initiating change within your practice setting

**Values and attitudes:**

- Critically evaluate and appraise how the psychosocial effects of CHD and/or Heart Failure can impact on a client’s health

### HOW WILL I LEARN?

**Teaching pattern:**

<table>
<thead>
<tr>
<th>Teaching component</th>
<th>Teaching type</th>
<th>Contact hours (scheduled)</th>
<th>Self-directed study hours (independent)</th>
<th>Placement hours</th>
<th>Total student learning hours</th>
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<tbody>
<tr>
<td>Public Health</td>
<td>Lectures, work based learning, skills based scenarios, case study presentations, group discussion, self directed learning, discussion with patients and carers</td>
<td>22</td>
<td>128</td>
<td>0</td>
<td>150</td>
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**Totals** | 22 | 128 | 0 | 150 |

### WHAT TYPES OF ASSESSMENT AND FEEDBACK CAN I EXPECT?

**Assessments**

Lectures, work based learning, skills based scenarios, case study presentations, group discussion, self directed learning, discussion with patients and carers.

**Assessment pattern:**

<table>
<thead>
<tr>
<th>Assessment component</th>
<th>Assessment type</th>
<th>Weighting</th>
<th>Minimum qualifying mark</th>
<th>Pass/Fail?</th>
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<tbody>
<tr>
<td>3000 word essay</td>
<td>Written</td>
<td>100%</td>
<td>50%</td>
<td>N/A</td>
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**Assessment criteria**

Assessment Criteria are descriptions of the skills, knowledge or attributes students need to demonstrate in order to complete an assessment successfully and Grade-Related Criteria are descriptions of the skills, knowledge or attributes students need to demonstrate to achieve a certain grade or mark in an assessment. Assessment Criteria and Grade-Related Criteria for module assessments will be made available to students prior to an assessment taking place. More information will be available from the module leader.

**Feedback on assessment**

Following an assessment, students will be given their marks and feedback in line with the Assessment Regulations and Policy. More information on the timing and type of feedback that will be provided for each assessment will be available from the module leader.

**Assessment Regulations**

The Pass mark for the module is 50%. Any minimum qualifying marks for specific assessments are listed in the table above. The weighting of the different components can also be found above. The Programme Specification contains information on what happens if you fail an assessment component or the module.

**INDICATIVE READING LIST**


ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart
Failure Association (HFA) of the ESC - McMurray, J. J. V. 2012-07


2012 focused update of the ESC Guidelines for the management of atrial fibrillation: An update of the 2010 ESC Guidelines for the management of atrial fibrillation * Developed with the special contribution of the European Heart Rhythm Association - Camm, A. J. 2012-11


E-book:


WEBSITES.

http://www.bcs.com
http://bhf.org.uk
http://www.bmjournals.com
http://www.dh.gov.uk
http://www.escardiocontent.org
http://www.failinghearts.com
http://www.had-online.org.uk
http://www.incirculation.net
http://www.lho.org.uk
http://www.london.nhs.uk
http://www.sciencedirect.com
http://www.nursingcenter.com

Version: 1.0
Version date: April 2015
For use from: 2015–16
Appendix: see [http://www.hesa.ac.uk/content/view/1805/296/](http://www.hesa.ac.uk/content/view/1805/296/) for the full list of JACS codes and descriptions

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<td>HESA Code</td>
<td>Description</td>
<td>Price Group</td>
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<td>05</td>
<td>Nursing and Paramedical Studies</td>
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<td>JACS Code</td>
<td>Description</td>
<td>Percentage (%)</td>
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<tr>
<td>B710</td>
<td>The study of principles and techniques for the provision of care for the sick, disabled and infirm within a community.</td>
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