

## SCHEDULE 2 – THE SERVICES

### A. Service Specifications (B1)

Mandatory headings 1-4. Mandatory but detail for local determination and agreement  
Optional heading 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

<b>Service Specification No.</b>	03/CVDS/0016
<b>Service</b>	Community Heart Failure Specialist Nursing Service
<b>Commissioner Lead</b>	CVD CCP
<b>Provider Lead</b>	
<b>Period</b>	01/09/2014 – 31/03/2015
<b>Date of Review</b>	01/04/2015

#### 1. Population Needs

##### 1.1 National/local context and evidence base

Heart failure affects at least one in every 100 people in the UK, increasing steeply with age to about 7% in men and women over 75 years. The number of patients with heart failure is set to rise in the next twenty years, due to the combined effects of improved survival in patients who develop cardiovascular disease, such as heart attacks, and an ageing population.

Heart failure is one of the commonest reasons for emergency medical admissions (about 5%), readmissions and hospital bed-days occupancy. (NHS InformationCentre, National Heart Failure Audit (2010)). Over a third of people diagnosed with chronic heart failure will die within a year and if they have diabetes they have a risk 3.6 times higher.

The national recorded prevalence (1.8%) of heart failure is lower than expected (2.3%), with 140,000 fewer people than estimated reported as having heart failure, indicating that improvements in diagnosis are required. (NICE Chronic Heart Failure Clinical Guidelines CG108 2010)

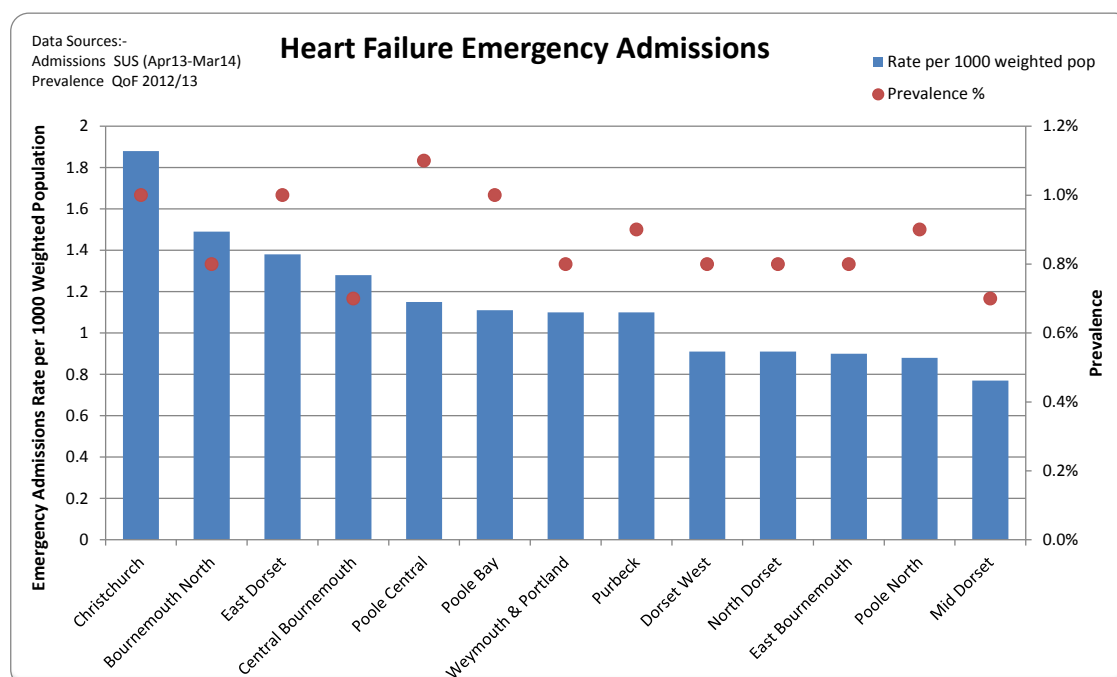
The NICE Chronic Heart Failure Clinical Guidelines (2010) and the more recent Cardiovascular Disease Outcomes Strategy (2013) make the following recommendations for all patients with Heart failure:

- On admission to hospital for heart failure people to have advice on their management plan from a specialist in heart failure.
- Provision of in-patient care is from cardiology teams.
- Patients are discharged from hospital only when their clinical condition is stable and the management plan is optimised.
- The primary care team, patient and carer are aware of the management plan.
- The patient/carers know how to access advice, particularly in the high risk period immediately following discharge.
- Clinical assessment from a specialist in heart failure takes place within 2 weeks of discharge.

In addition it has been identified that there needs to be improvement in the early identification and management of heart failure in primary care.

In NHS Dorset CCG the prevalence recording of heart failure is about half the expected (approximately 2%), indicating that improvements in diagnosing heart failure should be an area of focused clinical activity. (Source: Public Health Department NHS Bournemouth and Poole. Ref: Ellis C, Gnani S and Majeed A (2001) Prevalence and management of heart failure in General Practice in England and Wales, 1994-1998. Health Statistics Quarterly 11: 17-24). The chart below gives weighted emergency admissions and prevalence by locality, where the primary diagnosis is heart failure. The value of these 946 admissions in 2012/13 was £3,046,611. There will be a significant number of admissions with heart failure as a secondary diagnosis. The recording of co-morbidities is not good in all our providers and this data has not been reviewed as it is not considered robust.

## Emergency Admissions For Heart Failure Per 1000 Weighted Population and Prevalence



Data Period April 12- March 13 for activity with a primary diagnosis of heart failure  
Prevalence data by practice from 2011-12

There are currently two providers of heart failure services for people living in the community. DHUFT is the main provider and DCH is the other provider to a smaller geographical area.

## 2. Outcomes

### 2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	√
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill-health or following injury	√
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

### 2.2 Local defined outcomes

The service will optimise medical therapy for people with heart failure and upskill primary and

community care to manage lower risk patients. As skills develop within primary care the service will evolve.

The outcomes of this service will be:

- Improved management of medical therapy for people with heart failure;
- a reduction in emergency admissions with heart failure complications and the associated cost savings;
- a reduction in cardiology follow ups and A&E attendances;
- raised standards of care and monitoring by other primary and community healthcare staff – GPs, practice nurses, matrons, case managers;
- increased skills and confidence in primary care in titrating heart failure medication;
- strong interface between cardiology services and general practice;
- increased ability of patients to self-manage their condition;
- strong integration with the current inpatient heart failure nurses;
- improved patient experience.

### 3. Scope

#### 3.1 Aims and objectives of service

The aim of this heart failure specialist nurse service is to work across primary and secondary care teams, improve communication, ensure a more integrated and seamless care pathway for patients and in so doing, reduce admissions and increase survival. The service will ensure the whole of the County is served and will integrate with the other provider of specialist heart failure nursing services. The service will need to take account of the geographical distribution of patients and how to deliver care economically and efficiently in conjunction with the other service provider. It is expected that the two services will collaborate to ensure people with greatest risk of admission are proactively managed.

The service will compliment hospital based heart failure teams and focus on developing community based services. The key challenge will be to optimise heart failure management, promote self-management strategies and reduce unnecessary hospitals admissions and readmissions for those with heart failure. Effective communication between health, social and voluntary sectors will be key to successful outcomes.

The service will work with cardiologists

- across the 5 main acute providers for Dorset; or

The service provider DCH will work primarily with

- cardiologists in DCH but other providers where patients from their defined primary care practices have had an interface.

The nurses will better support safe discharge and management of care within the community. The service will see patients within 2 weeks of discharge from secondary care. This will involve individual case management of high risk patients and close liaison with case managers (matrons) and general practice for planned discharge from active case management for stable patients.

The service will enhance the skill base within community and primary care staff to enable discharge from the active caseload to either community matrons or primary care.

The service will work as part of an extended multi-disciplinary team to support the discharge process and the interface with primary care.

The service will participate in practice MDTs for high risk patients.

The commissioner recognises that the service will need to prioritise resources to optimise

medical therapy for people post discharge from secondary care and up-skilling primary and community care to manage lower risk patients. This will be the priority for the service. The service will support primary care with newly diagnosed heart failure patients who require additional support in the initiation and up-titration of medication, referral to cardiac rehabilitation services or to help avoid emergency admissions.

### 3.2 Service description/care pathway

The service will be delivered by specialist heart failure nurses. It is anticipated that 90% of the service care will be delivered within the community and 10% in conjunction with secondary care services. A hospital may be a community venue for many patients.

The service will establish relationships across the 5 main acute providers and ensure systems are in place to be notified of patient discharges where heart failure has been diagnosed, DHUFT only.

The service will support the development of an individual management plan. The service will provide intensive disease management support, and ensure that those with additional health and wellbeing needs are appropriately managed within community and social services.

The service will provide concurrent management of co-morbidities, such as ischemia, atrial fibrillation, hypertension, peripheral vascular disease, diabetes and renal disease.

The service will provide medication management for up-titration until the target dose is achieved or maximum tolerance is reached and the patient is stabilised. It is expected that this will be achieved for the majority of patients between 12-18 weeks of initiation.

All patients will be reassessed after optimisation of medical treatment and an assessment made of need:

- for continued management within the community heart failure specialist service;
- discharge to the care of their GP;
- involvement of secondary care or locality GPSI services for advanced management; or
- discharge to more generalist community case management (eg. matrons).

The expectation is that on-going case management after up-titration will be minimal. The service will support primary care through training and advice rather than direct care delivery. It is anticipated that the active case management workload will be approximately 50 patients at any one time.

The service will make referrals to cardiac rehabilitation services and encourage uptake of a group programme.

The service will support planned admissions to secondary care to optimise outcomes and early discharge.

The service will develop information in appropriate formats for patients, families and carers. This information will cover the causes, definition of heart failure as well as advice on living with the condition.

Patients will be supported to self-care with the support of tele medicine and be given advice about local support groups.

Patients/carers will know how to contact the service for advice and support.

Lifestyle advice will be offered to patients throughout their pathway of care and will include as a minimum:

- smoking cessation
- nutritional advice
- sensible drinking
- exercise/physical activity

- sexual activity
- vaccination
- air travel
- driving regulations
- natural supplementary therapies

The service will provide training opportunities for primary care clinicians to support expansion of expertise in heart failure. The service will facilitate joint working across localities and the development of locality 'heart failure champions' (primary care staff able to provide advice and guidance to other primary care staff).

The service will co-ordinate a shared care approach to end of life care with other members of the multi-disciplinary team.

The service will have the ability to access diagnostic tests as required, including 12 lead ECG, and echocardiograms, biochemistry etc.

### Care Pathway

The service will comply with the Dorset Cardiac Network heart failure guidelines 2012.

Discharge back to the GP will take place for:

- patients stable on maximal therapy who have NYHA grade I or II
- patients stable on maximal therapy who have heart failure with preserved ejection fraction (HFPEF)

The registered GP will receive a copy of the patient's management plan and a discharge summary indicating the timescale in which the patient should be followed up.

Discharge to intensive case managers will take place for patients who do not meet the above criteria for more generalist management of co-morbidities.

Should the patient's condition subsequently change, re-referral pathways will be established for prompt advice and guidance, re-assessment and specialist case management if considered appropriate. An email advice line will be developed for GPs and other community staff to ensure on-going training and support to primary care for discharged patients. Providers will collaborate to deliver comprehensive services across the County.

### 3.3 Any acceptance and exclusion criteria and thresholds

#### Acceptance Criteria

People with heart failure confirmed with and Echo or angiogram

DHUFT:

New referrals from:

- Cardiologists in Yeovil, Salisbury, Bournemouth, Poole, Dorchester and occasionally Southampton and Lymington;
- other heart failure specialist nurse providers.

DCH

- cardiologist in DCH;
- DHUFT heart failure specialist nurses;
- Other providers for specified practices.

Re-referrals will be accepted from primary care or community matrons for advice and guidance re-assessment and specialist case management if considered appropriate.

Referrals from primary care and locality services for newly diagnosed patients will be accepted within capacity constraints, as the service develops.

### **Exclusions**

People under the age of 18 years  
People registered with GP practices outside the CCG  
The prison service  
Military personnel and their families not registered with CCG practices

### **3.5 Interdependence with other services/providers**

This service will require close working relationships between:

Dorset CCG GPs  
Practice Nurses and Practice Managers  
Cardiologists in the 5 main hospitals serving the population of Dorset based in Yeovil, Salisbury, Poole Bournemouth and Dorchester  
GP with Special Interests  
Community nursing and community case managers  
Diabetes nurse specialists and the Practice lead nurse for diabetes  
Cardiac rehabilitation  
Palliative care services  
Intermediate care services  
Cardiac technicians  
Dorset CCG Commissioners  
Locality Managers  
Service Users

## **4. Applicable Service Standards**

### **4.1 Applicable national standards (eg NICE)**

NICE Chronic Heart Failure Clinical Guidelines CG108 2010

### **4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**

### **4.3 Applicable local standards**

Dorset Cardiac Network Heart Failure Guidelines 2012.

All new referrals following discharge from secondary care will be seen within 2 weeks of referral either within their home or in a locality venue or through a telephone consultation. The locality venue may be from a hospital site.

The service will aim to see frail elderly patients within 1 week of referral following discharge.

The service will ensure on-going professional development in conjunction with secondary care specialists.

Performance Information will be required and will include:

Activity reporting

- Number of new contacts
- Number of follow up contacts
- Number of telephone consultations
- Number of teaching sessions

- Number of discharges to community case managers
- Number of emergency admissions from active caseload
- Number of referrals to heart failure cardiac rehabilitation

Performance Reporting

- Percentage of referrals seen within 1 week
- Percentage of referrals seen in 2 weeks (target 100%)
- Percentage of patients whose medication is optimised within 16 weeks

## 5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

## 6. Location of Provider Premises

The Provider's Premises are located at:

7.