SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**03/CVDS/0016 v2**
Service	**Community Heart Failure Specialist Nursing Service**
Commissioner Lead	**Primary and Community Care**
Provider Lead	**Dorset HealthCare**
Period	**From 01/04/2023** *(v1 01/09/2014 – 31/03/2023)*
Date of Review	***This service specification should be reviewed every 2 years unless new guidance or legislation dictates a review any sooner***

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. This is around 920,000 people living with Heart Failure with 60,000 new cases annually. 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. Each year in the NHS, heart failure accounts for approximately 1,000,000 bed days, 2% of the NHS budget and is responsible for 5% of all emergency hospital admissions.

NICOR update https://www.nicor.org.uk/wp-content/uploads/2022/06/NHFA-DOC-2022-FINAL.pdf

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
- MDTs supporting integrated care
- Supporting PC liaison with the Heart Failure MDT
- improved patient experience
- Advanced/terminal care planning including use of the Dorset Care Plan via MDT
- Supporting patient with End of Life care
- Auditable and regular reporting/capture of performance (DiiS)
- New York Heart Association (NYHA) reduction in symptom classification.
- Optimised on all four pillars for treatment for HFrEF (ACEi / ARB, ARMI, Betablocker, MRA & SGLT2i)

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. In conjunction with hospital-based heart failure services. It is expected both hospital and community heart failure services will collaborate to identify and support people with the greatest risk of readmission.

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 hospital 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

- across the main acute providers for Dorset; and/or
- Primary Care Networks

The nurses will better support safe discharge and management of care within the community. The service will assess patients within 2 weeks of discharge from secondary care. This service will collaborate with locally based frailty teams and community teams and Primary Care 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 link with practice MDTs and/or PCN MDTs where appropriate and provide clear channels of communication within the community.

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.

The service will engage with, look to support and incorporate digital assessment and self-management tools including applications (apps) where appropriate patients are identified, this may be with shared care providers.

These could be applications that support self-care, assist in recording information and symptoms, or those that link with clinicians to be able to remotely monitor the patient, such as NHSE Heart Failure at home (HF@home).

3.2 Service description/care pathway

The service will be delivered by specialist heart failure nurses. It is anticipated that the majority of the service care will be delivered within the community with secondary care services on a case-by-case basis as appropriate.

The service will establish relationships across the main acute providers and ensure systems are in place to be notified of patient discharges, where heart failure is the primary diagnosis or when there is a new diagnosis of heart failure. Working collaboratively to ensure that the patient receives the right service.

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

The service will Initiate and up-titrate evidence-based heart failure drug therapies in line with Dorset Formulary and locally agreed pathways. **The service will have access to adequate prescribing budget**.

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 under LTC management
  or
- discharge to more generalist primary care community case management

The service will make referrals to cardiac rehabilitation services where appropriate, to include digital technologies.

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

Patients will be supported to self-care with the support of digital health apps and be given advice about local support groups.

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

Lifestyle advice and relevant signposting will be offered to patients throughout their pathway of care.

The service will provide training opportunities for primary care clinicians to support the expansion of management in heart failure.

The service will support 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 via Primary or Secondary Care as appropriate, including 12 lead ECG, and echocardiograms, biochemistry, NT-ProBNP etc.

The provider will ensure that the appropriate clinical supervision is in place. *Consideration should be given to the epidemiology of the conditions the patient has,or is being treated/assessed for and steps should be in place to ensure that areas of risk are managed due to ethnicity and health inequalities. This could also include opportunistic screening for associated diseases they may be at risk from.*

Care Pathway

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

Discharge back to the GP will take place for:

- patients stable on maximal therapy
- patients on Maximum tolerated therapy
- Stable or controlled heart failure symptoms
- Patients who are unwilling to engage or refuse support from a community hf service
- patients deemed palliative via MDT and not requiring specialist HF support (following agreement at MDT)

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 with recommendations for personalised ongoing management in primary care. This should include nationally recognised diagnosis terms and classification.

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 is available 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. Please see Annex 1

3.3 Population Covered

As per information below 3.4

3.4 Any acceptance and exclusion criteria and thresholds

Acceptance Criteria

Dorset patients with heart failure confirmed with and Echocardiogram, MRI or angiogram.

- new diagnosis of heart failure requiring optimisation of specialist heart failure drug therapy
- post hospital admission with heart failure as primary cause for admission

New referrals from:

- Primary Care
- GP referrals (please see Annex 1)
- Acute providers
- Other community teams

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

Exclusions

People under the age of 18 years
People registered with GP practices outside NHS Dorset ICB
Patients already managed by other heart failure services

3.5 Interdependence with other services/providers

This service will require close working relationships between:

Dorset Primary Care Practice Nurses and Practice Managers
Cardiologists in the main hospitals serving the population of Dorset based in Dorchester, University Hospital Dorset, Salisbury, Southampton and Yeovil
Community teams
Cardiac Rehabilitation
Palliative Care services
Intermediate Care services
Cardiac Technicians
NHS Dorset ICB
Locality Managers
Service Users
Community Hubs
Community Rehab Teams

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Chronic Heart Failure in Adults; Diagnosis and Management
Overview | Chronic heart failure in adults: diagnosis and management | Guidance | NICE

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 assessed within 2 weeks of referral either within their home if housebound or in a locality venue or through a telephone consultation.

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

Performance Information will be required and will include:
Activity reporting

- Number of new contacts
- Number of follow up contacts
- Number of telephone/remote 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 assessed within 2 weeks (target 95%)
- Percentage of contact made within 2 weeks of referral
- Percentage of referrals seen within 2 weeks post discharge (as per NICE guidance)
- Average length of time from Referral to discharge from service