SERVICE SPECIFICATION FOR COMMUNITY HEART FAILURE SERVICES 2013-15

Service Specification No.	
Service	**Specialist Service for Community Heart Failure Nursing**
Commissioner Lead	**Andrew Rix : Lincolnshire East CCG**
Provider Lead	**David Dunham : LCHST**
Period	**April 2013 to March 2015**
Date of Review	**April - December 2013**

1. Population Needs

1.1 National/local context and evidence base

Around 900,000 people in the UK have chronic heart failure. Almost as many have damaged hearts but have no symptoms of heart failure. 65,000 new cases are diagnosed each year with a 50% mortality rate within 3-5 years. Both the incidence and prevalence of heart failure increase steeply with age, with the average age at first diagnosis being 76 years. The prevalence of heart failure is expected to rise in the future as a result of an ageing population, improved survival of people with ischaemic heart disease and more effective treatments for heart failure.

People with chronic heart failure often experience a poor quality of life; symptoms include breathlessness, fatigue and ankle swelling, and over one third of people with chronic heart failure experience severe and prolonged depressive illness. Chronic heart failure has a poor prognosis: 30–40% of people diagnosed with chronic heart failure die within 1 year; thereafter the mortality is less than 10% per year. Chronic heart failure accounts for 2% of all NHS inpatient bed-days and 5% of all emergency medical admissions to hospital. Readmissions are common: about one in four people with chronic heart failure are readmitted within 3 months.

The NICE Clinical Guideline 108 on chronic heart failure recommends that heart failure care should be delivered by a multidisciplinary team with an integrated approach across the healthcare community. Effective multidisciplinary specialist services for people with chronic heart failure can have a positive effect on a person's life expectancy and quality of life and evidence suggests they can help to reduce recurrent hospital stays by 30–50%.

1.2 Estimation of local demand

The NICE Commissioning Guide for heart failure uses the following assumptions:

- The estimated expected prevalence of heart failure in the population aged 45 years or older is around 2.3%. Some of these people will have been diagnosed with heart failure, whereas others will be currently undiagnosed;
- The estimated prevalence of confirmed heart failure in the population aged 45 years or more is around 1.8%;
- An increase of around 30% in the estimated current levels of people aged 45 years and older diagnosed with heart failure would be required to reach the expected prevalence of heart failure in this population;
- The current annual detection rate of new cases (that is, the incidence of diagnosed heart failure) is 0.16% of people aged 45 years or older per year;
- Increasing the current annual detection rate of new cases by around 30% (the difference between current estimated and expected prevalence levels) comes to around 0.21% per year;
- The estimates from published research suggests that around 40% of people aged 45 years or older with suspected heart failure referred for specialist assessment have the diagnosis of

heart failure confirmed; and

- Increasing the estimate of new referrals (0.21%) to take into account the estimated 60% of people who are referred but not subsequently diagnosed with heart failure results in a benchmark of 0.53%.

Therefore the population benchmark for new referrals into a heart failure service is estimated to be 0.5% of the population aged 45 years or older per year, of which around 40% (around 0.2%) are likely to have the diagnosis of heart failure confirmed.

2. Scope

2.1. Service Aims

- To improve health outcomes for all patients with heart failure by the provision of consistent, comprehensive, effective, equitable, accessible and appropriate specialist services in line with NICE guidance and local needs assessment. In so doing reducing the incidence of premature death and disability resulting from heart failure and improving long term quality of life.
- To enable the provision of affordable and value for money services, thus bringing the outcomes for all patients with heart failure to a level comparable with the top quartile of services

2.2. Service Objectives

- To provide a standardised specialist heart failure service in primary care which is based on best practice, NICE Clinical Guidance 108, provided by staff with appropriate competencies which is integrated with primary care services and interacts with other relevant community and secondary care services
- To provide management of patients with a confirmed diagnosis of chronic heart failure and/or severe heart failure (NYHA class IV - Complete rest is required; confined to bed or chair, Any activity brings discomfort; symptoms occur at rest)
    - Heart failure that does not respond to treatment
    - Heart failure that can no longer be managed effectively in the home setting

- To provide personalised education and support that equips service users with the knowledge and skills to help them manage their own health, improve self-care, avoid cardiac de-compensations (where relevant) and enhance their quality of life by increasing their ability to cope with living with a long-term condition. Information should be available in a format to suit the diverse needs of the population.
- To provide a dedicated Heart Failure Nurse Specialist responsible for care delivery, reducing duplication and repetitive visits within the healthcare system, around long-term conditions (LTC), in line with the National Commissioning Specifications. Specifically unstable symptomatic heart failure (NYHA class III-IV – Breathless at mild- moderate exertion or at rest, with fatigue and/or oedema.
- To provide cost-effective services showing best use of NHS resources ensuring value for money
- To optimise pharmacological treatment for service users to maintain clinical stability.
- To provide support to primary and other community clinicians by providing specialist advice when needed and improve communication between provider services ensuring a seamless provision of care, for ease of service evaluation audit/monitoring
- To offer people with chronic heart failure discussions about advance care planning while they are in a stable state. This can result in a range of outcomes, including preferred priorities for

care, an advance decision to refuse treatment and/or appointment of a Legal Power of Attorney.

2.3. Service provision, description and care pathway

Lincolnshire Community Health Services (LCHS) currently provides the specialist element of the pathway that supports people with unstable heart failure in line with CQC and NICE recommendations.

The current service provision funds 7 posts: 6 wte nurses at band 7 and 1 wte at band 8a across the county.

The posts are aligned to the CCGs and located in the following areas

- South Lincolnshire CCG : South Holland:1 wte at Band 7
- Lincolnshire East CCG : Boston, Skegness and Coast, East Lindsey: 3 wte at Band 7
- Lincolnshire West CCG : 2 wte at Band 7 and 8A
- South West Lincolnshire CCG & South Lincolnshire CCG (shared): 1 wte Band 7

Nurses performing this specialist role are expected to have the following level of qualification and competence

- RGN-NMC registered
- Relevant cardiac post basic training (ENB)
- Educated to degree level or equivalent experience or working towards
- Teaching and assessing qualification (C+G 730/ ENB 998 or equivalent)
- Non-medical prescribing qualification or working towards
- Minimum 5 years post registration with 3 years in a relevant speciality

2.3.1 Service Model

The overarching approach to care is for patients to be promptly and effectively diagnosed supported by specialist advice, a care plan to be initiated to stabilise their condition which will be delivered in primary care with a level of specialist support appropriate to the patient, then for stable patients to receive their on-going treatment and review through their GP practice throughout their lifetime. Patients should receive rehabilitation and education which enables them to self-manage their condition more effectively. Specialist services will complement these services by providing prompt and effective treatment and advice both to patients and primary care practitioners when complications or other circumstances present requiring specialist opinion.

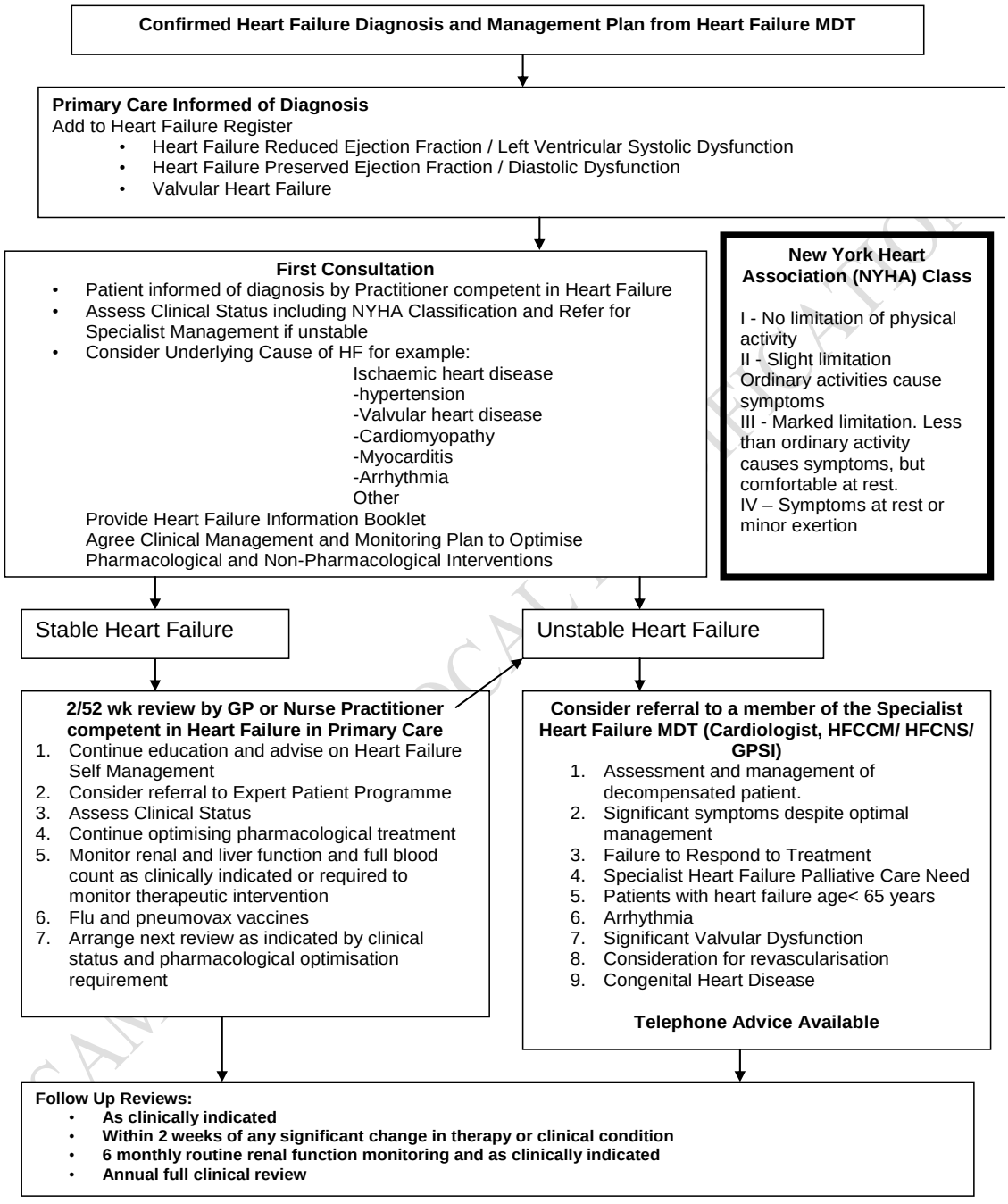
The specialist service should organise their mechanisms of service delivery to be as flexible and responsive as possible. This should include:

- Offering telephone consultations/advice to both clinicians and patients to enable a rapid response to issues such as de-compensation, poor compliance with treatment
- Providing a specialist heart failure nursing team that is able to work within the multidisciplinary heart failure team to deliver care in community settings based on defined referral and discharge criteria
- Providing education to patients, including menu-based rehabilitation programmes
- Facilitating access to educational support to GPs, primary healthcare teams and community teams, through formal and informal presentations, sessions, case note review and other opportunities
- Utilising new technologies for the management of care

The Heart Failure Multidisciplinary Team consists of members of staff from primary and secondary care who work together using team meetings and electronic referral pathways to ensure consistent care delivered to patients in the most appropriate place by a suitably qualified and competent practitioner.

2.3.2 Care Pathway

These have been developed through consultations with clinicians from primary, community and secondary care from across the East Midlands and are based on the NICE Clinical Guidance 103.



Specialist Community Heart Failure Nurse Referral Criteria:

- **Objective evidence of significant cardiac dysfunction** – confirmed left ventricular systolic or diastolic dysfunction or at least moderate impairment of aortic or mitral valve function.

  AND EITHER

- **Recent hospital admission for deteriorating heart failure**
- **Newly diagnosed heart failure with high risk of readmission**
- **Unstable clinical condition in community setting**, as indicated by need for recent increase in diuretic dosage, with high risk of admission

NB: Objective evidence e.g. echocardiogram, angiogram, Cardiovascular Magnetic Resonance Imaging

Service Offered

- Initial full assessment, from which a decision will be made as to whether case management is appropriate, with referral on to other services as indicated.
- Patients accepted onto caseload will be supported until heart failure symptoms are considered to be stable.
- Patients will be reviewed within 2 weeks if there is any significant change in symptoms / condition or medication relating to heart failure in line with NICE Guidance (2003)
- A review of appropriateness for case management will be undertaken 3 monthly
- The Heart Failure Specialist Team is part of a wider integrated community team which works with partners from other organisations to provide each patient with a suitable package of care to meet their health and social needs. This includes palliative care providers and social services.
- Care will be delivered as close to home as possible, with most patients receiving care in their own home (whether that be a private house, residential or nursing home), supplemented by telephone, clinic and hospital reviews as indicated.

Criteria for Discharge from HFCCM Service

- Symptoms stable and able to self-manage or be monitored by case manager / other support
- Patients, who are stable but require further optimisation of established therapies will be referred back to GP practice with a management plan to support this.
- GP Practice will be notified when patients are discharged and routine monitoring will continue via the coronary heart disease, heart failure and/or palliative and supportive care register recall systems.

All patients will be provided with a clear on-going management plan that details of how to monitor their condition and how to seek advice /review when symptoms deteriorate / condition changes significantly.

Exceptions

- Patients unwilling to have nurse-led support
- Other immediately life threatening illness
- < 8 weeks post-Acute Myocardial Infarction except via cardiologist or cardiac rehabilitation specialist nurse referral
- Patients registered with GPs outside the Lincolnshire area
- Underlying aetiology of heart failure non-cardiac e.g. cor pulmonale

2.3.3 Initial Diagnosis

- Specialist diagnosis can be undertaken by a cardiologist, GPSI or doctor with special interest in heart failure.

2.3.4 Initial treatment

The heart failure nurse will:

i. agree a management plan on the day of clinical assessment.

ii. offer patients with chronic heart failure personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management if they wish ***(NICE Quality Standard 5).***

iii. oversee the creation of a personalised care plan by the multi-disciplinary team as early as possible, which will include the following core components ***(NICE Quality Standard 11)***:

Optimisation of pharmacological treatment

- System for up-titration of first line treatment: ACE inhibitors and beta blockers
- Diuretics
- Monitor symptoms, haemodynamic status, serology
- Weight monitoring
- Smoking cessation support: NRT as indicated

Non-pharmacological management:

- British Heart Foundation booklet
- Drugs and compliance
- Symptom recognition
- Dietary advice
- Anxiety
- Heart failure plan
- Relationships
- Exercise and rest
- BHF Advice line number
- Smoking cessation advice
- Information/referral to local support groups where available

Management of co-morbidity

- Ischaemic heart disease
- Hypertension
- Atrial fibrillation and other cardiac arrhythmias
- Diabetes
- COPD
- Depression

iv. The personalised management plan will be shared with the patient, their carer(s) and general practitioner (***NICE Quality Standard 10***).

2.3.5 Pharmacological Treatment

Both angiotensin-converting enzyme (ACE) inhibitors, aldosterone antagonists and beta-blockers licensed for heart failure should be offered to all patients with heart failure due to left ventricular systolic dysfunction

For all patients receiving ACE inhibitor therapy, the therapy should be started at a low dose and titrated upwards at short intervals (for example every 2-4 weeks) until the optimal tolerated or target dose is achieved.

The following should be measured in all patients at initiation of an ACE inhibitor and after each dose increment:

- Serum urea
- Creatinine
- Electrolytes
- Estimated glomerular filtration rate (eGFR)

The following should be assessed for all patients after each beta-blocker titration:

- Heart rate
- Blood pressure
- Clinical status

All patients with heart failure due to left ventricular systolic dysfunction who are taking aldosterone antagonists should have the following closely monitored:

- Potassium and creatinine levels
- eGFR

All patients that have had an acute MI and who have symptoms and/or signs of heart failure and left ventricular systolic dysfunction should be treated with aldosterone antagonist licensed for post-MI treatment within 3-14 days of the MI, preferably after ACE inhibitor therapy. The clinical management of this cohort of patients should be led by the Cardiac Rehabilitation Team for at least the first 8 weeks with individual discussion about patient care as required

All patients with heart failure due to left ventricular systolic dysfunction who are taking an angiotensin-receptor antagonist (ARB) or aldosterone antagonists should have the following monitored for signs of renal impairment or hyperkalaemia as per clinical guidelines:

- serum urea
- electrolytes
- creatinine
- eGFR

Diuretics should be routinely used for the relief of congestive symptoms and fluid retention in all patients with heart failure.

All patients taking amiodarone should have a routine 6-monthly clinical review including the following:

- liver and thyroid function test
- review of side effects

All patients with the combination of heart failure and atherosclerotic arterial disease (including coronary heart disease) should be prescribed aspirin (75-150 mg once daily) or assessed for the most appropriate anticoagulation

2.3.6 Special Further Treatments

- Secondary care teams should be available for consultation to advise and support primary or community care practitioners who are considering the use of second line treatments, including inotropic agents, IV diuretics and vasodilators. Secondary care teams will where necessary

assistance in provision of these treatments.

- Device therapy – secondary care teams will consider referral for specialist device therapy for appropriate patients, specifically cardiac resynchronisation (CRT) and implantable cardioverter defibrillator (ICD) therapy.

2.3.7 Acute episode treatment

- Ideally patients hospitalised with a primary diagnosis of heart failure should be managed by a team led by a consultant cardiologist or specialist with an interest in heart failure on a specialist ward (cardiology or nominated ward with an interest in heart failure).
- Patients hospitalised with a secondary diagnosis of heart failure, e.g. patient admitted with diabetes with an existing diagnosis of heart failure, should be notified to the specialist heart failure team and an appropriate management plan agreed where this is clinically indicated and appropriate e.g. unstable heart failure symptoms
- A nominated specialist will lead the multidisciplinary heart failure team consisting of professionals with appropriate competencies from primary and secondary care. All heart failure patients will be given a single point of contact for the team ***(NICE Quality Standard 6).***
- Where clinically appropriate, diuretic treatment will be commenced and optimised.
- Patients with chronic heart failure due to left ventricular systolic dysfunction will be offered angiotensin-converting enzyme inhibitors (ACEI) (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with ACEI) and beta-blockers licensed for heart failure, which will be gradually increased up to the optimal tolerated or target dose, with monitoring after each increase ***(NICE Quality Standard 7).***
- The provider shall ensure that the services are arranged to suit patients' needs, including provision of the service in patients' homes or at specified external venues. Venues shall be easily accessible by public transport.
- The specialist team will initiate a multi-disciplinary team discussion before a patient is discharged from the acute trust including liaison/communication with the specialist community practitioner, patient's GP and other involved healthcare professionals in order to agree discharge process and on-going monitoring.
- Following initial diagnosis, stabilisation and discharge of the patient, the specialist team will continue to provide follow up in outpatient clinic as required or until the DC criteria in 2.4.1 below are met.
- The specialist team will ensure notification to the patient's primary care practitioner to ensure they are aware that the patient has been in hospital. A copy of the discharge letter will be provided to the patient.

2.3.8 Specialist community follow up

- The community specialist heart failure nurses provide an expert resource across the health community, acting as a focal point for advice.
- Where the patient is under the care of their GP for commencement of treatment but requires additional specialist community support and meets the appropriate criteria, they will be referred to the specialist heart failure nurse.
- When agreed in the multi-disciplinary meeting, ideally once a fortnight, the community specialist heart failure nurse will follow up patients in the community with a clinical assessment within **two weeks of discharge from the acute trust**, such assessment to include assessment of fluid status (including weight) and renal function ***(NICE Quality Standard 12)***.
- When a patient is stable they will be discharged from the community specialist heart failure nurse caseload back to the GP for further monitoring and six month primary care reviews

(NICE Quality Standard 9).

- All patients will be provided with personalised information and education, which allows them to understand the changes to care of their condition and who to contact in the event of deterioration in their condition.

2.3.9 Cardiac Rehabilitation

NICE Cardiac Rehabilitation Commissioning Guidance 40 suggests that the majority of people with an ICD implant would be suitable for cardiac rehabilitation and the uptake of those referred would be 85%. In addition on average around 70-80% of people with chronic heart failure would be suitable for rehabilitation and take up of these would be 60-80%

- All patients diagnosed with heart failure should be considered for a menu based cardiac rehabilitation course as clinically indicated. For patients with no-precluding condition or device, this should include the offer of a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support ***(NICE Quality Standard 8).***

2.3.10 Self Care and patient and carer information

A central aim of this service is to improve service user's ability to self-care. This should be addressed in particular through personalised patient education (which provides service users with the skills to better self-manage their condition, should they wish to do so) and through care planning. While primary care teams are ultimately responsible for managing the individualised care plan with the patient, secondary care teams will use the care plan as a tool to guide their discussions with the patient and to help set appropriate patient goals. In so doing, the specialist heart failure team should have due cognisance of the role of the voluntary sector and Local Authority social services in offering practical and emotional support to patients and carers and completing appropriate carers' assessments.

2.3.11 Supportive and Palliative Care

- Where the condition of a patient with moderate to severe chronic heart failure deteriorates and they are approaching the end of their life, the patient and carer will have access to a heart failure specialist and appropriate palliative care ***(NICE Quality Standard 13).***
- The multidisciplinary heart failure team will ensure that all patients at end stage heart failure have an end of life care plan agreed and understood by the patient and carer(s).
- Care pathways should be in place to ensure the de-activation of devices towards the end of life

2.3.12 Population covered

Patients registered with Lincolnshire CCG GPs.

2.3.13 Days/hours of operation

- Inpatient acute provision will be provided on a 24/7 basis
- Outpatient services will be available in normal working hours for weekdays
- LCHS services core working hours are Monday – Friday 9.00am-5.00pm. There will be a requirement for providers to review the impact alternative working arrangements will have on improved accessibility and responsiveness of the service, and where appropriate work towards the delivery of out of hours working within the current establishment.

2.4 Any acceptance and exclusion criteria

The specialist service will work to ensure that all appropriate patients are able to access the service, including those who may be house-bound or isolated.

2.4.1 Referral Route

- Referrals for routine outpatient Cardiology appointments ideally be made through the Choose and Book process
- Referrals for diagnostics should ensure that all necessary pre-referral investigations in primary care have been completed prior to referral

2.4.2 Referral criteria & discharge criteria

Secondary Care Referral Criteria:

- New diagnosis of heart failure with left ventricular systolic dysfunction
- Heart failure due to valve disease
- Severe heart failure (NYHA III/IV)
- Heart failure that can no longer be managed effectively in the home setting
- Consideration for device therapy
- QRS >120ms (particularly with LBBB pattern)
- Ischaemic cardiomyopathy
- Aetiology of heart failure not established
- One or more of the following co-morbidities: chronic obstructive pulmonary disease, cardiac arrhythmia, renal dysfunction, anaemia, thyroid disease, peripheral vascular disease, nocturnal polyuria, or gout
- Heart failure with preserved ejection fraction or other cause
- Women who are planning a pregnancy or who are pregnant

Secondary Care Discharge Criteria:

Stable clinical condition where the following criteria are met:

- No hospital admission within previous 3 months with heart failure
- Stable doses of diuretic (disease modifying therapy) in previous 2 months
- Patient fully investigated and on optimal pharmacological medical treatment including ACE/ARB/Beta Blockers
- Patient considered for further treatment, which has been declined or device has been successfully fitted
- Systems and processes in place to manage UTA's and DNA's

Specialist Community Heart Failure Nurse Referral Criteria:

The following patients should be referred to the service:

- Objective evidence of significant cardiac dysfunction – confirmed left ventricular systolic or diastolic dysfunction or at least moderate impairment of aortic or mitral valve function.

and either

- Recent hospital admission for deteriorating heart failure/newly diagnosed heart failure with high risk of readmission

or

- an unstable clinical condition in community setting, as indicated by need for recent increase in diuretic dosage, with high risk of admission

and

- previously discharged patients self-referring during episode of decompensation

NB: Objective evidence e.g. echocardiogram, angiogram, Myocardial Resonance Imaging

2.4.3 Heart Failure Rehabilitation Referral Criteria:

All patients to be offered a supervised group exercise programme designed for patients with heart failure ensuring that,

- the patient is stable and does not have a condition or device that would preclude an exercise based programme
- it includes a psychological and educational component in the programme
- the programme may be incorporated within an existing cardiac rehabilitation programme
- systems and processes are in place to manage UTA's and DNA's

2.4.4 Palliative care referral criteria to either heart failure nurse or palliative care service:

- Patients with chronic heart failure and moderate to severe symptoms (typically progressive NYHA classes III or IV) and carers living in their own homes (including residential homes)
- Patients assessed as being in last week's/days of life and have been accepted for "fast track" funding for continuing care, indicating the patient has rapidly deteriorating health. The patient has a written care plan in the home, which the support worker follows, and where appropriate this should follow the agreed end of life care pathway.

2.4.5 Exclusion criteria

- Cor pulmonale; these patients should be referred to the appropriate respiratory service
- Pulmonary hypertension
- Where a patient has been referred for a specialist assessment and echocardiogram without the required investigations being undertaken the specialist service may advise the referrer of the derogations from the required investigations or return the referral for these to be carried out
- Stable patients with no complications should be managed solely in primary/community care and will not come into contact with the secondary care service until they meet any of the referral criteria set out in section **2.4.2.** Patients and carer(s) within this category will be provided with access to information and education after diagnosis, including signposting to the voluntary sector and Local Authority social services for appropriate patient and carer assessment.

2.5 Interdependencies with other services

Heart failure care needs to be delivered in partnership with different organisations, necessitating the delivery of inter-dependent programmes of care. In particular, the partnership between GP practices and specialist teams needs to work as effectively as possible, since patients will access care from these services through a collaborative approach up to and including end of life.

In order to deliver this service, the community care Service Provider must work together with teams in the following service area/organisations:

- East Midlands Ambulance Service NHS Trust
- Secondary Care Providers
- Primary care, including GP practices and pharmacists
- Community care, including community matrons / case managers, district nurses, dietetics, podiatry,
- Palliative care services
- Mental health (counselling and psychology services)
- Smoking cessation services
- Voluntary sector services

- Housing and Local Authority care

The Service Provider is responsible for communicating with these teams where patients require referral.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

NICE clinical guideline 108 – Chronic heart failure

NICE Commissioning Guide 39 – Services for people with chronic heart failure

NICE Commissioning Guide 40 – Cardiac rehabilitation services

Coronary heart disease; NSF for coronary heart disease – modern standards and service models

NHS Outcomes 2011/12

NICE Quality Standards for Chronic heart failure

3.2 Applicable local standards

Non-elective referrals
Patients admitted to hospital with a diagnosis of heart failure will receive a specialist opinion within 24 hours. If appropriate to patient management, patients will also receive an echocardiogram as soon as is practical, ideally within 48 hours during the week and 72 hours at weekends.

4. Key Service Outcomes

This service specification for a multidisciplinary specialist heart failure service supports the following outcome domains;

Domain 1 - preventing people from dying prematurely
Domain 2 - enhancing the 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 that people have a positive experience of care.

Key Performance Indicators

- Enhancing Quality of Life for people with LTC – Proportion feeling supported
- Patient satisfaction questionnaire 8-12 weeks including friend and family test.
- Hospital Avoidance Criteria
    - diuretic titration and addition of thiazide
    - palliative care at home (NICE QS13)
    - referral for admission to care other than hospital
    - hospital admission avoided
- patients seen within 2 weeks of discharge from hospital / new referral (NICE QS 6,12)
- % patients with personalised care plan (NICE QS 5)

Clinical Care

- Reduce the frequency of inappropriate acute admission as the result of decompensated heart failure
- Demonstrate that a plan for optimisation is in place and the patient is being managed by the

appropriate person in order to slow progression of disease Improvement (or slow progression) in symptom status
- Increased access to specialist teams

Patient Experience

- Improved quality of life for service users
- Improved experience of service users and carer(s)
- Enhanced ability to self-care in service users
- Improved knowledge and understanding to enable lifestyle changes
- Improve patient choice due to wide range of available specialist treatments

Inequalities

- Reducing inequalities by improving access to diagnostics and pharmacological treatments for women, who are less likely to receive them than men.
- Improve access to specialised heart failure rehabilitation services
- Improving knowledge of heart failure among patients from ethnic minority groups
- Improved access to end of life care

Access

- Improved access to timely diagnosis
- Reduction in the number of admissions with heart failure into acute secondary care year on year by an agreed proportion.
- All heart failure patients who are on heart failure registers will be reviewed as a minimum every 6 months

5. Location of Provider Premises

The Provider's Premises are located at appropriate locations throughout the county

The following acute hospitals are centres of heart failure service delivery:

- Derby Hospitals NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- Nottingham University Hospitals NHS Trust
- Northampton General Hospital NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University Hospitals of Leicester NHS Trust

The service will be generally provided in a mixture of locations including:

- Acute hospital
- Outpatient clinics
- Community setting for provision of outpatient care (provided where possible to offer patient's a choice of setting)
- Patient's own home