Services for people with chronic heart failure

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1 Commissioning services for people with chronic heart failure

Chronic heart failure is a complex clinical syndrome of symptoms and signs that suggest the efficiency of the heart as a pump is impaired. It is caused by structural or functional abnormalities of the heart. Some individuals have chronic heart failure due to left ventricular systolic dysfunction (LVSD), which is associated with a reduced left ventricular ejection fraction. Others have chronic heart failure with a preserved ejection fraction (HFPEF). Most of the evidence on treatment is for chronic heart failure due to LVSD. The most common cause of chronic heart failure in the UK is coronary artery disease, and many people with chronic heart failure have had a myocardial infarction in the past.[1]

Around 900,000 people in the UK have chronic heart failure. Almost as many have damaged hearts but have no symptoms of heart failure[1]. Both the incidence and prevalence of heart failure increase steeply with age, with the average age at first diagnosis being 76 years[1]. 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.[1]

People with chronic heart failure often experience a poor quality of life; symptoms include breathlessness, fatigue and ankle swelling[1], and over one third of people with chronic heart failure experience severe and prolonged depressive illness[1]. 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[1,4].

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[1]. NICE support for commissioners and others using the quality standard for chronic heart failure indicates that although there may be cost implications in implementing NICE guidance to meet the quality standard for chronic heart failure, there is potential for overall savings as a result of reduced hospital admissions.
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[1], and evidence suggests they can help to reduce recurrent hospital stays by 30–50%[2].

1.1 Commissioning for outcomes

Commissioners should refer to NICE clinical guideline 108 on chronic heart failure and the NICE quality standard for chronic heart failure when commissioning services which contribute to delivering the following NHS outcomes (2011/12):

- preventing people from dying prematurely
  - commissioning multidisciplinary care for people with chronic heart failure may contribute to achievement of health outcomes from domain 1 of the NHS outcomes framework

- enhancing the quality of life for people with long-term conditions

- helping people to recover from episodes of ill health or following injury

- ensuring that people have a positive experience of care.

1.2 Key clinical and quality issues

Key clinical and quality issues in providing effective services for people with chronic heart failure include:

- early identification and referral for specialist assessment, making use of echocardiography or measurement of natriuretic peptides in accordance with NICE clinical guideline 108

- ensuring that appropriate referral pathways are in place and that a multidisciplinary specialist chronic heart failure care pathway is integrated with other services including primary, secondary and social care, and that the care pathway is seamless across services
providing information, education and support for people with chronic heart failure and encouraging self-management

providing effective pharmacological treatment as recommended in NICE clinical guideline 108

offering supervised cardiac rehabilitation based on group exercises for people with chronic heart failure that includes education and psychological support

monitoring all people with chronic heart failure, the frequency of which should be dependent on the clinical status and stability of the patient as recommended in NICE clinical guideline 108

ensuring that people admitted to hospital due to chronic heart failure receive input to their management plan from a multidisciplinary heart failure team and that this management plan is shared with the person, their carers and their GP

eye early identification and partnership working to meet the supportive and palliative care needs of people with moderate to severe chronic heart failure and offering advance care planning

providing the best possible outcomes for individuals, their carers and local communities

providing a quality assured service (see section 6 within this guide).


2 An integrated approach to commissioning high-quality care for people with chronic heart failure

Commissioning services for people with chronic heart failure sits within the wider commissioning strategy for cardiovascular disease and long-term conditions.

Commissioners should consider the whole care pathway for long-term conditions when commissioning services for people with chronic heart failure. They should also consider how services for people with chronic heart failure are integrated across health and social care.

The long-term conditions workstream of the Quality, Innovation, Productivity and Prevention (QIPP) programme advocates a proactive generic management model of care for people with long-term conditions. Commissioners should ensure that people with chronic heart failure and their carers have appropriate access to specialist, condition-specific information and support when indicated.

Commissioners should work with health and wellbeing boards, local authorities, primary care, acute and secondary care, community services and social care.

Commissioners should ensure joint working across health and social care using the generic long-term conditions model and long-term conditions (LTC) commissioning pathway. They may also find the exemplar CQUIN goals on long-term conditions useful.

Commissioners may wish to work with service providers to carry out baseline assessment and clinical audit using NICE implementation support for NICE clinical guideline 108 on chronic heart failure. This will enable commissioners to identify where recommendations from NICE clinical guideline 108 have been implemented and highlight areas for improvement.
3 Determining local service levels for a chronic heart failure service

Before commissioning a service for people with chronic heart failure, commissioners should conduct a local needs assessment in order to determine local service levels for people with chronic heart failure. Available data suggest that the indicative benchmark rate for:

- the number of adults aged 45 or over with suspected heart failure per year is 450 or per 100,000 population, or 0.45%
- the number of adults aged 45 or over who should have their serum natriuretic peptides measured per year is 360 per 100,000, or 0.36%.

The population benchmark is based on the following sources of information:

- epidemiological data on the prevalence/incidence of chronic heart failure
- 'Hospital episode statistics' (HES) data to establish the rate of emergency admissions for chronic heart failure
- current practice on detection rates of chronic heart failure
- published research on chronic heart failure
- expert clinical opinion of the topic-specific advisory group, based on experience in clinical practice and literature review. Use the chronic heart failure commissioning and benchmarking tool section within this guide (section 6) to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

3.1 Current practice

Analysis of data extracted from IMS Disease Analyser, a database that holds data from a sample of GP practice systems, indicates that the annual incidence of diagnosed heart failure (that is, the average detection rate of new cases in a year) is around 0.07%\(^1\) of the population or 0.15%\(^1\) of the population aged 45 years or over.
In England, 0.15% of people aged 45 years or over will be newly diagnosed with heart failure each year. It is estimated that around a third of cases of suspected heart failure result in a diagnosis (see published research section). Therefore it is calculated that around 0.45% of people aged 45 years and over will present in England each year with suspected heart failure.

Of those who present with suspected heart failure, around 20% will have had a previous myocardial infarction (MI)\(^1\). These individuals, in accordance with NICE clinical guideline 108, will be referred for specialist assessment and echocardiography within 2 weeks to confirm the diagnosis.

NICE clinical guideline 108 on chronic heart failure recommends measuring serum natriuretic peptides (B-type natriuretic peptide [BNP] or N-terminal pro-B-type natriuretic peptide [NTproBNP]) in individuals with suspected heart failure without previous MI.

Data extracted from IMS Disease Analyser also showed that around 6%\(^1\) of individuals with newly diagnosed cases of heart failure currently have serum natriuretic peptides measured. Future practice to meet the above recommendation will require 100% of individuals with suspected heart failure without previous MI to have serum natriuretic peptides measured. This would currently be approximately 0.36% or 360 per 100,000 population aged 45 or over per year.

An estimated 46% of people\(^1\) with suspected heart failure who have serum natriuretic peptides measured will have raised or high levels and will be referred for specialist assessment and echocardiography to confirm the diagnosis.

Using the above assumptions, this equates to around 0.17% or 170 per 100,000 population aged 45 or over who would need to be referred for specialist assessment and echocardiography to confirm the diagnosis. This is an increase on current levels.

In addition, commissioners should be aware that the 20% of people with suspected heart failure who have had a previous diagnosis of MI will also need to be referred for specialist assessment and echocardiography to confirm the diagnosis.

Hospital episode statistics data shows that in 2009/10 approximately 10,500 individuals in England with a primary diagnosis of heart failure\(^1\) underwent transthoracic echocardiography\(^1\).
This is much lower than the number of patients who would be expected to have the procedure if the recommendation was fully implemented.

### 3.2 Epidemiological data

The incidence of heart failure varies significantly between different studies. However, all the studies examined showed that the incidence of heart failure increases rapidly with age. Figure 1 illustrates that the greatest incidence of heart failure for both men and women is the 75 and over age group[^1].

**Figure 1 Incidence of heart failure by age and gender in England**

![Incidence of heart failure by age and gender in England](image)

The quality and outcomes framework (QOF) data from 2009/10 shows the prevalence of diagnosed heart failure at 0.7% of the England population. This is a lower prevalence than other studies. One reason is that heart failure is known to be under-diagnosed in primary care. Access QOF data to show local prevalence of diagnosed heart failure.

### 3.3 Activity data - 'Hospital episode statistics' and other data

The 'Hospital episode statistics' (HES) database contains details of all admissions to NHS hospitals in England. It includes private patients treated in NHS hospitals, patients who were
resident outside England and care delivered by treatment centres (including those in the independent sector) funded by the NHS.

Analysis of 2009/10 HES data suggests that the number of emergency admissions into secondary care for heart failure was around 110 per 100,000 population. Admissions into secondary care showed wide variation across the country.

The National Heart Failure Audit 2010 states that heart failure is one of the most common reasons for:

- emergency medical admissions (around 5% of emergency admissions)
- readmissions
- hospital bed-days occupancy.

Heart failure readmission rates are among the highest for common conditions – the 2010 national heart failure audit shows a 20% readmission rate. This readmission rate could be an underestimate, with some studies showing around 1 in 4 patients are readmitted within 3 months\(^*\).

It has been estimated that the effective management of heart failure after an acute admission can reduce re-admission into secondary care by 30–50% in the short and medium term\(^[22]\).

As seen, a proportion of people with diagnosed heart failure will be at high risk of emergency admission and readmissions. This group of patients is likely to benefit from the coordinated care of a multidisciplinary heart failure team and this could impact on the local service provision needed. The PARR (Predicting and Reducing Re-admission to Hospital) tool can support commissioners to identify the local high risk population and plan service requirements. See also the National Cardiovascular Disease (CVD) profiles.

HES mortality data reveals the large number of finished admission episodes for heart failure resulting in death. Around 16% of finished admission episodes result in death within 30 days of admission, 90% of which are in hospital. This rises to 25% within 90 days of admission, and around 80% of these deaths are in hospital.
3.4 Published research

Not all people with suspected heart failure are subsequently diagnosed with heart failure. The proportion of people referred who are subsequently diagnosed with heart failure varies between studies and services. The mid-point of these estimates suggests that around 30%–40% of patients with suspected heart failure have the diagnosis confirmed. For the purpose of this benchmark a figure of one-third has been used.

The prevalence of heart failure is expected to rise in the future as a result of an ageing population, improved survival of people with ischemic heart disease and more effective treatments for heart failure. The 2006 study ‘Effect of socioeconomic deprivation on the population risk of incident heart failure hospitalisation’ showed a link between social deprivation and the risk of developing heart failure, irrespective of baseline cardiorespiratory status and cardiovascular risk factors.

3.5 Expert clinical opinion

The consensus opinion of the topic advisory group was that:

- It may be possible to increase the detection and diagnosis rates of people with heart failure by raising awareness among clinicians of the public health importance of heart failure, and by improving referral pathways, access to diagnostic services and access to coordinated care.

- Commissioners should examine local observed versus expected prevalence and incidence to determine potential levels of unmet need in their populations and possible levels of misdiagnosis.

- Commissioners may find it helpful to examine their local emergency admissions rates for heart failure, see the commissioning and benchmarking tool and other data such as Quality and Outcomes Framework (QOF) and prescribing data to assess current service provision.

- Examining length of hospital stay may also prove helpful as some people with heart failure may be discharged before they are clinically stable.

- The auditing of heart failure services to assess if there is age and gender bias may also prove useful.
3.6 Conclusion

Based on the epidemiological data and other information outlined above, it is concluded that the benchmark for the number of people aged 45 or over with suspected heart failure who should have serum natriuretic peptides measured is \textbf{0.36\%} or 360 per 100,000 population, \textit{per year}. This is based on the following assumptions:

- The annual incidence of diagnosed heart failure (that is, the average detection rate of new cases per year) is around 0.15\% of the population aged 45 years or over.

- It is estimated that around a third of cases of suspected heart failure result in a diagnosis. Therefore around 0.45\% of the population aged 45 years or over will present with suspected heart failure.

- Of those who present with suspected heart failure around 20\% will have had a previous myocardial infarction (MI) and will be referred for specialist assessment and echocardiography to confirm the diagnosis.

- Approximately 0.36\% or 360 per 100,000 population aged 45 or over would have serum natriuretic peptides measured to confirm the diagnosis.

- Around 46\% of people with suspected heart failure who have serum natriuretic peptides measured will have raised or high levels and will be referred for specialist assessment and echocardiography to confirm the diagnosis.

- This equates to around 0.17\% or 170 per 100,000 population aged 45 or over who would need to be referred for specialist assessment and echocardiography to confirm the diagnosis.

Therefore the population benchmark for the number of people aged 45 or over with suspected heart failure who should have the diagnosis confirmed through testing is \textbf{0.36\%} or 360 per 100,000 population, \textit{per year}.

Commissioners should use their local needs assessment to determine local service provision. Commissioners should note that the benchmark rates do not represent NICE's view of desirable, or maximum or minimum, service levels.
Commissioners should use this benchmark and local data to facilitate local discussion on optimum service levels. There is considerable variation in the prevalence and identification of chronic heart failure. This is influenced by the social, economic and demographic profile of the local population. Therefore commissioners are encouraged to consider local assumptions.

Use the chronic heart failure commissioning and benchmarking tool to determine the level of service that might be needed locally and to calculate the cost of commissioning the service using the indicative benchmark and/or your own local data.

[1] Patients aged 45 and above available in their practice for the whole of the 12 months from 01/01/2009 to 31/12/2009 with a diagnosis of heart failure during 2009 (medical event) and no previous diagnosis.

[2] Patients age 45 and over available in their practice for the whole of the 12 months from 01/01/2009 to 31/12/2009 with a diagnosis of heart failure during 2009 (medical event) and no previous diagnosis.

[3] Incidence of adults (18+) with newly diagnosed case of heart failure with a diagnosis of myocardial infarction (MI) anywhere in their record - as medical event. Study Year 01/01/2010 to 31/12/2010.

[4] Incidence of adults (18+) with newly diagnosed cases of heart failure who had test to measure serum natriuretic peptides (B-type natriuretic peptide [BNP] or N-terminal pro-B-type natriuretic peptide [NTproBNP]) [searching Tests and Medical Event] Study Year 01/01/2010 to 31/12/2010.


4.1 Specifying the identification, assessment and diagnosis of chronic heart failure

Commissioning services for the assessment and diagnosis of chronic heart failure, underpinned by NICE guidance and quality standards, is likely to contribute to achieving outcomes under domains 1, 2 and 4 of the NHS outcomes framework 2011/12 by:

- diagnosing people with chronic heart failure earlier
- putting effective intervention in place following earlier diagnosis
- improving people's experience of outpatient care through one-stop and rapid access models of outpatient care
- more timely identification of supportive and palliative care needs following assessment and diagnosis and while people with chronic heart failure are in a stable condition.

Commissioners should ensure there are services in place for the assessment and diagnosis of chronic heart failure.

The key components of an effective service for the assessment and diagnosis of chronic heart failure are:

- section 4.1: identification, assessment and diagnosis
- section 4.2: multidisciplinary management
- section 4.3: supportive and palliative care
- section 4.4: commissioning high-quality care for people with chronic heart failure.

4.1.1 Identification and assessment

NICE clinical guideline 108 on chronic heart failure makes new recommendations on the assessment and diagnosis of chronic heart failure. Commissioners should review current service provision to ensure that new recommendations are being implemented:
• Refer patients with suspected heart failure and previous myocardial infarction (MI) urgently, to have transthoracic Doppler 2D echocardiography and specialist assessment within 2 weeks. [new 2010] (recommendation 1.1.1.2)

• Measure serum natriuretic peptides (B-type natriuretic peptide [BNP] or N-terminal pro-B-type natriuretic peptide [NTproBNP]) in patients with suspected heart failure without previous MI. [new 2010] (recommendation 1.1.1.3)

• Because very high levels of serum natriuretic peptides carry a poor prognosis, refer patients with suspected heart failure and a BNP level above 400 pg/ml (116 pmol/litre) or an NTproBNP level above 2000 pg/ml (236 pmol/litre) urgently, to have transthoracic Doppler 2D echocardiography and specialist assessment within 2 weeks. [new 2010] (recommendation 1.1.1.4)

• Refer patients with suspected heart failure and a BNP level between 100 and 400 pg/ml (29–116 pmol/litre) or an NTproBNP level between 400 and 2000 pg/ml (47–236 pmol/litre) to have transthoracic Doppler 2D echocardiography and specialist assessment within 6 weeks. [new 2010] (recommendation 1.1.1.5)

Commissioners should ensure that services are implementing NICE recommendations and, where necessary, changing practice to achieve the NICE quality standard on chronic heart failure. NICE quality standard for chronic heart failure

Quality statement 1: Urgent referral for people with previous myocardial infarction

'People presenting in primary care with suspected heart failure and previous myocardial infarction are referred urgently, to have specialist assessment including echocardiography within 2 weeks'

Quality statement 2: Measuring serum natriuretic peptides

'People presenting in primary care with suspected heart failure without previous myocardial infarction have their serum natriuretic peptides measured'

Quality statement 3: Two week assessment and diagnosis

'People referred for specialist assessment including echocardiography, either because of suspected heart failure and previous myocardial infarction or suspected heart failure and high
serum natriuretic peptide levels, are seen by a specialist and have an echocardiogram within 2 weeks of referral'

Quality statement 4: Six week assessment and diagnosis

'People referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels are seen by a specialist and have an echocardiogram within 6 weeks of referral'

Earlier assessment and diagnosis of chronic heart failure in line with NICE clinical guideline 108 is dependent on timely identification of suspected heart failure. Commissioners should expect providers to demonstrate that healthcare professionals are skilled and competent to recognise the signs and symptoms suggestive of suspected heart failure, including 'red flags' that indicate the need for emergency assessment within secondary care.

To improve the assessment of people who have not had a myocardial infarction, commissioners should ensure that:

- all primary care clinicians have access to serum natriuretic peptides testing for either B-type natriuretic peptide (BNP) or N-terminal pro-B-type natriuretic peptide (NTproBNP)
- information on how to access and interpret the test is communicated effectively to all relevant clinicians.

Commissioners may wish to work alongside clinicians to consider the cost effectiveness of different options for serum natriuretic peptides testing, including B-type natriuretic peptide (BNP) or N-terminal pro-B-type natriuretic peptide (NTproBNP) and laboratory testing or near patient testing (see table 1). See also A Commissioning Toolkit for use of Natriuretic Peptide assessment for suspected heart failure in Primary Care for further information.

Table 1 Factors to consider when commissioning B-type natriuretic peptide (BNP) or N-terminal pro-B-type natriuretic peptide (NTproBNP) testing[^1]

<table>
<thead>
<tr>
<th>Consideration</th>
<th>BNP</th>
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</thead>
<tbody>
<tr>
<td>Mode</td>
<td>Laboratory or near patient testing</td>
</tr>
</tbody>
</table>
Commissioners should determine which is the most appropriate serum natriuretic peptide test for their area, by considering advantages and disadvantages such as:

- current availability of serum natriuretic peptides testing
- estimated local need and cost impact
- timescales for receiving the results in order to meet NICE recommendations for assessment by a specialist where appropriate
- local geography
- arrangements for quality control of testing, particularly if near patient testing is used
- procurement considerations
- potential for contribution to QIPP programme and financial efficiencies through reduction in unnecessary outpatient and echocardiography appointments.

Commissioners should expect providers to demonstrate that local processes are in place for quality assurance of serum natriuretic peptides testing, including those of the Medicines and Healthcare products Regulatory Agency.

Commissioners may wish to specify a maximum turnaround time for testing – for example, stating that the maximum report time should be 2 working days and that the majority of test results should be reported on the same day. Longer turnaround periods would prevent individuals from being referred to a specialist within the timeframes recommended in NICE clinical guideline 108 on chronic heart failure.

As the volume of testing increases, it may be expected that the price per assay will decrease. It is important therefore for commissioners to maximise the use of the pathology network to negotiate the best price with suppliers.
Specialist assessment within 6 weeks is recommended for people with suspected heart failure and intermediate levels of serum natriuretic peptides – that is, BNP levels between 100 and 400 pg/ml (29–116 pmol/litre) or NTproBNP levels between 400 and 2000 pg/ml (47–236 pmol/litre) in untreated patients. Lower natriuretic peptide thresholds should be considered for patients already on treatment appropriate for heart failure. For example, see A commissioning toolkit for use of natriuretic peptide assessment for suspected heart failure in primary care.

4.1.2 Timely access to specialist assessment and echocardiography

NICE clinical guideline 108 on chronic heart failure makes new recommendations on timeframes for referring people with suspected heart failure and previous MI for echocardiography and assessment by a specialist:

- Refer patients with suspected heart failure and previous myocardial infarction (MI) urgently, to have transthoracic Doppler 2D echocardiography and specialist assessment within 2 weeks. [new 2010] (recommendation 1.1.1.2)

- Because very high levels of serum natriuretic peptides carry a poor prognosis, refer patients with suspected heart failure and a BNP level above 400 pg/ml (116 pmol/litre) or an NTproBNP level above 2000 pg/ml (236 pmol/litre) urgently, to have transthoracic Doppler 2D echocardiography and specialist assessment within 2 weeks. [new 2010] (recommendation 1.1.1.4)

- Refer patients with suspected heart failure and a BNP level between 100 and 400 pg/ml (29–116 pmol/litre) or an NTproBNP level between 400 and 2000 pg/ml (47–236 pmol/litre) to have transthoracic Doppler 2D echocardiography and specialist assessment within 6 weeks. [new 2010] (recommendation 1.1.1.5)

Figure 2 Diagnosing chronic heart failure
Commissioners should ensure that specialist services and echocardiography services have the capacity to assess people with suspected chronic heart failure within the timeframes recommended in the guideline and may wish to consider different service models to provide specialist assessment and transthoracic Doppler 2D echocardiography. For examples see the service models later in this section (4.1.3). Specialist assessment and transthoracic Doppler 2D echocardiography should be commissioned as a function of a multidisciplinary heart failure service (see section 4.2), as recommended in NICE clinical guideline 108 on chronic heart failure:
• Refer patients to the specialist multidisciplinary heart failure team for:
  
  - the initial diagnosis of heart failure
  
  - the management of:
    
    ◊ severe heart failure (NYHA class IV)
    
    ◊ heart failure that does not respond to treatment
    
    ◊ heart failure that can no longer be managed effectively in the home setting.
    
    [new 2010] (recommendation 1.5.1.1)

The National Cardiovascular Disease (CVD) profiles provide a snapshot of key issues relating to heart disease and stroke, including heart failure emergency admission rates. A cardiovascular health profile can be downloaded for each PCT and cardiac network in England. Commissioners may wish to review local prevalence rates, GP referral rates, emergency admissions and readmission rates, and mortality rates to benchmark local variation and carry out a baseline assessment of current services. This will provide the opportunity to review current practice and to develop an integrated care pathway, thereby seeking to overcome some of the barriers to effective diagnosis and treatment and discharge planning. Commissioners may wish to involve clinicians and providers in the analysis of the results to ensure a joint approach in collecting and analysing the data, and implementing any new plans.

### 4.1.3 Service models

#### Quality, innovation, productivity and prevention

Commissioners may wish to work with their local Quality, Innovation, Productivity and Prevention (QIPP) lead to develop service models for assessment and diagnosis of chronic heart failure. Example outputs may include:

- increasing the availability of serum natriuretic peptides testing
- reducing the number of inappropriate outpatient and echocardiography appointments
- reducing the number of emergency hospital admissions relating to chronic heart failure
• reducing the rate of diagnosis of chronic heart failure on emergency hospital admission, when the patient has been seen with the same symptoms previously in primary care (delayed diagnosis)

• developing rapid access heart failure clinics.

Case studies

Commissioners may wish to refer to examples of services for the assessment and diagnosis of chronic heart failure. Some examples are included in table 2.

Table 2 Examples of service models for the assessment and diagnosis of chronic heart failure

<table>
<thead>
<tr>
<th>Setting</th>
<th>Examples of service models or settings</th>
<th>Case study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>• Commissioning of serum natriuretic peptides testing</td>
<td>• Use of scenario simulation in the introduction of serum natriuretic peptide testing</td>
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<tr>
<td></td>
<td></td>
<td>• A commissioning toolkit for use of natriuretic peptide assessment for suspected heart failure in primary care</td>
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<tr>
<td>Acute hospital trust settings</td>
<td>• Rapid access heart failure clinics within secondary care</td>
<td>See examples of rapid access heart failure clinics from:</td>
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<td></td>
<td></td>
<td>• Brighton</td>
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<td></td>
<td></td>
<td>• Guys and St Thomas’, London</td>
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<td>• West Middlesex</td>
</tr>
</tbody>
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Please note – these examples are offered to share good practice and NICE makes no judgement on the compliance of these services with its guidance.

Available at www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=447
4.2 Specifying the multidisciplinary management of chronic heart failure

Commissioning a multidisciplinary heart failure service, underpinned by NICE guidance and the NICE quality standard for chronic heart failure, is likely to contribute to achieving outcomes under domains 1, 2, 3 and 4 of the NHS outcomes framework 2010/2011 by:

- increasing the proportion of people cared for by a multidisciplinary heart failure team
- providing regular clinical monitoring of people with chronic heart failure
- prescribing medication in line with NICE guidance
- empowering people to feel supported to manage their own condition where they wish to
- providing access to information, education and support for people with chronic heart failure
- providing physical activity, education and psychological support through cardiac rehabilitation.

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. (recommendation 1.5.3.1).

Commissioners should ensure that services are implementing NICE recommendations and where necessary, changing practice to achieve quality statement 6 from the NICE quality standard for chronic heart failure.

Quality statement 6: multidisciplinary heart failure team

'People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for the team.'

NICE clinical guideline 108 on chronic heart failure provides the following definition of a specialist:
Throughout this guideline, the term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Unless otherwise specified, within this guideline specialist assessment or management refers to assessment or management by this specialist multidisciplinary heart failure team. The team will decide who is the most appropriate team member to address a particular clinical problem.

The multidisciplinary team will be made up of a number of professionals who may work with the patient at any point in the care pathway; this should encompass primary and secondary care. It is the view of the topic advisory group for the guide for commissioners that the core members of a specialist multidisciplinary heart failure team should include:

- a specialist physician and clinical lead
- a GP
- a heart failure specialist nurse.

Commissioners may also wish to consider the skills and competencies required by healthcare professionals to provide the expected outcomes of an integrated care pathway for people with chronic heart failure. Further sources of information include the Skills for Health website, which includes a number of competency related tools on heart failure.

The long-term conditions workstream of the Quality, Innovation, Productivity and Prevention (QIPP) programme advocates a proactive generic management model of care for people with long-term conditions. Commissioners should ensure that services for people with chronic heart failure are integrated with other services for people with long-term conditions, particularly for people with comorbidities. Commissioners and clinicians will need to work together to agree the relationship between specialist support, integrated teams and self care (see the LTC commissioning pathway for further information and examples).

The key components of an effective multidisciplinary heart failure service are:

- referral to a specialist multidisciplinary heart failure team
• optimising pharmacological treatment
• care of people admitted to hospital
• cardiac rehabilitation
• monitoring.

4.2.1 Referral to a specialist multidisciplinary heart failure team

When commissioning a specialist multidisciplinary heart failure team commissioners should:

• work with clinicians to agree clear inclusion and exclusion criteria for the team
• agree clear thresholds/triggers for referral to a multidisciplinary heart failure team at key points in the care pathway and in line with NICE clinical guideline 108 on chronic heart failure
• ensure that clear local referral pathways are in place to optimise the use of the multidisciplinary heart failure team and ensure the team is integrated with other primary and secondary care services for people with long-term conditions.

NICE clinical guideline 108 on chronic heart failure recommends:

• Refer patients to the specialist multidisciplinary heart failure team for:
  
  - the initial diagnosis of heart failure
  
  - the management of:
    
    ◇ severe heart failure (NYHA class IV)
    
    ◇ heart failure that does not respond to treatment
    
    ◇ heart failure that can no longer be managed effectively in the home setting. [new 2010] (recommendation 1.5.1.1)

Commissioners will need to consider the whole care pathway for long-term conditions when commissioning a multidisciplinary heart failure service. They should consider how services for
people with heart failure and comorbidities are integrated, particularly for people with heart failure and diabetes and/or chronic obstructive pulmonary disease (COPD) and in line with recommendation 1.2.2.33 made within NICE clinical guideline 108 on chronic heart failure:

- Manage comorbidities according to:
  - 'Hypertension', NICE clinical guideline 34[^1]
  - 'MI: secondary prevention', NICE clinical guideline 48
  - 'Type 2 diabetes', NICE clinical guideline 87 and other relevant NICE guidance. This is particularly important in heart failure with preserved ejection fraction. [new 2010] (recommendation 1.2.2.33)

4.2.2 Optimising pharmacological treatment

Optimising pharmacological treatment for people with chronic heart failure is important, and a number of recommendations are made regarding first and second line pharmacological treatment for people with heart failure within section 1.2.2 of NICE clinical guideline 108 on chronic heart failure.

Commissioners should expect providers to demonstrate that their prescribing is in line with NICE guidance and that they are working towards achieving statement 7 of NICE quality standard for chronic heart failure:

Quality statement 7: Treatment with angiotensin-converting enzyme inhibitors, angiotensin II receptor antagonists and beta blockers

'People with chronic heart failure due to left ventricular systolic dysfunction are offered angiotensin-converting enzyme (ACE) inhibitors (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with angiotensin-converting enzyme inhibitors) and beta-blockers licensed for heart failure, which are gradually increased up to the optimal tolerated or target dose with monitoring after each increase.'

The National Heart Failure Audit 2010 identified variation in the prescribing of angiotensin-converting enzyme inhibitors and beta blockers – in particular that:

- beta blockers are underused
• Of 5929 patients with a reported dose of an ACE inhibitor, 49 per cent received less than 50 per cent of the target dose

• Of 5214 patients with a reported dose of a beta-blocker, 66 per cent received less than 50 per cent of the target dose

• doses may have been titrated up at a later stage but, in clinical practice, this often does not happen unless the patient receives specialist follow-up.

In order to benchmark current practice against the quality standard commissioners should assess current prescribing practice locally through audit, medication review by medicine management teams and/or review of prescribing rates and exception coding rates.

Commissioners may need to consider how service models and care pathways facilitate optimal pharmacological management, including:

• clinical monitoring

• prompt and clear information on discharge from hospital sent to the person's GP (for example, to ensure optimisation of ACE inhibitors)

• systems in place for dose titration

• educational programmes to promote prescribing in line with NICE guidance.

Commissioners should take account of the resources needed to administer dose titration as part of pharmacological treatment, and methods to support this may include:

• heart failure nurse led service

• pharmacist led service.

Commissioners may wish to consider the skills and competencies required by a multidisciplinary heart failure team. This may include additional skills and competencies required by nurses and allied healthcare professionals in the pharmacological treatment of people with chronic heart failure, including the availability of nursing and/or allied healthcare professionals as supplementary or independent prescribers and the funding available to support this. Healthcare professionals administering dose titration should also be competent in assessment and heart failure education as titration requires use of specialist assessment and judgment.
4.2.3 Care of people admitted to hospital

Commissioners should expect providers to demonstrate that the care of people admitted to hospital due to chronic heart failure is in line with NICE guidance and NICE quality standard on chronic heart failure (see table 3).

Table 3 Commissioning considerations for people admitted to hospital due to chronic heart failure

<table>
<thead>
<tr>
<th>NICE recommendation: CG108 on chronic heart failure</th>
<th>Implications for commissioners</th>
</tr>
</thead>
</table>
| When a patient is admitted to hospital because of heart failure, seek advice on their management plan from a specialist in heart failure. [new 2010] (recommendation 1.4.1.5) | • Expect to see evidence that people admitted to hospital with chronic heart failure receive input to their management plan from a multidisciplinary heart failure team with access to the necessary diagnostics and resources.  
  
• Expect providers to demonstrate that clear processes are in place to alert the multidisciplinary heart failure team to the admission of a person due to chronic heart failure, and that the team is alerted to every person admitted to hospital due to chronic heart failure. |
Patients with heart failure should generally be discharged from hospital only when their clinical condition is stable and the management plan is optimised. Timing of discharge should take into account patient and carer wishes, and the level of care and support that can be provided in the community. [2003] (recommendation 1.5.2.1)

| The primary care team, patient and carer must be aware of the management plan. [2003] (recommendations 1.5.2.2) | Commissioners should expect providers to demonstrate that processes are in place to ensure the safe discharge of people with chronic heart failure from hospital.  
Where local admission rates for chronic heart failure are higher than expected commissioners should seek assurance that acute hospitals have processes and procedures in place to ensure safe discharge from hospital.  
Commissioners should determine the availability and responsiveness of services within the community to support hospital discharge – for example, district nursing and intermediate care services. |
| Clear instructions should be given as to how the patient/carer can access advice, particularly in the high-risk period immediately following discharge. [2003] (recommendation 1.5.2.3) | Commissioners should expect providers to demonstrate that management plans take account of a patient's personal goals and a holistic assessment of their needs, and the agreed interventions to achieve the patient's goals.  
Commissioners may wish to refer to the Department of Health's [information sheets for professionals on personalised care planning.](#) |

**NICE recommendation: NICE QS on chronic heart failure**

**Implications for commissioners**

- Consider how people with chronic heart failure and their carers are able to access advice in a timely manner, particularly out of hours.
| Quality statement 10: People admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP | • Expect providers to demonstrate that people admitted to hospital due to chronic heart failure have a personalised management plan.  
• Expect to see evidence that management plans are shared with the person's GP in a timely manner, for example within 24 hours of discharge from hospital.  
• Consider the availability locally of IT infrastructure that supports the sharing of management plans across organisations  
• Commissioners may wish to consider using the CQUIN payment framework as a lever for improving the provision and sharing of information when a person is discharged from hospital, for example the inclusion of detailed discharge instructions as a clinical process measure as part of a heart failure CQUIN for Aintree University Hospitals NHS Trust. |
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Quality statement 11: People admitted to hospital because of heart failure receive input to their management plan from a multidisciplinary heart failure team.</td>
<td>As 1.4.1.5 above.</td>
</tr>
</tbody>
</table>
| Quality statement 12: People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge. | • As 1.5.2.1 above.  
• Commissioners will need to ensure that a multidisciplinary heart failure team is available locally, and that the role of the team includes post-discharge assessment. |
People with chronic heart failure are at high risk of emergency admission to hospital. When commissioning services for people with chronic heart failure commissioners may wish to review local readmission rates for people with heart failure and identify variation from national averages. Information on heart failure emergency admission rates can be found in the National Cardiovascular Disease (CVD) profiles.

The admitted patient care commissioning datasets contain the data needed for calculating readmissions for people admitted to hospital because of heart failure. More information is available at HES Online.

Information on readmissions is monitored by the National heart failure audit for people who have an unplanned admission to hospital with heart failure.

Where practice is currently not in line with the quality statements above, and hospitals put in place measures to improve care in order to achieve quality statements 10, 11 and 12 for people admitted to hospital because of heart failure, local readmission rates may decrease.

Commissioners should take account of ambulatory care pathways for people with an exacerbation of chronic heart failure who require urgent or emergency health care. Commissioners may wish to consider where the NICE recommendations and quality statements above should apply to people receiving urgent care within an ambulatory care environment.

4.2.4 Cardiac rehabilitation

Commissioning cardiac rehabilitation for people with heart failure, including service components and the commissioning and benchmarking tool for commissioners is addressed separately in Cardiac rehabilitation service: NICE guide for commissioners.

4.2.5 Monitoring

Chronic heart failure is a progressive condition and regular monitoring and review is an important part of care. Section 1.4 of NICE clinical guideline 108 on chronic heart failure makes a number of recommendations regarding the monitoring of people with chronic heart failure, including:
All patients with chronic heart failure require monitoring. This monitoring should include:

- a clinical assessment of functional capacity, fluid status, cardiac rhythm (minimum of examining the pulse), cognitive status and nutritional status
- a review of medication, including need for changes and possible side effects
- serum urea, electrolytes, creatinine and eGFR\(^{[2]}\). [2003, amended 2010] (recommendation 1.4.1.1)

More detailed monitoring will be required if the patient has significant comorbidity or if their condition has deteriorated since the previous review. [2003] (recommendation 1.4.1.2)

The frequency of monitoring should depend on the clinical status and stability of the patient. The monitoring interval should be short (days to 2 weeks) if the clinical condition or medication has changed, but is required at least 6-monthly for stable patients with proven heart failure. [2003] (recommendation 1.4.1.3)

Patients who wish to be involved in monitoring of their condition should be provided with sufficient education and support from their healthcare professional to do this, with clear guidelines as to what to do in the event of deterioration. [2003] (recommendation 1.4.1.4)

Consider specialist monitoring of serum natriuretic peptides in some patients (for example, those in whom uptitration is problematic or those who have been admitted to hospital). [new 2010] (recommendation 1.4.3.1)

Quality statement 9: monitoring stable chronic heart failure

'People with stable chronic heart failure receive a clinical assessment at least every 6 months, including a review of medication and measurement of renal function.'

Commissioners should expect providers to demonstrate that people with chronic heart failure are monitored in accordance with the NICE guideline and quality standard.

Commissioners may wish to use risk profiling data as a way to proactively identify people at risk and target more frequent monitoring in order to prevent deterioration in an individual's condition and hospital admissions.
Commissioners should consider how monitoring for people with chronic heart failure integrates with other arrangements for monitoring people with long-term conditions and co-existing morbidities, including the support of people to self care and the development of telehealth and telemonitoring.

### 4.2.6 Service models

**Quality, innovation, productivity and prevention**

The [long-term conditions workstream of the Quality, Innovation, Productivity and Prevention (QIPP) programme](https://www.nice.org.uk/topics/qualityinnovation) advocates a proactive generic management model of care for people with long-term conditions.

Commissioners may wish to work with their local [Quality, Innovation, Productivity and Prevention (QIPP)](https://www.nice.org.uk/topics/qualityinnovation) lead to develop service models for the multidisciplinary management of chronic heart failure. Example models are included in table 4.

#### Table 4 Delivering QIPP through chronic heart failure services

<table>
<thead>
<tr>
<th>QIPP model</th>
<th>Example output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population risk stratification</td>
<td>• Reducing frequent and recurrent hospital attendance by targeting interventions for high risk populations.</td>
</tr>
</tbody>
</table>
| Regular use of risk profiling data within MDT discussions to proactively identify people in need of support | • Identifying and reducing gaps and duplication in support.  
• Agreeing the most appropriate person to act in care coordinator role.  
• Preventing/reducing crises and acute episodes.  
• Increasing confidence in services.  
• Improving relationships between organisations/professionals. |
Regular MDT discussion of patients

- Review of people with chronic heart failure, including outcomes, current care plan and possible improvements and potential discharge/referrals.
- Improved relationship between team members.
- Use of online video conferencing for weekly MDT heart failure meetings to reduce travel time and costs.

Promotion of self management

- Increasing the number of people with personalised care plans to support and increase confidence to self manage.

Commissioning for quality and innovation

Commissioners may wish to consider working with clinicians when using the Commissioning for Quality and Innovation (CQUIN) payment framework as a lever for service change. For example:

- inclusion of detailed discharge instructions as a clinical process measure as part of a heart failure CQUIN for Aintree University Hospitals NHS Trust and University Hospital of Manchester in 2011/2012

- CQUIN to personalisation of care planning and self-management among people with long-term conditions included within exemplar CQUIN goals

- Further examples are available from the NHS Institute for Innovation and Improvement.

Case studies

Commissioners may wish to refer to examples of services for the multidisciplinary management of chronic heart failure. Examples are included in table 5.

Table 5 Examples of service models for the multidisciplinary management of chronic heart failure
### Setting | Examples of service models or settings | Case study
---|---|---
**Primary care** | GP-led clinics | • GP-led one-stop diagnostic clinic that includes echocardiography and BNP testing in Bournemouth
• **Chronic disease management team** in Bolton – an initiative to help improve the quality of care for people with chronic disease in primary care, focusing on chronic obstructive pulmonary disease and heart failure.

**Community** | Care within the community | • Monitoring by community matrons in Blackburn with Darwen.
• Monitoring by heart failure nurses.
• Community heart failure services:
  • Medway and Swale
  • Tameside and Glossop.
  • **Medicine Management Team** in Manchester.
  • Clinics for starting treatment and increasing medication doses, including role of specialist heart failure nurses.

**Secondary care** | Hospital-based specialist clinics | • Hastings Heart Failure service: Integrated heart failure service at Conquest Hospital

A number of examples can also be found at [NHS Improvement: heart](http://www.nice.org.uk/nicemedia/live/12446/14770/14770.pdf).

(Please note – these examples are offered to share good practice and NICE makes no judgement on the compliance of this service with its guidance.)

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[a] Updated August 2011: 'Hypertension', NICE clinical guideline 128
This is a minimum. Patients with comorbidities or co-prescribed medications will require further monitoring. Monitoring serum potassium is particularly important if a patient is taking digoxin or an aldosterone antagonist.
4.3 Specifying supportive and palliative care for people with chronic heart failure

Commissioning supportive and palliative care for people with chronic heart failure, underpinned by NICE guidance and the NICE quality standard for chronic heart failure and end-of-life care, is likely to contribute to achieving outcomes under domain 4 of the NHS Outcomes framework 2011/12 by:

- improving the experience of care for people at the end of their lives
- enabling people to die in the place of their choice
- developing a skilled workforce in supportive and palliative care.

The needs of people with advanced heart failure are very different to those of people with cancer, including the difficulty of predicting prognosis. The disease trajectory of heart failure is described in detail in End of life care in heart failure: a framework for implementation.

The End of Life Care Strategy recommends a care pathway approach both for commissioning services and for delivery of integrated care for individuals (see figure 3).

Figure 3 End-of-life care pathway
The NHS outcomes framework 2011/12 includes actions for end-of-life care as follows:

- **4.33:** The NHS should continue to ensure implementation of the 'End of Life Care Strategy – promoting high quality care for all adults at the end of life', working to offer individuals the choice of where to be cared for as they approach the end of life, and where to die, regardless of their condition. It should ensure that staff are trained for this, including using the e-learning modules available as part of blended learning.

- **4.34:** The QIPP End of Life Care workstream is driving the first two steps on the strategy's end-of-life care pathway – identifying people as they approach the end of life and planning for their care, including asking about their preferences for care. Making that choice a real option requires implementation of the other strands of the strategy – commissioning the care people want, coordinating care across sectors and training the workforce to provide it. In particular, commissioners need to ensure that adequate 24/7 community services are available in their locality.

Commissioners should ensure that they are working towards the NICE quality standard on end-of-life care following its publication late 2011.

The key components of a care pathway for supportive and palliative care for people with moderate to severe chronic heart failure are:
• Early recognition and assessment

• Advance care planning

• Deactivation of devices towards the end of life

• Coordination of care and access to a full range of services

• Symptom management at the end of life

• Care in the last days of life

• Care and support after death.

4.3.1 Early recognition and assessment

NICE clinical guideline 108 recommends:

• Prognosis should be discussed with patients and carers in a sensitive, open and honest manner. (recommendation 1.5.6.1)

• Issues of sudden death and living with uncertainty are pertinent to all patients with heart failure. The opportunity to discuss these issues should be available at all stages of care. (recommendation 1.5.9.1)

• The palliative needs of patients and carers should be identified, assessed and managed at the earliest opportunity. (recommendation 1.5.9.2)

Statement 13 from the NICE quality standard for chronic heart failure states:

Quality statement 13: moderate to severe chronic heart failure

'People with moderate to severe chronic heart failure, and their carer(s), have access to a specialist in heart failure and a palliative care service.'

Moderate to severe chronic heart failure refers to people with chronic heart failure and moderate to severe symptoms (typically New York Heart Association (NYHA) Classes III or IV).

To enable the early recognition and assessment of the supportive and palliative care needs of people with chronic heart failure, commissioners should:
Work with clinicians to agree locally the triggers or indicators for moderate to severe chronic heart failure that should be used to identify a cause for concern and when a person's supportive and palliative care needs should be assessed.

Ensure referral pathways are in place for assessment by a specialist to ensure that optimal intervention is in place, and whether further intervention should be considered.

Be satisfied that primary care teams ensure that the palliative care needs of people with moderate to severe chronic heart failure are regularly assessed, and that information is communicated within the primary care team. This includes out-of-hours services, ambulance services and with other health and social care staff.

Ensure that information on end-of-life care is made available for people with chronic heart failure, their families and carers while they are in a stable state. This may include discussions regarding the deactivation of devices (see section 2.3.3).

People with chronic heart failure should be offered 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. (See Planning your future care: a guide and step one of the end-of-life care pathway).

### 4.3.2 Advance care planning

It is important to offer discussions about advance care planning, which can result in a range of outcomes, such as preferred priorities for care, an advance decision to refuse treatment, and/or appointment of a legal power of attorney.

Advanced care planning should be in line with legislation and best practice and commissioners should:

- Expect providers to record the number of people with chronic heart failure who have a care plan in place for supportive and palliative care, including an advance care plan
- Expect providers to demonstrate that care planning addresses the holistic needs of people with severe chronic heart failure, including psychological and social needs and financial help, for example access to benefits and entitlements
• Expect providers to demonstrate that a carer's assessment is offered to carers of people with moderate to severe chronic heart failure

• Specify that providers involved in the care of people with severe chronic heart failure are aware of legislation regarding end-of-life care and follow in particular the provisions of the Mental Capacity Act 2005

• Be aware that although it is important that people with severe chronic heart failure are supported to make informed decisions and offered the opportunity to discuss their future care, some may choose not to do so and this should be respected.

• Be satisfied that a key worker is identified for people with moderate to severe chronic heart failure and that the person, their family and carers know who their key worker is and how to contact them.

• Expect providers to demonstrate that advance care planning includes 'Preferred priorities for care' to enable people with chronic heart failure to plan ahead their preferred place of death if they chose. See Advance care planning: a guide for health and social care staff for information.

• Ensure people with severe chronic heart failure are able to discuss and agree decisions regarding future care should they wish – for example, Advanced Decisions to Refuse Treatment (ADRT) and Decisions relating to cardiopulmonary resuscitation – and that the infrastructure is in place to make this information available to relevant services – for example, the ambulance service and out-of-hours services.

Commissioners should consider the skills and competencies needed by health and social care staff to identify and address the supportive and palliative care needs of people with chronic heart failure, for example:

• communication skills

• assessment and care planning

• advance care planning

• symptom management.
4.3.3 Deactivation of devices towards the end of life

Commissioners should ensure that care pathways are in place for deactivation of devices towards the end of life. Placement of patients on the palliative care register should prompt discussion about deactivation of implantable cardioverter defibrillators (ICD) between the GP or cardiologist, specialist nurse or other health care worker and the patient, their carers and relatives. This will help ensure that decisions are taken when the patient has capacity to participate, and that the procedure can be planned and carried out in a timely fashion.

Commissioners may wish to refer to Implantable cardioverter defibrillators (ICDs) in patients who are reaching the end of life for further information.

Commissioners may also wish to refer to the following documents:

- North of England cardiovascular network: policy for the activation/deactivation of implantable cardioverter defibrillators
- Kent cardiovascular ICD deactivation policy: ICD consent at fitting and deactivation at the end of life

4.3.4 Coordination of care and access to a full range of services

Once assessment and care planning has taken place services should provide coordinated care for people with severe chronic heart failure. Therefore, commissioners should:

- Scope existing care pathways and services providing end-of-life care for people with severe chronic heart failure, including palliative care teams, hospices, and nursing homes.
- Ensure that health and social care managers integrate working across all agencies involved in the treatment and care of people with moderate to severe chronic heart failure. This includes jointly agreeing written policies and procedures (see supporting people to live and die well: a framework for social care at the end of life for information on integrated health and social care at the end of life).
• Ensure that palliative care services work jointly with the multidisciplinary heart failure team, have access to specialist clinicians and agree clear local guidance on the role of specialist palliative care for people with severe chronic heart failure.

Commissioners should consider the **skills and competencies** needed by health and social care staff in supportive and palliative care. Commissioners should ensure all staff working with people with moderate to severe chronic heart failure, including in hospices, are competent in the provision of palliative care for people with severe chronic heart failure, including symptom control and disease-specific needs. The level of skill and expertise should be proportionate to the level of contact that staff have with people with chronic heart failure. Commissioners should ensure that:

- cardiac and primary care clinicians are competent in assessing a person's supportive and palliative care needs
- palliative care clinicians are competent in identifying a person's cardiac care needs.

4.3.5 Symptom management at the end of life

Commissioners should ensure that care pathways are in place to ensure people with chronic heart failure are able to access effective management of their symptoms at the end of life. This may include:

- medication across a range of end-of-life settings, including storage of controlled drugs such as diamorphine
- multi-specialist input for people with comorbidities
- specialist review
- training on symptom management for health and social care staff who are inexperienced in dealing with heart failure, for example out-of-hours services.

4.3.6 Care in the last days of life

Commissioners should ensure high-quality care is available during the last days of life, and ask providers to demonstrate that they are working towards achieving the NICE quality standard on end-of-life care (publication due late 2011) and the End-of-Life Care Strategy.
Commissioners should ensure that palliative care is available and care in the last days of life is available 24 hours a day, including rapid access services, integrated delivery of care and care coordination across geographic boundaries. This may include:

- access to medication
- hospices
- care homes
- the voluntary sector
- domiciliary home care
- health and social care organisations, including domiciliary palliative care services
- transport services.

Commissioners should ensure a high standard of care out of hours. Commissioners should assess unmet needs and assess the impact of the supportive and palliative care services on out-of-hours services locally, such as community nursing.

More information on out-of-hours care is available from the Gold Standards Framework and the Macmillan out-of-hours toolkit available through the Macmillan learn zone (please note – you will need to register to use this toolkit).

People with severe chronic heart failure should have access to a full range of services that enables them to die in their preferred place of death, where stated. Commissioners should ensure there is a choice of settings available locally as a place of death for people with chronic heart failure, including home, hospice and hospital. Care pathways should be in place to enable this to happen, in accordance with the End-of-Life Care Strategy and the Operating Framework for the NHS in England 2011/12 (see page 38). See also the Liverpool Rapid Discharge Pathway.

### 4.3.7 Care and support after death

Expert opinion suggests that care after death, step 6 of the national end-of-life care pathway, is under-resourced in all clinical areas including chronic heart failure.
Commissioners should take account of the following considerations that relate specifically to care after death for people with chronic heart failure:

- Sudden death due to heart failure or a comorbidity may require involvement of the coroner.
- There are a number of specific considerations regarding implanted devices, such as deactivation of defibrillator function (see Guidance for staff responsible for care after death and medical device alert MCA/2008/068 for further information).

Commissioners may wish to consider the following:

- Ensure services are available to provide support to family and carers after death, for example bereavement support.
- Ensure there is access to spiritual care and chaplaincy services.

For further information see the End-of-Life Care Strategy and End of life care in heart failure: a framework for implementation. A number of resources on care after death are also available from the National End of Life Care Programme.

4.3.8 Service models

Quality, innovation, productivity and prevention

The End of Life Care workstream of the QIPP programme focuses on improving systems and practice for identifying people as they approach the end of life and planning their care. The aims of the workstream include helping clinicians know when and how to start the conversation about end-of-life care and supporting systematic care planning, including advance care planning, for people approaching the end of life.

Commissioners may wish to work with their local Quality, Innovation, Productivity and Prevention (QIPP) lead to develop service models for the supportive and palliative care for people with chronic heart failure. Example models are included in table 6.

Table 6 Delivering QIPP through supportive and palliative care in chronic heart failure

<table>
<thead>
<tr>
<th>QIPP model</th>
<th>Example output</th>
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### Services for people with chronic heart failure

#### NICE commissioning guide 39

**Advance care planning**
- Increased number of people with chronic heart failure with an advanced care plan.
- Reduced number of inappropriate interventions – for example, cardiopulmonary resuscitation (CPR) where an Advanced Decisions to Refuse Treatment (ADRT) or Decision relating to cardiopulmonary resuscitation is in place.

**Place of death**
- Increased proportion of people dying within their preferred place of death.
- Reduction in the number of inappropriate deaths within a hospital setting.

**Access to palliative care services 24 hours a day**
- Reduction in the number of hospital admissions where alternative care is in place.
- Increased proportion of people dying within their preferred place of death.
- Timely access to symptom control and medication.

**Use of recognised tools already developed, such as the Liverpool care pathway for the dying patient**
- Individualised care.
- Timely access to medication.

**Development of a skilled workforce across all services providing end-of-life care**
- Improved patient, family and carer satisfaction.
- Increased competency.

See NHS evidence: QIPP for further examples.
Commissioning for quality and innovation

Commissioners may wish to consider working with clinicians when using the Commissioning for Quality and Innovation (CQUIN) payment framework as a lever for service change. For example:

- **Death in place of choice: an exemplar CQUIN goal**
- **End of life care CQUIN for Central Manchester University Hospitals Foundation Trust in 2010/11** that included use of the Liverpool care pathway and recording preferred place of death.

Case studies

Commissioners may wish to refer to examples of services for the supportive and palliative care of people with chronic heart failure. Examples are included in table 7.

**Table 7 Examples of service models for the supportive and palliative care of people with chronic heart failure**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>• North Cumbria Palliative Care: an online palliative care educational and information resource for primary care teams</td>
</tr>
<tr>
<td>Home</td>
<td>• Training and education for domiciliary care staff in end of life care</td>
</tr>
<tr>
<td>Hospices</td>
<td>• Hospice-based respite and day services for people with supportive and palliative care needs</td>
</tr>
<tr>
<td></td>
<td>• Hospice-based heart failure clinic</td>
</tr>
<tr>
<td></td>
<td>• Respite day care facilities in North Northamptonshire, South Leicestershire and Rutland, including a hospice-based heart failure support programme</td>
</tr>
<tr>
<td></td>
<td>• End-of-life core care competencies: community hospital project</td>
</tr>
</tbody>
</table>
All

- **Caring Together: A five-year programme for patients with heart failure: Marie Curie Cancer Care and British Heart Foundation Scotland are collaborating with NHS Greater Glasgow and Clyde**

- **Role of the BHF heart failure palliative care specialist nurse: A retrospective evaluation**

A number of examples can also be found at National End of Life Care Programme and NHS Improvement: heart.

(Please note – these examples are offered to share good practice and NICE makes no judgement on the compliance of this service with its guidance.)
4.4 Commissioning high-quality integrated care for people with chronic heart failure

Commissioning high quality care for people with chronic heart failure, underpinned by NICE clinical guideline 108 on chronic heart failure and the NICE quality standard for chronic heart failure, is likely to contribute to achieving outcomes under domains 2, 3 and 4 of the NHS Outcomes framework 2011/12 by:

- ensuring people feel supported to manage their conditions through personalised care planning and strategies for promoting self management
- sharing a person's management plans with their GP in a timely manner following an admission to hospital
- supporting people with anxiety and depression in line with NICE guidance.

The key components of a high quality chronic heart failure service are given below.

4.4.1 Management plans

NICE clinical guideline 108 on chronic heart failure recommends:

- Management plans for patients with heart failure should be discussed with non-NHS agencies where they are involved in or responsible for the care of a person with heart failure. [2003] (recommendation 1.5.4.2)

Quality statements 10 and 11 of the NICE quality standard for chronic heart failure state:

Quality statement 10: Management plans for people admitted to hospital

'People admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP'

Quality statement 11: Contribution of a multidisciplinary heart failure team to management plans
'People admitted to hospital because of heart failure receive input to their management plan from a multidisciplinary heart failure team.'

Commissioners should expect providers of acute hospital care to demonstrate that:

- people with chronic heart failure have an individualised comprehensive management plan
- information is available in a format to suit the diverse needs of the population
- the information is systematically shared with the person's GP, care coordinator and carers where appropriate
- the disease-specific management plan relates to a person's personalised care plan.

Commissioners will need to ensure that the recommendations within the NICE clinical guideline and quality statements 10 and 11 from the NICE quality standard on chronic heart failure are incorporated into an overall strategy for care planning.

Commissioners may wish to consider the availability locally of IT infrastructure that supports the sharing of management plans across organisations.

Care planning is a key element of the generic long-term conditions model and long-term conditions workstream of the QIPP programme. Commissioners should consider how comprehensive management plans for people with chronic heart failure are integrated with existing services that support people with chronic heart failure – for example, personalised care planning, the expert patients programme and use of telehealth and assistive technology.

### 4.4.2 Self management

Encouraging people with long-term conditions to manage their own health is a key element of the generic long-term conditions model and long-term conditions workstream of the QIPP programme.

**NICE clinical guideline 108** on chronic heart failure recommends:

- Patients who wish to be involved in monitoring of their condition should be provided with sufficient education and support from their healthcare professional to do this, with clear guidance as to what to do in the event of deterioration. (recommendation 1.4.1.4) [2003]
The NICE quality standard for chronic heart failure includes quality statement 5 that relates to this area of care for people who have chronic heart failure:

**Quality statement 5: Education and self management**

'People with chronic heart failure are offered 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.'

People with chronic heart failure have a high re-hospitalisation rate. Their treatment requires regular review and adjustment to correct any oedema or weight gain that may result in clinical deterioration and hospitalisation. Some people with chronic heart failure, with appropriate education, can self monitor through regular weighing and adjusting their diuretic therapy accordingly. This requires easy access to the heart failure team[^31].

Commissioners should expect providers to demonstrate that people with chronic heart failure are:

- provided with personalised information and education regarding their condition
- given the opportunity to be involved in the monitoring and management of their condition.

Commissioners may wish to consider how local strategies to support people with long-term conditions to monitor and manage their conditions can support people with chronic heart failure. Relevant schemes may include:

- information prescriptions
- patient and carer education programmes
- medicines management advice and support
- patient access to their own records
- systematic training for GPs in consultation skills that help engage their patients.

A package of education or information for people with chronic heart failure may include information on:
• health factors such as symptoms, medication

• lifestyle factors such as physical activity, smoking, alcohol, sexual activity, weight management (see recommendations 1.2.1.1 to 1.2.1.8 in NICE clinical guideline 108 on chronic heart failure)

• sources of information and advice for welfare and benefits support, such as carers assessment or attendance allowance

• sources of information and advice regarding employment and income support

• local support groups.

Commissioners may wish to consider the role of assistive technologies to support self-care and independent living. This may include telehealth (home monitoring), telecare and telecoaching.

See the Department of Health’s webpage on long-term conditions for more information. Further resources are available from LTC commissioning pathway.

4.4.3 Anxiety and depression

Chronic heart failure leads to disabling and distressing symptoms. Individuals can become socially isolated and have to give up activities that they enjoy. These factors may lead to the development of anxiety and depression.

NICE clinical guideline 108 on chronic heart failure:

• The diagnosis of depression should be considered in all patients with heart failure. [2003] (recommendation 1.5.8.1)

• Where depression is likely to have been precipitated by heart failure symptoms then reassessment of psychological status should be undertaken once the physical condition has stabilised following treatment for heart failure. If the symptoms have improved no further specific treatment for depression is required. [2003] (recommendation 1.5.8.2)
Where it is apparent that depression is co-existing with heart failure, then the patient should be treated for depression in line with *Depression: the treatment and management of depression in adults* (NICE clinical guideline 90) and *Depression in adults with a chronic physical health problem: treatment and management* (NICE clinical guideline 91). [2003](recommendation 1.5.8.3)

The **NICE quality standard for depression in adults** includes a number of quality statements relating to the assessment of depression, and provision of psychological therapy for people with a chronic physical health problem.

Commissioners should specify that clinicians working with people with chronic heart failure are able to address the psychological needs of people in line with:

- NICE clinical guideline 108 on chronic heart failure
- NICE quality standard for depression in adults
- NICE clinical guideline 91 on the treatment and management of depression in adults with chronic physical health problems
- NICE clinical guideline 113 on anxiety: Generalized anxiety disorder and panic disorder (with or without agoraphobia) in adults.

### 4.4.4 Service models for integrated care

**Quality, innovation, productivity and prevention**

In addition to examples provided in previous sections example models for high quality integrated care for people with chronic heart failure and long-term conditions are included in table 8.

**Table 8 Delivering QIPP through integrated care for people with chronic heart failure**

<table>
<thead>
<tr>
<th>QIPP model</th>
<th>Example output</th>
</tr>
</thead>
</table>

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Regular MDT discussion of patients

- Review of people with chronic heart failure, including outcomes, current care plan and possible improvements and potential discharge/referrals.
- Improved relationship between team members.
- Use of online video conferencing for weekly MDT heart failure meetings to reduce travel time and costs.

Use of NHSnet email accounts to support confidential sharing of information across organisations

- Better coordinated care across services.
- Reduced duplication and unnecessary service provision due to lack of information.

Shared electronic records

- Better coordinated care across services.
- Reduced duplication and unnecessary service provision due to lack of information.

Personalised care plans for long-term conditions

- Increased proportion of people with chronic heart failure with a personalised care plan in place.
- Interventions and actions set around a person's own goals and objectives to support patient self-management and achieve desired clinical outcomes.

Self care support for long term conditions

- Reduce reliance on care services
- Increase confidence and capability of individuals to manage their conditions and improve quality of life.

See also the [LTC commissioning pathway](#) for further examples.

**Commissioning for quality and innovation**

Commissioners may wish to consider working with clinicians when using the Commissioning for Quality and Innovation (CQUIN) payment framework as a lever for service change. For example, two CQUIN goals relating to long-term conditions are included within exemplar CQUIN goals.
Further examples are available from the NHS Institute for Innovation and Improvement.

Case studies

Commissioners may wish to refer to the examples of integrated care for people with chronic heart failure provided within section 4.2.

Examples can also be found at the LTC commissioning pathway.

5 Service specification for chronic heart failure services

Commissioners should collaborate with clinicians, local stakeholders, and service users when determining what is needed from services for people with chronic heart failure in order to meet local needs. The care pathway should be person/patient-centred and integrated with other elements of care for people with long-term conditions.

Commissioners may wish to consider commissioning services for people with chronic heart failure in a number of different ways, and mixed models of provision are likely to be appropriate within a local area. Commissioners may wish to take action to stimulate the local market if there are identified shortages of providers at any point in the pathway and should note that any qualified providers may include health, local authority, other statutory partners, and private or third sectors.

Commissioners should ensure that providers implement the recommendations stipulated in NICE guidance and that providers are taking steps to achieve the standards set out in NICE quality standards for chronic heart failure and end of life care (under development).

Commissioners should ensure the services they commission represent value for money and offer the best possible outcomes for their service users. Commissioners should refer to the NICE quality standards for chronic heart failure and end of life care when commissioning services and should include quality statements and measures within the service specification element of the standard contract where appropriate. If poor performance is identified, commissioners can discuss the level of performance with their providers and address any issues and concerns before introducing more formal contractual remedies.

Commissioners may choose to use quality standards to ensure that high-quality care is being commissioned through the contracting process, to establish key performance indicators as part of a tendering process and/or to incentivise provider performance by using the indicators in association with incentive payments such as Commissioning for Quality and Innovation (CQUIN).

Commissioners should ensure that they consider both the clinical and cost effectiveness of the service, and any related services, and take into account clinicians’ and individuals’ and carers views and those of other stakeholders when making commissioning decisions.
Table 9 includes considerations for commissioners when developing a contract specification for heart failure services.

**Table 9 Considerations for contract specification**

<table>
<thead>
<tr>
<th>Heading</th>
<th>Section</th>
<th>To be described in service specification</th>
</tr>
</thead>
</table>
|         | Policy context | • National policy drivers for chronic heart failure (CHF), long-term conditions and end-of-life care.  
|         |         | • Evidence base, for example NICE guidance and quality standards, NHS evidence and national strategy consultation. |
| Purpose | Local strategic context | • Local commissioning drivers (for example reducing hospital admissions and length of stay, QIPP, CQUIN).  
|         |         | • Invest to save.  
<p>|         |         | • Results of joint strategic needs assessment (JSNA). |
|         | Aims and objectives of service | • The expected outcomes of the service(s). |</p>
<table>
<thead>
<tr>
<th>Service scope</th>
<th>Define service user groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Demographic profile of the local population (age, gender, ethnicity, socio-economic status).</td>
</tr>
<tr>
<td></td>
<td>• Local recorded and expected prevalence of CHF.</td>
</tr>
<tr>
<td></td>
<td>• Estimated prevalence of comorbidities (for example, hypertension, stroke, COPD, depression).</td>
</tr>
<tr>
<td></td>
<td>• Evidence of inequalities in outcomes between specific groups.</td>
</tr>
<tr>
<td></td>
<td>• Number of wholly attributable and partially attributable CHF-related hospital admissions, bed days and readmissions.</td>
</tr>
<tr>
<td></td>
<td>• Number of people currently being treated in community-based heart failure services and other relevant services, such as cardiac rehabilitation.</td>
</tr>
<tr>
<td></td>
<td>• Number of people who see their GP and have a recorded incidence of chronic heart failure related ill health.</td>
</tr>
<tr>
<td></td>
<td>• Population groups that will be targeted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion criteria</th>
<th>Define exclusion criteria in accordance with NICE guidance and locally determined criteria.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Geographical population</th>
<th>Proportion of people living in urban and/or rural areas.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Areas of higher-than-average need for example, areas of deprivation and areas with a high population of older people.</td>
</tr>
<tr>
<td></td>
<td>Population coverage required or geographical boundaries.</td>
</tr>
<tr>
<td>Service delivery</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| Service description / care package | • Mapping existing services for people with CHF.  
• Commissioning of core service components (assessment, cardiac rehabilitation, care coordination and/or case management, aftercare, prescribing, end-of-life care).  
• Interface with other local services including social care, residential and nursing care, hospices, intermediate care services, ambulance service, out-of-hours services, and community mental health services. |
| Location | • Service location(s), defining accessibility requirements and discreet location(s).  
• Integration with other services for people with CHF and long-term conditions.  
• Home-based, locality-based services and centrally-based services. |
| Days/hours | • Expected hours of operation, including days, evenings and weekends.  
• Expected number of individuals for case finding, assessment, treatment, care coordination or case management, end-of-life care, taking into account potential increased flow through the system over defined periods. |
| Referral processes | • Referral criteria and processes for people with CHF.  
• Management of 'unable to attend' (UTAs) and 'did not attends' (DNAs). |
| **Response times** | • This should be needs based and outcomes based.  
  • Setting specific times, particularly for assisted discharge and rapid response services for end-of-life care. |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------|
| **Care pathways**  | • Agreed clinical protocols or guidelines to support decision-making in the patient pathway.  
  • Pathways for people with complex needs and comorbidities.  
  • Use of third sector.  
  • Care coordination. |
| **Discharge processes** | • Process for discharge from services for people with CHF, including aftercare and communication with other teams. |
| **Staffing** | • Profile of existing health and social care workforce.  
  • Staffing levels to be funded: minimum band or levels of level of experience and competency and expected skill mix.  
  • Skill mix and competencies of staff for specific areas of care. |
| **Information sharing** | • Define information sharing, confidentiality and audit requirements, including IT support and infrastructure.  
  • Raising awareness of services for people with CHF. Do individuals and health and social care professionals know how to access services? |
### Quality assurance and clinical governance

<table>
<thead>
<tr>
<th>Patient and public involvement</th>
</tr>
</thead>
</table>
| • Processes to understand patient experience of CHF services in order to develop and monitor services. See also [Patient experience online network](#).
| • Expectations of how patient opinion, preference and experience will be used to inform service delivery for example, focus groups, representation on working groups, and surveys.
| • Monitoring of complaints and complements and how used to inform service.
| • See also the [NICE Quality Standard for patient experience](#) (under development).

<table>
<thead>
<tr>
<th>1. Quality indicators</th>
</tr>
</thead>
</table>
| • Use [NICE quality standards](#) to define high-quality care.
| • Patient satisfaction surveys and access to treatment.
| • Define outcomes and (proxy) measures including outcomes provided within the [NICE Quality standard on chronic heart failure](#).

<table>
<thead>
<tr>
<th>Performance monitoring</th>
</tr>
</thead>
</table>
| • Local need and demand for treatment, including brief interventions.
| • Impact of service(s) on admissions to A&E, inpatient hospital care and length of stay in hospital.
| • Measurement of referrals and discharges. |
| Equality | • Measures to ensure equality of access to services, taking into account the risks of unintentional discrimination against groups who are often under-represented, such as people who do not speak English as a first language.  
  
  • Consider equity of access for people living within residential and nursing homes and those who are housebound; or people within prisons. |
| --- | --- |
| 1. Staff training and competency | • Training and competencies on recruitment and for ongoing development.  
  
  • Processes for monitoring clinical practice and competency, including professional registration and clinical supervision arrangements.  
  
  • Skill mix and competencies required across the care pathway, including competencies in: assessment, behavioural change and motivational interview, personalised care planning, provision of exercise and identifying palliative care. See [Skills for Health](#) for examples.  
  
  • Staff development – appraisal and personal development plans, and mandatory training. |
| Audit | • Specify expectations for audit, which may include assessment, intervention, prescribing practices and successful treatment outcomes.  
  
  • See [audit support](#) and [electronic audit tool](#) for NICE clinical guideline 108 and also [NICE audit support for CG91](#) on depression with a chronic physical health problem.  
  
  • Participation in national heart failure audit, including associated costs. |
### Staff and patient safety

- Procedures for risk assessment.
- Formal procedures for incident reporting and monitoring.
- Address any safeguarding concerns and promote the welfare of children and vulnerable adults.

### Activity plan

- Long-term impact of increased access to improved assessment and diagnosis of chronic heart failure on referrals to other services, hospital admissions and bed days.
- Planned service development setting out any productivity improvements.

### Cost

#### Value for money

- Likely cost of new or additional services
- Anticipated set-up costs.
- How will pricing be set?
- Potential for better value for money through reduced readmissions and reduced duplication of healthcare appointments through an integrated team and improved communication between teams
- Are individuals receiving most appropriate services for chronic heart failure?
- Cost of facilities, for example venue hire.
- Cost of staff travel to services and individuals' homes.
- **QIPP**.
- See the [Commissioning and benchmarking tool](#) for further information.
6 The commissioning and benchmarking tool

Download the chronic heart failure services commissioning and benchmarking tool.

Use the commissioning and benchmarking tool for chronic heart failure to determine the level of service that might be needed locally and to calculate the cost of commissioning the service, as described below.

6.1 Identify indicative local service requirements

Available data suggest that the indicative benchmark rate for:

- the number of adults aged 45 years or over with suspected heart failure per year is 450 per 100,000 population, or 0.45%.
- the number of adults aged 45 or over who should have their serum natriuretic peptides measured per year is 360 per 100,000 population, or 0.36%.

The commissioning and benchmarking tool helps you to assess local service requirements using the indicative benchmark as a starting point. With knowledge of your local population and its demographic, you can amend the benchmark to better reflect your local circumstances. For example, if your population is significantly younger or older than the average population, or has an ethnic composition different from the national average, or has a significantly higher or lower rate of chronic heart failure, you may need to provide services for relatively fewer or more people.

6.2 Review current commissioned activity

You may already commission a chronic heart failure service for your population. The tool provides tables that you can populate to help you calculate your total current commissioned activity and costs.

6.3 Identify future change in capacity required

Using the indicative benchmark provided, or your own local benchmark, you can use the commissioning and benchmarking tool to compare the activity that you might need to
commission against your current commissioned activity. This will help you to identify the future change in capacity required. Depending on your assessment, your future provision may need to be increased or decreased.

6.4 Model future commissioning intentions and associated costs

You can use the commissioning and benchmarking tool to calculate the capacity and resources needed to move towards the benchmark level, and to model the required changes over a period of 4 years.

Use the tool to calculate the level and cost of activity you intend to commission. The tool is pre-populated with data on the potential recurrent and non-recurrent cost elements that may need to be considered in future service planning, which can be reviewed and amended to better reflect your local circumstances.

Commissioning decisions should consider both the clinical and economic viability of the service, and take into account the views of local people. Commissioning plans should also take into account the costs of monitoring the quality of the services commissioned.

6.5 Potential savings

Diagnosing people with chronic heart failure sooner and providing evidence-based multidisciplinary integrated care may reduce the number of emergency hospital admissions. You can use the commissioning and benchmarking tool to calculate the potential savings.
7 Further information

Table 10 summarises national drivers that are relevant to commissioning chronic heart failure services. Local service redesign may address only one or two of them.

Table 10 National policy relevant to chronic heart failure

<table>
<thead>
<tr>
<th>Document</th>
<th>Author</th>
<th>Year</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease: national service framework for coronary heart</td>
<td>Department of Health</td>
<td>2000</td>
<td>Chapter 6 on heart failure sets out how the NHS and others can help people with heart failure to live longer, achieve a better quality of life and receive appropriate palliative care support when appropriate.</td>
</tr>
<tr>
<td>disease - modern standards and service models</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life Care Strategy - promoting high quality care for all adults at</td>
<td>Department of Health</td>
<td>2008</td>
<td>Recommends a whole systems approach both for commissioning services and for the delivery of integrated care for individuals.</td>
</tr>
<tr>
<td>the end of life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Outcomes Framework 2011/12</td>
<td>Department of Health</td>
<td>2011</td>
<td>Commissioning services for chronic heart failure can help to achieve outcomes under domains 1, 2, 3, and 4.</td>
</tr>
</tbody>
</table>
| Quality, innovation prevention and productivity (QIPP) | Department of Health | 2011 | • The workstream on long term conditions includes a generic model of care developed around the person with long-term conditions through the proactive use of risk profiling data, integrated care teams and supported self-management (see also the LTC commissioning pathway).

• The workstream on end of life care focuses on improving systems and practice for identifying people as they approach the end of life and planning their care. |

| Liberating the NHS: legislative framework and next steps | Department of Health | 2011 | Describes in detail how reforms of the NHS will be put into practice, including the development of NICE quality standards. |

| NHS operating framework for 2011/12 | Department of Health | 2011 | • Sets out the role of PCT clusters in oversee management and implementation of medium term QIPP plans.

• Sets out some of the mechanisms to support reform of the NHS including the NHS Outcomes Framework and extension of quality accounts to cover community services for 2010/11.

• Describes priorities for end-of-life care. |

| Using the Commissioning for Quality and Innovation (CQUIN) payment framework – a summary guide | Department of Health | 2010 | • Makes a proportion of providers' income conditional on quality and innovation. |
End of Life Care Strategy - promoting high quality care for all adults at the end of life

Department of Health 2008

- Describes a comprehensive framework aimed at promoting high quality care across the country for all adults approaching the end of life.

Additional resources

 Commissioners may also find the resources in table 11 useful when commissioning services for people with chronic heart failure.

Table 11 Additional resources

<table>
<thead>
<tr>
<th>Document</th>
<th>Author</th>
<th>Year</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE pathway: Chronic heart failure</td>
<td>NICE</td>
<td>2011</td>
<td>Provides quick and easy access to the range of guidance on chronic heart failure from NICE, including quality standards, technology appraisals, clinical and public health guidance and NICE implementation tools</td>
</tr>
<tr>
<td>Commissioning framework for health and well-being</td>
<td>Department of Health</td>
<td>2007</td>
<td>Annex A outlines the process and data needed to undertake a joint strategic needs assessment.</td>
</tr>
<tr>
<td>Commissioning of cardiac services – a resource pack from the British Cardiovascular Society</td>
<td>British Cardiovascular Society</td>
<td>2011</td>
<td>Provides a summary of existing standards and guidelines that can be used as a basis for commissioning decisions</td>
</tr>
<tr>
<td>Commissioning framework for health and well-being</td>
<td>Department of Health</td>
<td>2007</td>
<td>Annex A outlines the process and data needed to undertake a joint strategic needs assessment.</td>
</tr>
<tr>
<td>Service</td>
<td>Organisation and Date</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>NHS comparators</td>
<td>NHS Information Centre 2011</td>
<td>Analytical service for commissioners and providers. It helps improve the quality of care delivered by benchmarking and comparing activity and costs on a local, regional and national level.</td>
<td></td>
</tr>
<tr>
<td>Predicting and reducing readmission to hospital</td>
<td>The Kings Fund 2009</td>
<td>The tool is a risk prediction system to identify individuals at high risk of hospital readmission.</td>
<td></td>
</tr>
<tr>
<td>PRIMIS+</td>
<td>NHS Information Centre 2011</td>
<td>Provides support to general practices on information management (recording and analysis) of data quality, plus a comparative analysis service focused on key clinical topics.</td>
<td></td>
</tr>
<tr>
<td>Health Inequalities Intervention Toolkit</td>
<td>Association of Public Health Observatories and Department of Health</td>
<td>Designed to assist evidence-based local service planning and commissioning, including Joint Strategic Needs Assessments.</td>
<td></td>
</tr>
<tr>
<td>Indicators for Quality Improvement</td>
<td>NHS Information Centre 2011</td>
<td>A resource of robust indicators to help local clinical teams select indicators for local quality improvement. Assured by clinicians for use by clinicians. Published with full metadata for transparency.</td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
<td>National Audit Office 2008</td>
<td>Report of National Audit Office identifies that there is room for improved coordination between health and social care services in planning and delivering end-of-life care. Include case examples of service development work, including the Care Plus Project in Tower Hamlets to support carers of people with severe heart failure.</td>
<td></td>
</tr>
</tbody>
</table>
### End of life care in heart failure: a framework for implementation

<table>
<thead>
<tr>
<th>National End of Life Care Programme</th>
<th>National End of Life Care Programme and NHS Improvement</th>
<th>2010</th>
<th>Highlights how an end-of-life care service can best accommodate the specific needs of people with heart failure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>National End of Life Care Programme</td>
<td>National End of Life Care Programme</td>
<td>Various</td>
<td>A wide range of publications and resources to support health and social care staff working with people nearing the end of life.</td>
</tr>
<tr>
<td>Common core competences and principles for health and social care workers working with adults at the end of life</td>
<td>National End of Life Care Programme</td>
<td>2009</td>
<td>Supports workforce development, training and education and the development of new and enhanced roles.</td>
</tr>
<tr>
<td>A framework of national occupational standards to support common core competencies and principles for health and social care workers working with adults at the end of life</td>
<td>National End of Life Care Programme</td>
<td>2010</td>
<td>Provides the underpinning framework of core National Occupational Standards (NOS) for the end-of-life care workforce.</td>
</tr>
</tbody>
</table>

General information on quality and corporate assurance can be obtained from the following sources:

- **Indicators for Quality Improvement Programme** from the NHS Information Centre. A resource of robust indicators to help local clinical teams select indicators for local quality improvement and a source of indicators for benchmarking.

- **NHS Alliance online resources**. NHS Alliance is the representational organisation of primary care and primary care trusts, and provides them with an opportunity to network and exchange best practice. The alliance supports its members with an open-access helpline, in-house and joint publications and briefings, internal newsletters and a website.
NHS Institute for Innovation and Improvement support for commissioners, includes The Productive Leader programme to enable leadership teams to reduce waste and variation in personal work processes, and Better care, better value indicators to help inform planning, to inform views on the scale of potential efficiency savings in different aspects of care, and to generate ideas on how to achieve these savings.

The Qualities and Outcomes Framework is a voluntary quality incentive scheme that rewards general practices for implementing systematic improvements in the quality of patient care.

Skills for health works with employers and other stakeholders to ensure that those working in the sector are equipped with the right skills to support the development and delivery of healthcare services.

Sources of further information to help you in assessing local health needs and reducing health inequalities include:

- NHS Evidence provides free access to clinical and non-clinical information - local, regional, national and international. Information includes evidence, guidance and Government policy.

- The National Cardiovascular Disease (CVD) profiles provide a snapshot of key issues relating to heart disease and stroke - these profiles have been designed to help local health services to assess the impact of these elements of cardiovascular disease on their local populations and the services provided to meet those needs.

- Department of Health Delivering quality and value – focus on benchmarking.

- NICE Health equity audit – learning from practice briefing.

- NHS Comparators provides comparator data for NHS commissioning and provider organisations to enable users to investigate aspects of local activity, costs and outcomes.

- The Disease management information toolkit (DMIT) is a good-practice tool for decision-makers, commissioners and deliverers of care for people with long-term conditions, which presents data on conditions that contribute to high numbers of emergency bed days. It models the effects of possible interventions that may be commissioned at a local level and helps users to consider the likely impact of commissioning options.
- Disease prevalence models produced by the Association of Public Health Observatories provides primary care trust-level prevalence estimates for coronary heart disease.

- PARR (Patients at risk of rehospitalisation) is a risk-prediction system for use by primary care trusts to identify patients at high risk of hospital re-admission.

- PRIMIS+ provides support to general practices on information management, recording for, and analysis of, data quality, plus a comparative analysis service focused on key clinical topics.

- SHAPE (Strategic health asset planning and evaluation) application provides support to strategic health authorities and primary care trusts on strategic planning across a whole health economy.
8 Topic Advisory Group: services for people with chronic heart failure

A topic-specific advisory group was established to review and advise on the content of the guide for commissioners. This group met once, with additional interaction taking place via email.

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