Heart failure policy and practice in Europe

England

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The Heart Failure Policy Network

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About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary network of healthcare professionals, advocacy groups, policymakers and other stakeholders from across Europe. It was established in 2015 with the goal of raising awareness of unmet needs and seeking meaningful improvements in heart failure policy and care. Our aim is to help reduce the burden of heart failure – on people living with it, those supporting them, health systems and society at large.

All members of the HFPN provide their time for free. All Network content is non-promotional and non-commercial. The Secretariat is provided by The Health Policy Partnership Ltd, an independent health policy consultancy based in London, UK.

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About Heart failure policy and practice in Europe

Heart failure (HF) is a common and complex condition responsible for extensive avoidable morbidity, mortality and healthcare costs. There is a clear need to advance HF policy and practice across Europe, and this requires recognition of the real challenge in each country.

To this end, the Heart Failure Policy Network (HFPN) has developed *Heart failure policy and practice in Europe* – a comprehensive analysis of key gaps and best practice both in HF policy and in clinical performance across 11 European countries. In this work, we investigate each country's progress in addressing the HF challenge, for example in terms of the existence and implementation of HF policies and the provision of multidisciplinary and integrated HF care. Findings are presented in an overarching report, which outlines the methodology for this work and includes a pan-European narrative, and in standalone country profiles with dedicated national-level analysis.

Urgent action is needed to address the growing burden of HF and ensure the sustainability of our healthcare systems. This country profile aims to assist HF advocates across England in engaging healthcare system leaders to demand constructive changes to HF policy and care provision, to reduce the impact of HF on people living with the syndrome, their families and carers, the healthcare system and society.

Heart failure
in England

SUMMARY

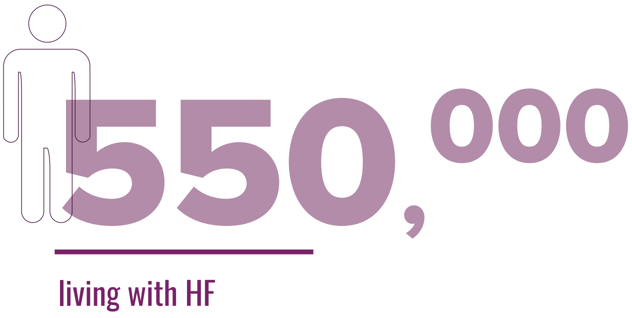
The burden of heart failure (HF) in England is high, both in terms of pressures on the healthcare system and impact on people with HF and their families.[1,2] Hospitalisations for HF were reported to have reached record levels in 2019, growing three times as fast as all other hospital admissions since 2013.[3] While data are still emerging, it is clear that the COVID-19 pandemic has seriously disrupted access to HF care and many HF teams now face the complex process of adapting their services to restore capacity.[4]

HF was highlighted in a centralised plan for the National Health Service (NHS) published in 2019,[5] and it remains essential that it also be prioritised by local decision-makers.[6] HF specialism is formally recognised for cardiologists and nurses, but many experience an unrealistic workload due to nationwide issues with staffing.[7,8]

While local initiatives lead the way in terms of multidisciplinary and integrated care,[9,10] HF care in England is typically fragmented. Improvements are urgently needed in diagnosis,[11,12] hospital care and discharge,[13] use of guideline-recommended medications,[13] cardiac rehabilitation[14] and information technology (IT) infrastructure[15] to ensure equitable access to high-quality HF care and better outcomes for people living with the syndrome.

HF is a common syndrome

The prevalence of HF in England was estimated at 1% of the population in 2018, with more than 550,000 people reported to be living with the syndrome.[16] While data on incidence in England are not available, in the UK – where approximately 920,000 people are estimated to be living with HF – there are about 200,000 new diagnoses every year.[17] As in other European countries, the burden of HF is increasing due to population ageing and reduced mortality rates for cardiovascular diseases overall.[3]



Patient outcomes and quality of life are often poor, while the burden on families and carers is significant

HF is the leading cause of hospitalisation in people aged 65 and over in the UK.[18] This is also true of England: from April 2018 to March 2019, hospitals reported more than 75,000 emergency admissions for HF, primarily in people over the age of 65.[1] The mean length of hospital stay was reported to be 10 days. For comparison, type 2 diabetes and lung cancer were responsible for 22,000 and 14,000 reported emergency admissions respectively, with a mean hospital stay of eight days for either condition.[1] According to the British Heart Foundation, hospitalisations for HF have reached record levels in England – admissions increased by 33% from 2013/14 to 2018/19, a rate of growth three times that for other causes.[3]

75,000

Hospital admissions per year

In a recent survey by the Pumping Marvellous Foundation, 50% of people living with HF reported that the condition was detrimental to their emotional wellbeing and mental health, and 30% reported that it negatively impacted their relationships with family and friends.[19]

Mortality rates for HF are high. Based on data from April 2017 to March 2018, in-hospital mortality for HF in England and Wales was estimated at 10%.[13] In England, mortality in the six and twelve months following hospital admission was estimated at 19% and 24% respectively, based on data from April 2018 to March 2019.[20]

The COVID-19 pandemic has seriously disrupted access to HF care and many HF teams now face the complex process of adapting their services to restore capacity.[4] According to national hospital data from England, admissions for HF were 66% lower than expected in April 2020, with preliminary data suggesting an even larger drop in May 2020.[21] In addition, 29% of people living with HF reported experiencing worsening symptoms during the pandemic, according to a survey conducted in June and July 2020.[22] This is a concerning trend, as outcomes may worsen when HF is not treated in a timely and appropriate manner.[12]

HF is associated with high healthcare expenditure and wider societal costs

In 2016, it was reported that the economic cost of HF in the UK was £2 billion, consuming 2% of national health expenditure.[23] A single hospital admission for HF was estimated to cost £3,690, based on data from April 2018 to March 2019.[24]

2%

of annual health expenditure

The economic impact of HF extends beyond healthcare costs, as the syndrome has a strong societal impact. In a recent survey, 44% of people reported that HF limited their ability to work and approximately one in three people reported that the syndrome hindered their career progression.[19] National experts emphasise that the proper management of HF may therefore help to support return to work, reducing reliance on financial support.[25]

Heart failure policy
in England

Formal plans on HF

HF is included in a national strategic healthcare plan

The *NHS Long Term Plan* was published in 2019 by NHS England,[5] the central authority appointed by the Government to guide long-term decision-making in healthcare. The plan includes a section on the diagnosis and management of HF.[26] It outlines commitments to support timely diagnosis of HF in primary care settings, mainly by screening patient records for people at high risk of developing HF and improving access to echocardiography.[5]

Recommendations to improve management of HF include expanding multidisciplinary HF teams in primary care, and increasing access to cardiac rehabilitation and HF specialist nurses in hospital settings.[5] At the level of healthcare organisation, the implementation of the *NHS Long Term Plan* falls to local NHS commissioners and policymakers, who submitted formal plans to NHS England in November 2019.[6] However, experts report that these local plans often do not consider HF explicitly.[27,28]

Investment in integrated HF models and facilitative tools

HF diagnostic tests are consistently reimbursed

National guidelines recommend natriuretic peptide (NP) testing, specifically for a peptide called NT-proBNP, and echocardiography to diagnose HF.[29] NP testing is commonly reimbursed and accessible in primary care and hospital settings.[12,15] This typically arises as part of a block contract for pathology services (diagnostic testing performed in laboratories). Echocardiography is usually reimbursed in hospital settings and is increasingly being funded for use in primary care.[30]

Inadequate IT infrastructure hinders integration of care

The NHS has committed to further improving information technology (IT) systems to support multidisciplinary care,[5 31] but national investment specifically for HF care is limited. From 2018, all NHS referrals made from primary care to specialist-led outpatient services, including those for HF, must be processed through an electronic referral service.[32] While this system has streamlined the referral process, national HF experts have called for further, comprehensive IT solutions as the necessary next step to support information sharing and collaboration across care settings.[15 33]

The value of telemedicine in HF management has been increasingly recognised

A national telemedicine programme in HF has yet to be developed, but local investment in telemedicine has delivered promising results (see *Case study 1*). Experts note that telemedicine approaches should be used to supplement guideline-based HF care tailored to patient needs and preferences[25] and should include remote monitoring equipment for vital signs such as blood pressure and heart rate.[8] Others have highlighted that remote technologies may support the HF care team in managing the growing demand for their services.[28 33]

The COVID-19 pandemic is likely to have accelerated the acceptance and adoption of technology among people living with HF and healthcare professionals,[4 27] but the long-term safety and effectiveness of these solutions will need to be systematically evaluated.[34]

CASE STUDY 1.

Telemedicine to support self-care in heart failure

The Liverpool Clinical Commissioning Group has invested in a nurse-led telemedicine service to support people living with HF, chronic obstructive pulmonary disease and/or type 2 diabetes.[35 36] People can access the service through a referral from their general practitioner (GP).

The service combines remote monitoring with therapeutic education and health coaching.[35] People enrolled in the programme receive a tablet and self-monitoring equipment, including a scale, blood pressure device and blood oxygen monitor, which are wirelessly connected via Bluetooth.[35] The tools are supplemented with a personalised schedule of educational videos and online questionnaires about physical and mental health.

Collected data are securely transferred to a clinical hub monitored by a nursing team, who have access to the primary care records of all people enrolled in the service.[35] Nurses receive an automated alert when there are any significant changes in a person's signs and symptoms, and can contact patients directly to provide support.

Between 2013 and 2017, the telemedicine service reduced emergency hospital admissions compared with standard practice for people living with HF.[35]

Development of the HF healthcare workforce

HF specialist roles are formally recognised, but there is a need for further investment in the HF workforce

The role of HF cardiologists and specialist nurses is formally accredited. Cardiologists can complete a sub-specialty in HF, which includes training in heart transplantation and cardiac devices.[37] HF nurses are typically nursing specialists (nurses who have pursued further clinical training in HF) or, less frequently, advanced nurse practitioners (nurses who usually have a master's degree and several years of clinical experience).[15 38]

While HF cardiologists and specialist nurses are recognised as essential members of the HF care team, many experience an unrealistic workload due to nationwide issues with staffing. National experts report that hospitals in some regions of England struggle to recruit cardiologists, with recruitment of HF specialists posing an even greater challenge.[8] HF cardiologists working in these settings may be under intense pressure due to the growing demand for specialist-led care.

In 2017, one in three HF nurses in the UK was reported to manage between 250 and 500 people living with HF, with 26 to 50 new referrals each month.[7] According to national experts, the shortage of HF specialist nurses can be partly attributed to limited public investment in nursing education and the fact that nurses typically specialise late in their careers.[15] The British Society for Heart Failure Nurse Forum recommends employing two to four full-time HF nurses per 100,000 people.[39]

National professional societies have also called for expanded roles for pharmacists, physiotherapists and cardiac physiologists in HF care[39] as well as programmes to grow the cardiac physiology workforce to support timely access to echocardiography.[40]

Guidance and local care pathways for delivery of quality care

National guidelines are supported by local care pathways for the diagnosis and management of HF

The National Institute for Health and Care Excellence (NICE) develops clinical guidelines for England and Wales.[18 29] The HF guidelines outline recommendations for the diagnosis, management and research of acute and chronic HF based on available evidence and national cost considerations. NICE guidelines are accompanied by resource impact reports, which estimate the financial benefit associated with their implementation.[41] In the case of chronic HF, the impact report estimates that NHS England would save up to £7.7 million if uptake of cardiac rehabilitation for HF increased from 5% to 33% by 2024.

Many local care pathways support the implementation of clinical guidelines, but these initiatives are not consistently available across England as each NHS locality has its own commissioning priorities and arrangements.[15] For example, several NHS trusts have developed rapid access pathways to support diagnosis and management of HF (see *Case study 2*), but this is not standard practice.

CASE STUDY 2.

Rapid access pathways for HF in the Midlands

The West Leicestershire Clinical Commissioning Group launched a Rapid Access Heart Failure Service in 2014 to reduce hospitalisations for HF.[9] The service has since been adopted by the Clinical Commissioning Groups for Leicester City and East Leicestershire and Rutland.

The Rapid Access Heart Failure Service supports timely referral from primary care to an HF outpatient clinic – GPs can refer people with suspected HF or signs of HF deterioration for a review with a cardiologist within 72 hours. Based on this review, people are monitored and treated as outpatients and, if needed, admitted to hospital for additional care.[9] People living with HF can also be referred to an Ambulatory Heart Failure Clinic for further monitoring and support following hospital discharge.[42]

A review of the Rapid Access Heart Failure Service found that it substantially reduced hospitalisations and mortality.[43] Similarly, the Ambulatory Heart Failure Clinic was shown to reduce the rate of readmissions in the 30 days following hospital discharge.[43]

Public audits of performance and high-level assessment initiatives

The national HF audit ensures oversight of performance and care quality in acute settings

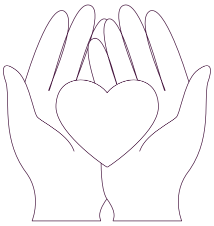
The National Heart Failure Audit is one of Europe's leading central audits into HF. It monitors performance in hospital settings and provides feedback directly to healthcare providers. It collects data on unplanned hospital admissions for HF in England and Wales.[44] The audit was established in 2007 and participation became mandatory for secondary care providers in England in 2011. It evaluates performance based on a standardised list of quality indicators, including measures for diagnostic testing, specialist-led admission and care, prescription of guideline-recommended treatments, discharge planning and outcomes.[13] Findings are published annually in an overarching report, with hospital-level data also made available.[13 45]

The audit does not include primary care data and therefore does not consider the impact of healthcare professionals working in community settings, such as community HF nurses.[15] Furthermore, experts state that it does not consider additional health conditions (comorbidities) such as dementia and frailty, which may affect referral rates for cardiac rehabilitation.[8]

National pay-for-performance schemes incentivise optimal HF care in hospital and community settings

Hospitals receive incentive payments from the Best Practice Tariff scheme, a pay-for-performance initiative aimed at acute care, when they meet two criteria: they must submit at least 70% of their relevant data to the National Heart Failure Audit, and at least 60% of patients recorded in the audit must receive specialist care.[46]

In primary care, the Quality Outcomes Framework (QOF), a pay-for-performance scheme for primary care settings, seeks to monitor and incentivise HF care in the community in England, Wales and Northern Ireland.[47] While participation in the scheme is voluntary, it is widely taken up. It includes standardised quality indicators for HF that cover data collection, diagnostic testing and guideline adherence.[47] The scheme was recently updated to include criteria for specialist-led diagnosis, guideline-recommended medications and an annual review with a primary care clinician.[48] When they meet performance criteria, primary care providers are awarded points which are converted into funding at the end of each financial year.[47]



Heart failure practice in England

Diagnosis

Diagnosis of HF is often delayed due to limited awareness of HF, suboptimal use of diagnostic tests and waiting times for specialist appointments

Limited public awareness of HF often leads people to dismiss their symptoms and not seek medical attention, while limited professional awareness contributes to misdiagnosis. In a recent UK survey, 25% of people living with HF reported that they waited more than four weeks to consult their GP.[49] One in three people reported being initially misdiagnosed, often with asthma, anxiety, depression or acid reflux. There are considerable gender differences in the diagnostic process for HF, as women are much more likely than men to delay seeking medical attention and to receive an incorrect diagnosis.[12] Almost 80% of HF cases are diagnosed in hospital,[50] despite one in every three people having first reported their HF symptoms in primary care.[51] This strongly suggests that far more must be done to identity early cases of HF in the community.

Suboptimal use of NP testing in primary care hinders timely diagnosis of chronic HF, despite supportive reimbursement policies. According to national experts, limited awareness of the benefits of NP testing and its role in established referral processes hinders its use in practice.[33] Primary care data from 2010 to 2013 suggest that only 15% of people presenting to their GP with symptoms of HF underwent NP testing,[51] and in a recent patient survey only 29% of people reported undergoing NP testing with their GP.[12] These findings highlight a missed opportunity to prioritise referrals for specialist-led diagnosis and reduce the burden on echocardiography services.

In the UK, diagnosis of HF has been reported to take approximately three months, with considerable variation between regions.[12] Experts in England report that in regions with few HF cardiologists, often less well-resourced areas away from the capital, waiting times for specialist appointments often exceed the limits stated in HF guidelines.[8] This can have a considerable impact on emotional wellbeing, as people living with HF have reported that they felt angry, anxious and embarrassed while awaiting diagnosis.[19]

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) identified substantial gaps in the diagnosis of acute HF, including incorrect or inconsistent use of NP testing during hospital admission and limited out-of-hours provision of echocardiography in hospitals.[11 52] It found that among people who died following diagnosis of HF in acute care, only 44% had undergone echocardiography and 18% had had their NP levels tested.[52] Use of echocardiography may be limited by the size and structure of echocardiography units, availability of trained staff and local inclusion criteria for this test.[30 40 53]

Hospital care and discharge

Specialist-led care is not regular practice in the management of acute HF

HF specialists often see people during admission for acute HF, but once a person is on the ward, further specialist-led care is often lacking. According to National Heart Failure Audit data from April 2017 to March 2018, most people hospitalised with acute HF in England saw an HF specialist during admission,[45] often a cardiologist and/or HF specialist nurse,[13] but only 40% to 50% of people were admitted to cardiology departments.[13 45] Given the clear evidence of specialist-led hospital care in improving long-term HF outcomes, this highlights an urgent need to improve this aspect of care.[52]

Discharge planning and follow-up remain fragmented

Post-discharge care for HF is inconsistent. Many people are discharged after an episode of acute HF without a scheduled follow-up appointment – this was the reality for 63% of people hospitalised with HF in England and Wales from April 2017 to March 2018.[13] In addition, only half of people seen by an HF specialist were prescribed all guideline-recommended medications before discharge. In people who are not seen by a specialist, this proportion dropped to 23%.[13] HF advocates report that many people leave the hospital feeling unprepared to manage HF and uncertain about where to find support.[25]

Discharge letters or summaries are an essential tool to transfer important patient information from hospital to community settings.[54] Experts report that general practice teams are increasingly involving pharmacists in addition to GPs and nurses, and discharge letters should reflect this multidisciplinary approach in community settings.[27]

Key components of quality care in community settings

Access to specialist support is inconsistent in community settings

Once HF is stabilised post-discharge, people typically transition from outpatient services led by the hospital care team to ongoing care from their GP.[29] This is an important step in the everyday management of the syndrome, particularly in regions with long waiting times for specialist-led hospital services.[8] However, national experts report that this period is difficult to navigate for people living in areas without an HF nurse or a GP with special interest in HF.[25]

Cardiac rehabilitation is not consistently provided for people with HF

Securing effective cardiac rehabilitation for HF is a challenge for many patients and healthcare professionals. Data from the most recent National Heart Failure Audit suggest that only about one in five people hospitalised with HF in England were referred to cardiac rehabilitation.[45] Major barriers include limited reimbursement and resources, such as trained staff and equipment.[55] The number of people with HF accessing cardiac rehabilitation has increased substantially since 2014, but they still made up less than 1% of cardiac rehabilitation participants in England from 2017 to 2018.[14] In addition, national experts highlight that standard cardiac rehabilitation programmes may be too short to have a long-term impact on a person's lifestyle and self-care behaviour.[25]

New home-based models have been developed to overcome some of these issues (see *Case study 3*) and their uptake has been recommended by national advocates to support the provision of cardiac rehabilitation throughout the COVID-19 pandemic.[4] In addition, the Pumping Marvellous Foundation streams weekly exercise sessions led by qualified professionals on its social media platforms.[25]

CASE STUDY 3.

Home-based cardiac rehabilitation for HF

The Rehabilitation Enablement in Chronic Heart Failure (REACH-HF) intervention is a home-based cardiac rehabilitation programme that was developed with input from healthcare professionals, people living with HF and carers.[56] It includes:

- a manual with chair-based and walking exercises to be performed at least three times per week
- an interactive booklet to help people living with HF track their progress based on symptoms, physical activity and self-care behaviour
- a manual for carers to support their own wellbeing and improve understanding of HF
- telephone and in-person support from trained cardiac nurses and physiotherapists.[57]

Compared with standard HF care, the REACH-HF programme improved quality of life and self-care behaviour.[57] As it was also shown to be cost-effective,[57 58] in May 2019 it was rolled out across four NHS sites in England and Northern Ireland.[59] The effectiveness of the programme has led to expert calls for rapid adoption across the UK.[60] The programme was also identified as a potential method to adapt cardiac rehabilitation services during the COVID-19 pandemic.[4]

Limited provision of palliative care contributes to the burden on people living with HF, their families and carers

Most hospitals and some community hospices have palliative care programmes for HF,[52 61] but limited uptake of these services is a persistent issue. In 2016, the NCEPOD reported that only 12% of people who died during hospitalisation for acute HF had previously accessed palliative care services.[52] It concluded that up to 14% of those final hospital admissions could potentially have been avoided if advance care planning and palliative care were accessed more widely. Healthcare professionals may find it difficult to recognise when HF treatment goals should be adapted, and limited communication between the care team, people living with HF and their families or carers can hinder advance care planning.[11 52]

Tools and methods to support multidisciplinary and integrated ongoing HF care

Centres of excellence offer various tools and models to encourage multidisciplinary HF care, which are largely unavailable in other settings

Overall, the implementation of tools and working methods that can promote multidisciplinary and integrated HF care has been inconsistent. Experts report that a national approach to ensure widespread use of integrated care pathways is lacking, and that their development is largely dependent on local healthcare professionals with an interest in HF.[15] Community HF services led by specialist nurses have been instrumental in many local best practice examples of multidisciplinary and integrated HF care (see *Case study 4*).

Innovative collaborations between healthcare professionals and industry partners are exploring solutions to link IT systems across care settings. For example, key clinical stakeholders in the South Lincolnshire Clinical Commissioning Group have focused on transforming the HF care pathway, which has included the development of a multidisciplinary IT platform that enables GPs, nurses and hospital specialists to hold virtual meetings, develop a joint care plan and assign clinical responsibilities in the management of HF.[27 62] The platform also includes a patient portal where people can outline their care goals and communicate with their HF team.

CASE STUDY 4.

Nurse-led support in community settings for people with HF in London

The Community Heart Failure Service in Barts Health NHS Trust in London is a nurse-led programme that takes referrals from a wide range of healthcare professionals, including hospital physicians, GPs, primary care nurses and community nursing specialists.[10] The programme is open to local residents with a confirmed HF diagnosis and established care plan.

Under this service, HF specialist nurses conduct home visits, community HF clinics and/or telephone consultations based on the needs and preferences of the person living with HF.[10] They provide therapeutic education to support self-care and, in some cases, can prescribe and adjust HF medication. They also facilitate access to other key components of HF care through close working links with hospital-based HF care teams, cardiac rehabilitation specialists, physical and occupational therapists, mental health professionals, social workers, pharmacists and palliative care specialists.[10]

The way forward

HF poses a challenge to the sustainability of healthcare systems in countries across Europe, including England. It is a manageable – and often preventable – syndrome, yet it continues to affect a great number of people and its burden on the national health system and society is significant.

The inclusion of HF in the *NHS Long Term Plan* presents a unique window of opportunity to ensure the syndrome is prioritised in local healthcare policy and provision. It is vital that local decision-makers move swiftly to address gaps in care to realise the vision outlined in the national plan.

SEVERAL ACTIONS ARE ESSENTIAL TO ADDRESS THIS CHALLENGE.

Increase awareness of HF among the public, healthcare professionals and decision-makers

Understanding of HF must be improved at all levels to address the growing burden it presents. Awareness campaigns aimed at the public may encourage people to see a healthcare professional as soon as they start experiencing signs and symptoms. Training opportunities in HF led by Health Education England and national professional societies could support the correct identification of symptoms and optimal management in line with the latest guidelines. It is essential that local decision-makers prioritise HF in the implementation of the *NHS Long Term Plan* and that funding is allocated to support these efforts.

Improve HF diagnosis through increased use of NP testing in primary care

Improving diagnosis of HF is a crucial step in a coherent response to the HF challenge. For this to happen, it is essential for GPs to consistently use NP testing to prioritise patients for referral to specialist-led echocardiography. This will likely reduce waiting lists for specialist examinations and appointments, thereby ensuring efficient use of healthcare resources and timely access to effective treatment. NP testing should be incorporated into local clinical pathways for HF to encourage uptake – for example, by making it a prerequisite for referrals to specialist services.

Invest in IT systems to support communication across care settings

There is an urgent need for IT infrastructure that facilitates integrated approaches across care settings. An advanced IT system will enable healthcare professionals to have access to the same information, promoting fully informed decision-making. Investment in connected digital systems is likely to help address gaps in HF care, including delayed referral to specialist-led diagnosis, fragmented post-discharge care and inconsistent implementation of joint care protocols.

Expand the HF workforce and invest in remote technologies to support healthcare professionals in managing growing demand

Accreditation of HF specialism is relatively advanced in England, which is a promising foundation for investment in the HF workforce. However, policymakers will only realise the long-term benefits for people living with HF and the healthcare system if they provide consistent funding and support for the education and training of HF specialist nurses. Employers should encourage further training to increase the number of HF nurses in senior roles, such as advanced nurse practitioner and nurse consultant, ensuring an optimal skill mix in HF care teams. As the development of this workforce may take several years, policymakers must also explore other solutions to help the existing workforce manage growing demand. This may include expanded roles for assistant nurse practitioners, pharmacists, physiotherapists and cardiac physiologists in supporting people living with HF, and investment in remote technologies to facilitate effective multidisciplinary working.

Roll out successful programmes shown to reduce hospitalisation and improve patient outcomes

Local and national decision-makers should examine the case for roll-out of successful initiatives, such as the Rapid Access Heart Failure Service in Leicester, the telemedicine service in Liverpool or the REACH-HF intervention. They should invite greater interest and competition from best-practice centres for existing funding by outlining transparent criteria for investment, for example based on improvement in patient and health system outcomes. Healthcare professionals involved in best-practice initiatives could be engaged in delivering peer-learning and training opportunities to facilitate implementation across England.

Focusing on these priority areas will likely offer a cost-effective opportunity to improve life for people with HF, reduce hospitalisations and mitigate future pressures.

This is an investment in a more resilient and prepared health system, not just for HF but for chronic diseases more generally.

The creation and maintenance of national strategies and plans in HF is likely to be vital to long-term success. There are many strengths and existing resources within the healthcare system on which to build. Lasting success will require effective central oversight of inequalities and unacceptable variations, as well as long-term collaboration and commitment from decision-makers, patient representatives, healthcare professionals and the private sector. Failure to pursue the actions recommended in this report will allow HF to continue to challenge the sustainability of the healthcare system in England.

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The Heart Failure Policy Network

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