Oxford Health NHS
NHS Foundation Trust

Referral to Oxfordshire Community Heart Failure Nursing Team

Referral criteria

- Patients with Heart Failure with reduced Ejection Fraction (HFrEF) confirmed by echocardiogram or other cardiac image modality; EF < 45%
- Must be registered at a GP practice encompassed by the Oxfordshire Clinical Commissioning Groups. (Brackley and Byfield practices included also).

Please refer patients who would benefit from assessment and support by the community heart failure nursing team.

Patient education – self-monitoring - dietary measures - monitoring fluid intake - smoking cessation – symptoms and signs of worsening heart failure – when to call for help - clinical assessment - psychological and social support - helping to implement drug treatments with appropriate monitoring to ensure full titration of evidence-based medications – prevention of hospital admission where possible - planning for the future and providing end of life care - close liaison with referring team and GP.

Please phone and discuss a referral first if you are uncertain whether the referral is appropriate. All referrals will be triaged and assessed on an individual basis.

Referral Process

There is not a referral form – referrals are accepted by email/phone if they meet the above criteria. Please provide the following when referring a patient:

- Reason for referral
- Echo report if available
- Recent relevant clinic letters
- Up to date list of medications
- Patient summary (GP referrals)

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Oxfordshire Community Heart Failure Nurse Service

Referral criteria for Community Heart Failure Nurse Service (CHFNS)

- **Pts with confirmed Heart Failure with reduced Ejection Fraction (HFrEF) – EF < 45%**
- **Registered at a GP practice encompassed by the Oxfordshire Clinical Commissioning Group. (Brackley and Byfield practices included also)**

Referral received from OUH, GP, outpatient clinic, or other HCP

Reasons for referral

- Clinical assessment
- Education and lifestyle advice
- Optimisation of medication
- Self-monitoring
- Symptom control
- Palliative management
- Psychological support

Initial patient contact

- Phone patient within 24 hours of referral being received.
- Explain the service, who has referred them and why.
- Assess the time frame of when they need to be seen.
- Assess whether they are suitable for a home visit or a clinic appointment.
- *See Triage Process for further info*

Home visit

Arrange home visit for within 10 working days of referral

Clinic appointment

Offer next available slot at clinic location of the patient's choice: Abingdon, Banbury, Bicester, Chipping Norton, Didcot, Henley, Kidlington, Oxford, Wallingford, Wantage or Witney

1st appointment

- Assess extent of patient's knowledge
- Explanation of term 'heart failure'
- Educate to recognise signs of early deterioration and when to seek help
- Medication regime and concordance
- Tailored lifestyle advice
- Encourage greater level of self-care
- Clinical assessment
- Psychological support to patient/carer
- Concerns and/or questions
- Written information and contact details given *(see patient information booklet for more info)*

Management plan options

- Optimisation of medical therapy as required and tolerated *(See clinical decision-making guide for further info)*
- Advice regarding appropriate blood chemistry monitoring
- Symptom management
- Consider referral to other services, i.e. palliative care, DN, SPA, H@H, ambulatory care, PN, volunteer services, charities
- Discuss at supervision

Medical liaison

Liaise with GP and/or cardiologist using preferred method of communication to discuss management plan and implement changes.

Follow up

- Follow up by telephone, home visit, email or clinic appointment
- Time frame of follow up will depend on status of patient
- Maintain close communication with patient's GP
- Advice from cardiologist where appropriate

Discharge from service

- Optimised on maximum tolerated doses of evidence-based HF medications as appropriate, euvolaemic and symptoms stable
- *See Guidance for discharging from the Heart Failure Specialist Nursing Service*

Discharge communication

- Letter to GP outlining continued management plan.
- GP to review patient every 6 months as per NICE guidelines

Re-referral

GP or patient can refer back into the service at any time