

Reference: FOI.ICB-2526/429

Subject: Adult Cardiometabolic Services

I can confirm that the ICB does hold some of the information requested; please see responses below:

QUESTION	RESPONSE
<p>1. Please provide a list of all providers the ICB holds contracts with for cardiometabolic services (covering any form of cardiometabolic, cardiology or cardiovascular services)</p> <ul style="list-style-type: none"> • Please include both statutory NHS and Independent Sector providers • Please include any broader services that include a cardiometabolic element (for example a broader cardiovascular service, or a community service that covers cardiology care.) 	<p>North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) are commissioned to provide acute cardiology services.</p> <p>Sirona care & health CIC is contracted to provide community heart failure services.</p>
<p>2. For each contracted provider listed in the answer to #1, please provide the following schedules as included in the contract the ICB holds:</p> <ul style="list-style-type: none"> • Schedule 2A or equivalent: Service Specification that describes the service (whether standalone or integrated in a broader Service Specification) • Schedule 3A, 3B or 3C or equivalents: Describing national currencies and any local prices that apply to the services 	<p>NBT and UHBW:</p> <ul style="list-style-type: none"> • All service details are published online here - https://remedy.bnssg.icb.nhs.uk/adults/cardiology/ • These are block contract arrangements for a range of cardiac services and as such it is not possible to provide spending on individual services. <p>Sirona care & health CIC:</p> <ul style="list-style-type: none"> • Schedule 2A – extract relating to Heart Failure enclosed

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| | <ul style="list-style-type: none">• This is a block contract arrangement for a range of adult community services and as such it is not possible to provide spending on individual services. |
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The information provided in this response is accurate as of 9 March 2026 and has been approved for release by Caroline Dawe, Deputy Director of Performance and Delivery, Acute and Integrated Care, MHLDA and EPRR for NHS Bristol, North Somerset and South Gloucestershire ICB.

BNSSG Adult Community Services Sirona Care & Health Contract Extract

3.3.2.2 Specialist heart failure care

The heart failure service supports people with chronic heart failure utilising the skills and expertise of specialist staff including specialist heart failure nurses properly integrated with consultant led cardiovascular services in secondary care. Collaboration with the secondary care team will extend to clinical supervision and governance, access to specialist medical opinion and the rotation of acute and community facing roles to build a well-rounded, highly skilled specialist workforce.

3.3.2.2.1 The heart failure service will provide input, assessment and treatment as part of a wider, holistic care plan delivered in collaboration with a patient's GP, and in conjunction with the relevant Integrated Network Team delivering core community services

3.3.2.2.2 The heart failure service is accessible to patients with all types of heart failure. The service should also accept clinically appropriate referrals where heart failure is suspected but a formal diagnosis has not yet been made.

3.3.2.2.3 The functions delivered by the heart failure service are described below:

3.3.2.2.3.1 *Provision of clinical advice and support*

One of the primary functions of the heart failure service is to provide specialist clinical advice and support to health and care professionals in both primary care and the wider out of hospital setting. This advice can take the form of telephone or email contact with other professionals in line with the response times set out paragraph 3.4.3.3 of this specification. Requests for advice will be easily accessible through a single email address and telephone number. Advising professionals will have access to the patient's care plan held by the GP and/or relevant Integrated Network Team, ideally through direct interoperability of clinical system.

3.3.2.2.3.1.1 Advice and recommended interventions should be captured as part of the care plan and communicated across both the GP and Integrated Network Team.

3.3.2.2.3.1.2 It is anticipated that the majority of requests for advice will originate from primary care and core community service professionals, however advice may also be requested from other care settings e.g. care homes, hospices, mental health teams. All requests should be prioritised and addressed in accordance with clinical need, however where an individual is potentially unknown to the Integrated Network Team the heart failure service should coordinate responses with the Integrated Network Team to ensure that specialist resources are only deployed in cases of the appropriate complexity.

3.3.2.2.3.1.3 The heart failure service should be properly integrated with the consultant-led specialist cardiovascular teams in secondary care and should therefore have rapid access to the advice and opinion of consultant medical staff whenever this is clinically required.

3.3.2.2.3.2 *Education, training and workforce development*

The heart failure service has an explicit and fundamental leadership role in developing the skills, confidence and capabilities of the wider health and care workforce with regards to the management of chronic heart failure.

3.3.2.2.3.2.1 The Provider, in partnership with the commissioner, is expected to proactively evaluate available outcomes and performance data from across the system and conduct training needs analyses to identify opportunities within the local workforce to improve staff capabilities, ultimately resulting in improved patient outcomes and a reduced variability in the quality of care.

- 3.3.2.2.3.2.2** This proactive evaluation of outcomes and training needs analyses should apply to primary care, core community services including the Integrated Network Teams, care homes, hospices, social care professionals and any other service where there is a clear opportunity to improve patient outcomes through training and staff development. Scoping of training opportunities should consider available outcomes data, including the Quality and Outcomes Framework (QOF) in primary care, as well as available acute admissions data relating to secondary care.
- 3.3.2.2.3.2.3** The heart failure service will develop a structured annual training programme for primary care staff (both GPs and practice nurses) and for core community service staff, in particular members of the Integrated Network Teams. This focused, proactive workforce development is integral to delivering a higher standard of generalist care across the out of hospital environment. Training should be provided over a wide range of channels and methodologies to optimise access and this may include:
- Formal group training
 - 'On the job' training including joint working and shadowing
 - Mentoring and individual support
 - Written information packs and guidance
 - Online training including webinars and video conferences
- 3.3.2.2.3.2.4** The heart failure service will use a range of approaches to maximise engagement with training and this may include delivery of education across clusters of organisations and professionals or the focussed training of specific staff/organisations within their regular clinical setting. Delivery of training to a specific organisation on-site at their place of practice may be particularly appropriate for sectors that find it difficult to release staff for training, particularly care homes and primary care. Training delivered in this way should be targeted to achieve the most significant improvement in outcomes.
- 3.3.2.2.3.2.5** All training and education will be evaluated and the service should be able to clearly demonstrate the additional skills developed across the workforce, the resulting outcomes and the level of engagement from different organisations and professionals across the area.
- 3.3.2.2.3.3** *Provision of direct assessment, treatment and intervention*
In the most complex of cases, that cannot be managed entirely within core generalist services and the Integrated Network Team, the heart failure service will be expected to provide direct specialist assessment, a treatment plan that forms part of the individual's overall care plan and the direct delivery of appropriate clinical interventions.
- 3.3.2.2.3.3.1** This period of specialist assessment and management should be coordinated with the relevant GP and Integrated Network Team and involve a short term period of intensive specialist support whilst titrating optimum therapy, linked to specific treatment goals and outcomes. Upon completion of this period of specialist support, or upon the achievement of defined treatment goals documented within the care plan, the individual will be discharged back to the care of the Integrated Network Team and the GP. Even during the period of specialist management, follow-up activity and monitoring will be coordinated across the Integrated Network Team and primary care to ensure the most efficient use of limited specialist resources is achieved.
- 3.3.2.2.3.3.2** Specialist assessment and intervention can be delivered within a person's usual place of residence, if housebound, or within community clinics operating within Bristol, North Somerset and South Gloucestershire's six localities. The Provider will ensure equitable face to face access to this service for residents in care homes. The heart failure service will be able to deliver a wide range of interventions as part of specialist treatment plans and contingency plans, including (but not limited to):
- Complex patients will be discharged from the heart failure service caseload once treatment goals have been achieved, titration of optimum treatment is reached, the condition is stabilised or the patient enters a palliative care phase.

- Patients with stable heart failure, under an optimised treatment regimen will be managed in primary care with the support of the Integrated Network Team and not retained on the specialist service caseload for longer than is clinically necessary