1.1.3 The specialist heart failure MDT should directly involve, or refer people to, other services, including rehabilitation, services for older people and palliative care services, as needed. [2018]

1.1.4 The primary care team should carry out the following for people with heart failure at all times, including periods when the person is also receiving specialist heart failure care from the MDT:

- ensure effective communication links between different care settings and clinical services involved in the person's care
- lead a full review of the person's heart failure care, which may form part of a long-term conditions review
- recall the person at least every 6 months and update the clinical record
- ensure that changes to the clinical record are understood and agreed by the person with heart failure and shared with the specialist heart failure MDT
- arrange access to specialist heart failure services if needed. [2018]

Care after an acute event

For recommendations on the diagnosis and management of acute heart failure see NICE's guideline on acute heart failure.

1.1.5 People 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 the wishes of the person and their family or carer, and the level of care and support that can be provided in the community. [2003]

1.1.6 The primary care team should take over routine management of heart failure as soon as it has been stabilised and its management optimised. [2018]

Writing a care plan

1.1.7 The specialist heart failure MDT should write a summary for each person with heart failure that includes: