Chronic heart failure in adults

NICE quality standard

September 2015

Introduction

This quality standard covers the assessment, diagnosis and management of chronic heart failure in adults (aged 18 years or older). For more information see the chronic heart failure topic overview.

It will update and replace the existing quality standard for chronic heart failure.

Why this quality standard is needed

Chronic heart failure is a complex clinical syndrome of symptoms and signs that suggest that the efficiency of the heart as a pump is impaired. It is caused by structural or functional abnormalities of the heart. Some people have heart failure due to left ventricular systolic dysfunction that is associated with a reduced left ventricular ejection fraction, some have heart failure with a preserved ejection fraction and others have a combination of valve disease, arrhythmia and ventricular dysfunction. Most of the evidence about treatment is for heart failure due to left ventricular systolic dysfunction. The most common cause of heart failure in the UK is coronary heart disease, and many people with heart failure have had a myocardial infarction in the past. The quality statements in this quality standard relate to all causes of chronic heart failure unless stated otherwise.

For both people with chronic heart failure and their family members and carers, the condition can be a financial burden and have adverse effects on their quality of life. People with chronic heart failure often experience poor quality of life; symptoms include breathlessness, fatigue and ankle swelling, and over one-third experience severe and prolonged depressive illness.

The British Heart Foundation 2014 report Cardiovascular Disease Statistics reported that about 550,000 people in the UK were living with heart failure in 2013. Both the

incidence and the prevalence of heart failure increase with age, with the average age at first diagnosis being 76 years.

The prevalence of heart failure is expected to rise in future as a result of an ageing population, improved survival of people with ischaemic heart disease and more effective treatments for heart failure.

Heart failure has a poor prognosis: 30–40% of people diagnosed with heart failure die within 1 year, but thereafter the mortality is less than 10% per year. Patients on GP heart failure registers, representing prevalent cases of heart failure, have a 5-year survival rate of 58%, compared with 93% in the age- and sex-matched general population.

The quality standard is expected to contribute to improvements in the following outcomes:

- mortality due to heart failure
- hospital admissions
- ability to manage a long-term condition
- quality of life
- medication safety.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- NHS Outcomes Framework 2015–16
- Public Health Outcomes Framework 2013–2016.

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2015–16

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** **Reducing premature mortality from the major causes of death** 1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4*)
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions (ASCOF 1A**) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions (ASCOF 1E**, PHOF 1.8*) **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers (ASCOF 1D**) **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions* (ASCOF 1A**)
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*) ***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures *i Physical health-related procedures* **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into

	reablement/rehabilitation service (ASCOF 2B[1]*) ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services 4b Patient experience of hospital care 4c *Friends and family test* *4d Patient experience characterised as poor or worse* *i Primary care* *ii Hospital care* ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to inpatients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of A&E services **Improving people's experience of integrated care** *4.9 People's experience of integrated care (ASCOF 3E**)*
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics are in development	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services (NHSOF 2.2*, ASCOF 1E**) 1.9 Sickness absence rate
4. Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)* 4.11 Emergency readmissions within 30 days of discharge

	from hospital* *(NHSOF 3b)* 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Patient experience and safety issues

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services relevant to chronic heart failure.

NICE has developed guidance and an associated quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside this quality standard. They specify that people receiving care should be treated with dignity, have opportunities to discuss their preferences, and be supported to understand their options and make fully informed decisions. They also cover the provision of information to patients and service users. Quality statements on these aspects of patient experience are not usually included in topic-specific quality standards. However, recommendations in the development sources for quality standards that affect patient experience and are specific to the topic are considered during quality statement development.

Coordinated services

The quality standard for chronic heart failure specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole chronic heart failure care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to adults with chronic heart failure.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of

NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality chronic heart failure service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating adults with chronic heart failure should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development sources on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting adults with chronic heart failure. If appropriate, healthcare professionals should ensure that family members and carers are involved in the decision-making process about investigations, treatment and care.

List of quality statements

Statement 1. Adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and specialist assessment.

Statement 2. Adults with suspected chronic heart failure and either a previous myocardial infarction (MI) or very high levels of serum natriuretic peptides are seen within 2 weeks of referral.

Statement 3. Adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose medication that is gradually increased until the optimal tolerated or target dose is reached.

Statement 4. Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of heart failure medication.

Statement 5. Adults with chronic heart failure have a review of their condition at least every 6 months.

Statement 6. Adults with chronic heart failure are offered a cardiac rehabilitation programme.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Question 3 Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Diagnosis by a specialist

Quality statement

Adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and specialist assessment.

Rationale

When an adult with suspected chronic heart failure is referred for diagnosis a specialist should see them and review their echocardiogram, to ensure that the correct diagnosis is made. The echocardiogram will show any valve disease and assess the function of the left ventricle. The specialist should consider the possible causes of chronic heart failure, recommend the appropriate treatment and develop a management plan.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and specialist assessment.

Data source: Local data collection.

Process

Proportion of adults with suspected chronic heart failure referred for diagnosis who have an echocardiogram and specialist assessment.

Numerator – the number in the denominator who have an echocardiogram and specialist assessment.

Denominator – the number of adults with suspected chronic heart failure referred for diagnosis.

Data source: Local data collection.

Outcome

Diagnosis of chronic heart failure.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices and hospitals) ensure that systems are in place so that adults presenting with symptoms of chronic heart failure who are referred for diagnosis have an echocardiogram and specialist assessment.

Healthcare professionals (such as GPs and specialists in cardiac care) ensure that adults presenting with symptoms of chronic heart failure who are referred for diagnosis have an echocardiogram and specialist assessment. Specialists in cardiac care should see the person after they have had an echocardiogram.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults presenting with symptoms of chronic heart failure who are referred for diagnosis have an echocardiogram and specialist assessment.

What the quality statement means for patients, service users and carers

Adults who have symptoms of heart failure have a test called an echocardiogram to check the structure of their heart and how well it is functioning. They are then seen by a specialist who will confirm whether they have chronic heart failure and, if so, try to find the cause, offer treatment and talk to them about how to manage the condition.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendations 1.1.1.2 and 1.1.1.4 (key priorities for implementation) and 1.1.1.5

Definitions of terms used in this quality statement

Adults referred for diagnosis

Adults with suspected chronic heart failure and either a previous myocardial infarction or raised levels of serum natriuretic peptides will be referred for diagnosis.

Levels of serum natriuretic peptides (B-type natriuretic peptide [BNP] and N-terminal pro-B-type natriuretic peptide [NTproBNP]) in the blood are raised in people with heart failure. Raised levels of serum natriuretic peptides are a BNP level above 100 pg/ml or an NTproBNP level above 400 pg/ml. [Adapted from Chronic heart failure (NICE guideline CG108), recommendations 1.1.1.2 and 1.1.1.4 (key priorities for implementation) and 1.1.1.5]

Suspected chronic heart failure

The most common symptom of chronic heart failure is shortness of breath, either with exercise or at rest. Weight gain and ankle swelling may occur. Fatigue and increased need to pass urine at night are common. A person who has heart failure may wake suddenly from a sound sleep, gasping for breath. Other signs of chronic heart failure can include a cough that won't go away, nausea, lack of appetite and confusion. [Adapted from Chronic heart failure (NICE guideline CG108) Information for the public]

Specialist assessment

An assessment by a physician with a subspecialty interest in heart failure, often a consultant cardiologist. The assessment takes place after the person with suspected heart failure has had an echocardiogram. [Adapted from Chronic heart failure (NICE guideline CG108), and expert opinion]

Quality statement 2: Specialist assessment within 2 weeks

Quality statement

Adults with suspected chronic heart failure and either a previous myocardial infarction (MI) or very high levels of serum natriuretic peptides are seen within 2 weeks of referral.

Rationale

Adults who have had a previous MI or who have very high levels of serum natriuretic peptides have a higher likelihood of heart failure and a poorer prognosis. Urgent specialist assessment within 2 weeks of referral can help to ensure that the person is started on the appropriate medication to reduce any further long-term damage to the heart.

Quality measures

Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with suspected chronic heart failure and either a previous MI or very high levels of serum natriuretic peptides are seen within 2 weeks of referral.

Data source: Local data collection.

Process

Proportion of adults with suspected chronic heart failure and either a previous MI or very high levels of serum natriuretic peptides who are seen within 2 weeks of referral.

Numerator – the number in the denominator seen within 2 weeks.

Denominator – the number of referrals for specialist assessment of adults with suspected chronic heart failure and either a previous MI or very high levels of serum natriuretic peptides.

Data source: Local data collection.

Outcome

a) Mortality due to heart failure.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as hospitals) ensure that systems are in place for adults with suspected chronic heart failure to be seen within 2 weeks of referral if they have had a previous MI or have very high levels of serum natriuretic peptides.

Healthcare professionals (such as specialists in cardiac care) ensure that adults with suspected chronic heart failure are seen within 2 weeks of referral if they have had a previous MI or have very high levels of serum natriuretic peptides.

Commissioners (such as clinical commissioning groups) ensure that they commission services in which adults with suspected chronic heart failure are seen within 2 weeks of referral if they have had a previous MI or have very high levels of serum natriuretic peptides.

What the quality statement means for patients, service users and carers

Adults who have symptoms of chronic heart failure are seen by a specialist within 2 weeks of being referred by their GP if they have had a heart attack before or if a blood test shows high levels of a substance (called a ‘serum natriuretic peptide’) that suggests they may have heart failure needing urgent treatment.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendations 1.1.1.2 and 1.1.1.4 (key priorities for implementation)

Definitions of terms used in this quality statement

Very high levels of serum natriuretic peptides

Levels of serum natriuretic peptides (B-type natriuretic peptide [BNP] and N-terminal pro-B-type natriuretic peptide [NTproBNP]) in the blood are raised in people with heart failure. Very high levels of serum natriuretic peptides are defined as a BNP level above 400 pg/ml or an NTproBNP level above 2000 pg/ml. [Adapted from Chronic heart failure (NICE guideline CG108), recommendation 1.1.1.4 (key priority for implementation)]

Quality statement 3: Medication for chronic heart failure due to left ventricular systolic dysfunction

Quality statement

Adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose medication that is gradually increased until the optimal tolerated or target dose is reached.

Rationale

Medication such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor antagonists and beta-blockers are of proven benefit for people with chronic heart failure due to left ventricular systolic dysfunction, and taking them at the optimum dose will provide the best outcome. However, ACE inhibitors and angiotensin II receptor antagonists can cause low blood pressure and renal impairment, and beta-blockers can initially make heart failure symptoms worse and cause low blood pressure and a low heart rate. Therefore people taking these medicines should have regular checks to reduce the risk of harm.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose medication which is gradually increased until the optimal tolerated or target dose is reached.

Data source: Local data collection.

Process

Proportion of adults newly diagnosed with chronic heart failure due to left ventricular systolic dysfunction started on low-dose medication who have documented titration up to the optimal tolerated dose.

Numerator – The number in the denominator who have documented titration up to the optimal tolerated dose.

Denominator – The number of adults newly diagnosed with chronic heart failure due to left ventricular systolic dysfunction started on low-dose medication.

Data source: Local data collection.

Outcome

a) Mortality due to heart failure.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices and hospitals) ensure that adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose medication that is gradually increased until the optimal tolerated or target dose is reached, and that there is monitoring for side effects after each dose titration.

Healthcare professionals (such as GPs and specialists in cardiac care) ensure that, when they prescribe medication such as ACE inhibitors, angiotensin II receptor antagonists or beta-blockers for adults with chronic heart failure due to left ventricular systolic dysfunction, they titrate the dose until the optimal tolerated or target dose is reached. They also ensure that they monitor the person's serum urea, creatinine, electrolytes, eGFR (estimated glomerular filtration rate), heart rate, blood pressure and clinical status after each increase in dose.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose medication that is gradually increased until the optimal tolerated or target dose is reached, and there is monitoring for side effects after each dose titration.

What the quality statement means for patients, service users and carers

Adults with chronic heart failure due to left ventricular systolic dysfunction (that is, where the part of the heart that pumps blood around the body isn't working as well as it should) who are prescribed medication for heart failure and blood pressure are given low doses of the medication at first. Doses are then increased gradually until they are taking the highest dose their body can cope with, or the ideal dose for their condition.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendations 1.2.2.5, 1.2.2.6 and 1.2.2.8

Equality and diversity considerations

ACE inhibitors are less effective in people of African or Caribbean family origin. Healthcare professionals should take this into account and monitor the effects of the medication closely, to ensure that the person receives additional treatment promptly if needed.

Quality statement 4: Assessment after changes in medication

Quality statement

Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of heart failure medication.

Rationale

Medication to treat chronic heart failure can cause significant side effects, including dehydration, low blood pressure, a low heart rate and renal impairment. Some may initially and temporarily make heart failure symptoms worse. When the dose or type of medication for chronic heart failure is changed, the person should have a review within 2 weeks to monitor the effects and prevent any long-term damage. This monitoring can also include a review of the effectiveness of the medication and whether any further changes are needed.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of heart failure medication.

Data source: Local data collection.

Process

Proportion of adults with chronic heart failure who have a review within 2 weeks of any change in the dose or type of heart failure medication.

Numerator – the number in the denominator where the person is reviewed within 2 weeks.

Denominator – the number of changes to dose or type of chronic heart failure medication.

Data source: Local data collection.

Outcome

a) Renal impairment.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices and hospitals) ensure that systems are in place so that adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of heart failure medication.

Healthcare professionals (such as GPs and specialists in cardiac care) ensure that they carry out a review for adults with chronic heart failure within 2 weeks of any change in the dose or type of heart failure medication. The review should include measuring blood pressure, serum urea, creatinine, electrolytes and eGFR if there is a change to the dose or type of ACE inhibitor or angiotensin II receptor antagonist, assessing heart rate, blood pressure and clinical status if there is a change to the dose or type of beta-blocker and testing of liver and thyroid functions if there is a change to the dose or type of amiodarone.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of heart failure medication.

What the quality statement means for patients, service users and carers

Adults with chronic heart failure are seen by their healthcare professional within 2 weeks of any change in the dose or type of medication they are taking for heart failure, to make sure that the medication is working and is not making them unwell.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendation 1.4.1.3

Definitions of terms used in this quality statement

Review when medication is changed

Blood pressure, serum urea, creatinine, electrolytes and eGFR (estimated glomerular filtration rate) should be measured if there is a change to the dose or type of ACE (angiotensin converting enzyme) inhibitor or angiotensin II receptor antagonist. Heart rate, blood pressure and clinical status should be assessed if there is a change to the dose or type of beta-blocker. Liver and thyroid function tests should be carried out if there is a change to the dose or type of amiodarone. [Adapted from Chronic heart failure (NICE guideline CG108), recommendations 1.2.2.6, 1.2.2.8, 1.2.2.15 and 1.2.2.22, and expert opinion]

Quality statement 5: Monitoring

Quality statement

Adults with chronic heart failure have a review of their condition at least every 6 months.

Rationale

Adults with chronic heart failure need to have a review of their condition at least every 6 months to ensure that their medication is working effectively and they are not experiencing any significant side effects. This will allow their healthcare professional to assess whether there has been any deterioration in their condition, if their medication should be changed, if other procedures (such as cardiac resynchronisation therapy) should be considered and whether referral to another member of the multidisciplinary team is needed.

Quality measures

Structure

Evidence of local arrangements to ensure that adults with chronic heart failure have a review of their condition at least every 6 months.

Data source: Local data collection.

Process

Proportion of adults with chronic heart failure who have had a review of their condition during the past 6 months.

Numerator – the number in the denominator who have had a review of their condition during the past 6 months.

Denominator – the number of adults with chronic heart failure.

Data source: Local data collection.

Outcome

a) Quality of life.

Data source: Local data collection.

b) Renal impairment.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices and hospitals) ensure that systems are in place so that adults with chronic heart failure have a review of their condition at least every 6 months.

Healthcare professionals (such as GPs and specialists in cardiac care) ensure that they review adults with chronic heart failure at least every 6 months. They should, as a minimum, assess the person's functional capacity, fluid status, cardiac rhythm and cognitive and nutritional status; review their medication, including the need for any changes and possible side effects; and measure their serum urea, electrolytes, creatinine and eGFR (estimated glomerular filtration rate).

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with chronic heart failure have a review of their condition at least every 6 months.

What the quality statement means for patients, service users and carers

Adults with chronic heart failure are seen at least every 6 months by their healthcare professional, who will check whether their condition has got better or worse, if their medication needs to be changed and if other types of treatment might be suitable for them. The person may also be referred to other members of the care team, such as a heart failure nurse specialist.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendation 1.4.1.3

Definitions of terms used in this quality statement

Review

This should include as a minimum:

- 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.

[Adapted from Chronic heart failure (NICE guideline CG108), recommendation 1.4.1.1]

Quality statement 6: Cardiac rehabilitation programme

Quality statement

Adults with chronic heart failure are offered a cardiac rehabilitation programme.

Rationale

Cardiac rehabilitation programmes can help to extend a person's life through monitored exercise, emotional support and education about lifestyle changes to reduce the risks of further heart problems. They can also reduce uncertainty and anxiety about living with chronic heart failure and, through better management of their condition, the person may have greater opportunities to return to work. Offering a cardiac rehabilitation programme to all adults with chronic heart failure when their condition is stable will help to prevent the person's heart failure from worsening, reduce their risk of future heart problems and improve their quality of life.

Quality measures

Structure

a) Evidence of local arrangements to ensure that adults newly diagnosed with chronic heart failure are offered a cardiac rehabilitation programme.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that the suitability of a cardiac rehabilitation programme is discussed every 6 months with adults with chronic heart failure.

Data source: Local data collection.

Process

a) Proportion of adults newly diagnosed with chronic heart failure who are referred to a cardiac rehabilitation programme.

Numerator – the number in the denominator who are referred to a cardiac rehabilitation programme.

Denominator – the number of adults newly diagnosed with chronic heart failure.

Data source: Local data collection.

b) Proportion of adults with chronic heart failure who discuss the suitability of a cardiac rehabilitation programme with their healthcare professional every 6 months.

Numerator – the number in the denominator who discuss the suitability of a cardiac rehabilitation programme with their healthcare professional every 6 months.

Denominator – the number of adults with chronic heart failure.

Data source: Local data collection.

Outcome

a) Quality of life.

Data source: Local data collection.

b) Self-management of symptoms.

Data source: Local data collection.

c) Hospital admissions, inpatient hospital days and readmissions.

Data source: Local data collection.

d) Mortality due to heart failure.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers (such as GP practices, community nursing teams and hospitals) ensure that supervised, group exercise-based cardiac rehabilitation programmes that include a psychological and educational component are available for adults with chronic heart failure.

Healthcare professionals (such as GPs, cardiac rehabilitation nurses, palliative care practitioners and specialists in cardiac care) ensure that they offer adults newly diagnosed with chronic heart failure a cardiac rehabilitation programme, once they

are well enough to attend. Healthcare professionals also discuss the suitability of a rehabilitation programme with adults with chronic heart failure every 6 months.

Commissioners (such as clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which supervised, group exercise-based cardiac rehabilitation programmes that include a psychological and educational component are offered to adults with chronic heart failure.

What the quality statement means for patients, service users and carers

Adults with chronic heart failure are offered a group exercise-based programme that is designed for people with heart failure, once they are well enough to attend. This programme will include help with understanding their condition and how to look after themselves.

Source guidance

- Chronic heart failure (2010) NICE guideline CG108, recommendation 1.3.1.1 (key priority for implementation)

Definitions of terms used in this quality statement

Cardiac rehabilitation programme

This is a supervised, group exercise-based programme designed for people with heart failure that includes a psychological and educational component. [Adapted from Chronic heart failure (NICE guideline CG108) recommendation 1.3.1.1]

Equality and diversity considerations

A cardiac rehabilitation programme should be available for all adults with chronic heart failure. To ensure equality of access to rehabilitation programmes, measures such as providing transport for people to attend sessions and providing the sessions in different locations should be considered. Cardiac rehabilitation should be held in centres that have access for disabled people.

Healthcare professionals should take into account the communication needs of people with chronic heart failure when delivering cardiac rehabilitation, including

people with cognitive impairment. All information should be culturally appropriate, and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People should have access to an interpreter or advocate if needed.

Status of this quality standard

This is the draft quality standard released for consultation from 17 September to 15 October 2015. It is not NICE's final quality standard on chronic heart failure. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 15 October 2015. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from February 2016.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health, public health and social care practitioners and adults with chronic heart failure is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Adults with chronic heart failure should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Heart failure – chronic (2015) NICE clinical knowledge summary
- Chronic heart failure (2010) NICE guideline 108

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2015) Living well for longer: progress 1 year on
- Welsh Government (2015) Together for health – a heart disease delivery plan
- British Heart Foundation (2014) The national audit of cardiac rehabilitation
- Health Committee (2014) Managing the care of people with long-term conditions – second report
- Department of Health (2014) Living well for longer: national support for local action to reduce premature avoidable mortality
- National End of Life Care Programme (2014) End of life care in heart failure: a framework for implementation
- Department of Health (2013) Cardiovascular Disease Outcomes Strategy: improving outcomes for people with or at risk of cardiovascular disease
- The Healthcare Quality Improvement Partnership (2013) National heart failure audit 2012–2013
- NHS Improvement (2011) A guide for review and improvement of hospital based heart failure services
- The Health Foundation (2010) Bridging the quality gap: heart failure
- Health and Social Care Information Centre (2010) National heart failure audit 2010

Definitions and data sources for the quality measures

- Chronic heart failure (2010) NICE guideline 108

Related NICE quality standards

Published

- Cardiovascular risk assessment and lipid modification (2015) NICE quality standard 100
- Secondary prevention after a myocardial infarction (2015) NICE quality standard 99
- Atrial fibrillation (2015) NICE quality standard 93
- Physical activity (2015) NICE quality standard 84
- Acute kidney injury (2014) NICE quality standard 76
- Acute coronary syndromes (including myocardial infarction) (2014) NICE quality standard 68
- Anxiety disorders (2014) NICE quality standard 53
- Smoking cessation (2013) NICE quality standard 43
- Familial hypercholesterolaemia (2013) NICE quality standard 41
- Hypertension (2013) NICE quality standard 28
- Stable angina (2012) NICE quality standard 21
- Patient experience in adult NHS services (2012) NICE quality standard 15
- End of life care for adults (2011) NICE quality standard 13
- Alcohol dependence and harmful alcohol use (2011) NICE quality standard 11
- Chronic heart failure (2011) NICE quality standard 9
- Depression in adults (2011) NICE quality standard 8

In development

- Acute heart failure Publication expected December 2015

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Long-term conditions, people with comorbidities, complex needs
- Medicines optimisation (covering medicines adherence and safe prescribing)
- Obesity (adults)

- Obesity − prevention and management in adults
- Readmissions

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 2. Membership of this committee is as follows:

Mr Ben Anderson
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Mr Barry Attwood
Lay member

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The following specialist members joined the committee to develop this quality standard:

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Consultant cardiologist, Sheffield Teaching Hospital

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard has been incorporated into the NICE pathway on chronic heart failure.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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