NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Chronic heart failure in adults.

Date of Quality Standards Advisory Committee post-consultation meeting:
12 November 2015

2 Introduction

The draft quality standard for chronic heart failure in adults was made available on the NICE website for a 4-week public consultation period between 17 September 2015 and 15 October 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Consultation responses were received from 18 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

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.

Responses to questions 1 and 2 are summarised in the following sections. No comments were made in relation to question 3.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- General support for, welcoming of, or agreement with the statements from a number of stakeholders.

- Two stakeholders commented that there is limited reference to palliative care.
- Several stakeholders noted that statements in Quality Standard 9 Chronic Heart Failure in Adults 2011 (QS 9) do not appear in the draft quality standard.
- Greater clarity on where monitoring and review of CHF should occur is needed (primary care structures may be better positioned).
- Standard should emphasise need for clinical discretion or the evolving multi-morbidity perspective (key issue with heart failure is that people are often frail, old or have comorbidities).

Responses to Consultation Questions

- One stakeholder felt the quality standard should include palliative care.
- Two stakeholders felt statements covered key areas but additional statements were needed.
- One stakeholder felt that local data collection may duplicate collection of data as part of national heart failure audit program, but another suggested that the national heart failure audit could be expanded to collect the information needed and extended to cover primary care.
- One stakeholder felt GP clinical systems would be able to collect and collate information.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Support for statement from one stakeholder - The Heart Failure Audit suggests that patient outcomes are improved where there is specialist input to care.
- Two stakeholders interpreted the statement differently with respect to referral: One commented that the statement leaves the referral decision for specialist assessment to the GP and asked if it should it instead recommend all patients who want specialist assessment are referred; the other commented that the statement does not allow for clinical discretion as all patients should be referred.
- Timely access to echocardiography was flagged as an obstacle to diagnosis by two stakeholders, and a third expected access to become more difficult in the future. The latter stakeholder suggested that specifying the time by which echo and specialist assessment should take place would be desirable.
- One stakeholder commented that timely access to echocardiography would help secure diagnosis and allow a primary care physician to follow CHF algorithms, but it is less clear what the added value is of time defined access to specialist assessment.
- One stakeholder made comments on access to services for people who are house bound or nursing home bound noting that specialist referral is impracticable, and that as an echocardiogram is a non-ambulatory investigation it may not be possible to organise.
- Clarity was sought by one stakeholder on the definition of specialist assessment and what it means for healthcare professionals.

Consultation question responses for statement 1

- Key area for quality improvement, but should specify ‘heart failure specialist assessment’.
- Denominator of ‘suspected heart failure’ is difficult to measure.
- Numerator and denominator will be very similar – propose that denominator is all adults with suspected CHF (as not all will be referred).
- Use of primary care data to measure statement could be problematic – many GPs rely on specialists to request and report findings of an echocardiogram in clinic letters; high level of exception reporting in QOF.

5.2 Draft 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.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- One stakeholder considered the 2-week target to be beneficial to high risk patients.
- In contrast, one stakeholder described the 2-week timescale as an artificial requirement that could affect timely access to cardiology opinion for conditions where rapid assessment has prognostic impact. It was suggested that it may be more appropriate to define a timescale for access to echocardiographic assessment as opposed to access to specialist opinion.
- The same stakeholder considered that the 2-week timescale would also require substantial investment and additional resources to achieve.
- One stakeholder commented that the rationale should note that starting on appropriate medication will alleviate symptomology; help reduce hospital admissions; and help to reduce mortality.

Consultation question responses for statement 2

- Identified as a key area to address.
- Data can be collected / measured according to one stakeholder.

5.3 Draft 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.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Two stakeholders described the statement as vague.
- One stakeholder felt the statement should say “where clinically appropriate” to reflect a multi-morbidity perspective, e.g. someone with complex palliative care needs. A question was also asked as to whether the ‘review’ included the very elderly and / or those with comorbidities.
- Several comments were made in relation to the medication covered by the statement:
  - Changing ‘low dose medication’ to ‘low dose evidence based medication’.
  - Referencing mineralocorticoid receptor antagonists, spironolactone and eplerenoneare.
  - Listing the medication in the statement rather than in the rationale.
  - Accounting for the development of new treatments to ensure patients can access them at appropriate times, e.g. angiotensin receptor-neprilysin inhibitors.
  - Specifying the need to add additional treatments if a patient remains symptomatic despite optimal therapy with an ACE inhibitor and a beta-blocker.
- One stakeholder considered that the statement lacked a timeline and sense that titration should increase gradually but progressively over a period of a few months and not years.
- A stakeholder commented that all heart failure patients should be referred to heart specialist nurse to achieve titration of medication.
- One stakeholder commented that the disease may not be well controlled despite optimal dose and a patient may need consideration for a cardiac rhythm device.

Consultation question responses for statement 3

- Denominator is not specific and therefore cannot be measured.
- Unclear how data could be collected with the structure being proposed.
- More precise definitions needed in order to collect data – what is optimal titration, what low dose medications are included etc.?
- Time to full titration should also be measured.

5.4 Draft 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.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Three stakeholders considered that a 2-week timescale was not appropriate in all cases. Examples provided included:
  - Whether the patient was tolerating the medication.
  - Certain types of medications in which repeat testing of thyroid / liver function at 2 weeks is unlikely to be informative, e.g. amiodrone for which testing should begin before starting, then at 3 months followed by 6 monthly checks.
  - Patients requiring multiple dose titrations.
- One respondent commented that the disease may not be well controlled despite medication and a person may need consideration for cardiac rhythm device.
- One stakeholder queried whether a review could be undertaken by telephone or other means for some patients.

Consultation question responses for statement 4

- It is not clear who is responsible for the review.
- Robust audit tools are required – titration will often occur in community settings not covered by heart failure audit.
- Process Measure: The number of changes to dose or type of medication may be difficult to ascertain. The denominator should therefore be the number of patients who have a change in medication and not the number of changes of medication.
- Outcome Measure: Renal Impairment: Renal impairment is a non-specific outcome measure – other conditions or comorbidities could be causative.

5.5 Draft statement 5

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Four stakeholders saw this as a key area for improvement, welcomed or agreed the statement.
- One stakeholder stated that a 6 month review will have a resource impact and if a patient has stable CHF then a 6 month review would be inefficient use of resources.
- A stakeholder commented that the 6-month review needs to be undertaken by a member of the cardiology MDT (referred to a specialist nurse) and an ECG undertaken to detect any abnormalities or indication for further intervention.
- One stakeholder felt the statement should include '…by a member of the multidisciplinary specialist team'. This would reflect importance of specialist input given that QS9 quality statement 6 has not been carried forward.
- The definition of review should include the patient's weight.
- One stakeholder noted that no reference is made to NICE technology appraisal guidance [TA314] 'Implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure'.

Consultation question responses for statement 5

- Difficult to measure as it is not clear who is responsible for review.
- Outcome Measure: Would mortality secondary to CHF be the primary outcome to consider in relation to regular review?
- Outcome Measure: Queries raised on which Quality of Life scoring tool would be used, and whether data can be collected in practice.

5.6 Draft statement 6

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

Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

- Three stakeholders identified this as a key area for improvement, agreed or supported the statement.
- One stakeholder commented that reference to palliative care in 'Healthcare Professionals' is 'strange' as it is not mentioned elsewhere.
- One stakeholder raised queries on who the statement relates to, e.g. those newly diagnosed, those whose conditions have changed, all with stable CHF etc.?
- Several comments were made on the 6-month timescale:
  - One stakeholder commented that if all people with CHF were able to be re-referred to cardiac rehabilitation every 6 months, it would place a huge strain on resources.
  - Two other stakeholders noted that it may not be necessary to offer rehabilitation services every 6 months.
- Comments were made relating to access to cardiac rehabilitation: - The offer would not be available to all, as the statement wording offers only group rehabilitation and no home programmes.
- Two stakeholders suggested changes to the rationale:
  - Amend rationale to reference need for cardiac rehabilitation programmes to empower patients to help manage their condition.
  - Expand rationale from 'greater opportunities to return to work' to also cover other activities such as hobbies, physical activity, volunteering etc. as patients with CHF are likely to be older.
- One stakeholder stated that the 'psychological component' should be replaced by specific content, e.g. anxiety and depression screening, access to counselling etc.

Consultation question responses for statement 6

- Baseline data could be collected through QOF.

- Outcome measure: More information sought on which Quality of Life scoring tool would be used; and concerns raised about the cost, resource and ability to collect in practice.
- Outcome measure: Self-Management – specific indicators are needed as the term is ambiguous.
- No standard systems in place to record quality measures.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Stakeholder felt that some statements from the original quality standard should be retained:
  - 2: People presenting in primary care with suspected heart failure without previous myocardial infarction have their serum natriuretic peptides measured.
  - 6: People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for the team.
  - 12: People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.
  - 13: People with moderate to severe chronic heart failure, and their carer(s), have access to a specialist in heart failure and a palliative care service.
- Cardiac rhythm device therapy - cardiac resynchronisation therapy pacing (CRT‑P) devices or cardiac resynchronisation therapy defibrillator (CRT‑D) devices.
- Second line treatment, ie people who remain symptomatic despite optimal therapy with an ACE inhibitor and a beta-blocker are offered one of the following: an aldosterone antagonist licensed for heart failure, an angiotensin II receptor antagonist (ARB) licensed for heart failure, or hydralazine in combination with nitrate.
- People with heart failure (stages C or D) who need regular at least monthly follow up from community based specialist heart failure nurses and advanced care planning.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement Number	Comments
1	Association for Palliative Medicine	General	We are glad to see that the quality standard acknowledges that chronic heart failure can have an adverse effect on a patient's quality of life and that 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; also that it acknowledges that heart failure has a poor prognosis. We support the quality standard's intention to contribute to improvements in hospital admissions, ability to manage a long-term condition & quality of life. We welcome that the quality standard 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.
2	Association for Palliative Medicine	General	Throughout the quality standard, reference is made to the symptoms that a person with chronic heart failure may experience. However, the management and specialist assessment outlined do not include palliative care which we believe is a significant omission.
3	Association for Palliative Medicine	General	Despite the above points in the document, we are disappointed that there is barely a mention of palliative care for patients with chronic heart failure in either the list of 6 quality statements or the rest of the document. Not all patients with chronic heart failure will need referral to specialist palliative care services. Referral should be needs-based rather than be diagnosis- or prognosis-based. Specialist palliative care services work with patients with complex needs when the usual medical team is struggling. Perhaps patients should be alerted to the existence of specialist palliative care teams in case

ID	Stakeholder	Statement Number	Comments
			their symptoms become complex, but it would be unworkable and unnecessary for all patients with chronic heart failure to be seen by specialist palliative care teams (and, if this were offered to patients with chronic heart failure it would have to be offered to all patients with life-limiting conditions).
4	British Society for Heart Failure	General	2011 QS 2 has been removed and should be reinstated. 'Adults with suspected heart failure should have serum natriuretic peptide tested.'
5	British Society for Heart Failure	General	2011 QS 6 has been removed and should be reinstated. 'People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist.'
6	Boston Scientific	General	We are disappointed to see that there is no reference or link to the recently updated NICE technology appraisal guidance on implantable cardioverter defibrillators & cardiac resynchronisation therapy for arrhythmias & heart failure (TA314, June 2014 - http://www.nice.org.uk/guidance/ta314). We would like to see an additional standard added to reference this point. It states on page 7 of the TAG 314 publication: "Treatment of heart failure aims to improve life expectancy and quality of life. Chronic heart failure: management of chronic heart failure in adults in primary and secondary care (NICE clinical guideline 108) recommends pharmacological treatment initially. However, as the condition becomes more severe, cardiac function and symptoms may no longer be controlled by pharmacological treatment alone, and can be improved by the implantation of a cardiac rhythm device which can sense and stimulate the atria and right and left ventricles independently. These devices are known as cardiac resynchronisation therapy pacing (CRT-P) devices or cardiac resynchronisation therapy defibrillator (CRT-D) devices." The guidance in 2014 clearly defined the patient groups and indications who should have access to a CRT device. The 2010 Clinical Guidelines on heart failure includes the provision of CRT therapy to heart failure patients. However the recommendations have been significantly updated and refreshed. More patients are now indicated for CRT therapy and should have access to the best quality option available – the implantation of a device. This is a key area for quality improvement because of the continuing low implant rates for these devices in the UK versus other European countries and variation across the UK itself. The NICOR audit for cardiac rhythm devices (https://nicor5.nicor.org.uk/__802571400070B77E.nsf?OpenDatabase) has consistently

ID	Stakeholder	Statement Number	Comments
			reported that the UK implant rates for ICD and CRT implants are lower than our European neighbours and – perhaps more significantly – there is a wide variation of implant rates across the UK. This means that patients do not have access to the same quality of care across the country. It is worth noting that implant rates have increased steadily over the years but the latest NICE TAG 314 indicates that more patients are indicated for the implant of a CRT. For this NICE guidance to be implemented, all healthcare professionals – from GPs, to HF specialists to cardiologists and electrophysiologists who implant devices – need to be involved in its implementation. This NICE technology appraisal guidance identifies (cost-effective) mortality benefits from the use of these devices in defined patient groups, helping to support the delivery of the NHS Outcomes Framework 2015/16. For this NICE guidance to be implemented, all healthcare professionals – from GPs, to HF specialists to cardiologists and electrophysiologists who implant devices – need to be involved in its implementation. For this reason, we believe it is important to include a specific reference to this part of the treatment pathway in the Quality Standards for chronic heart failure. We would recommend that an additional Quality Standard is added to reference the consideration of CRT-P/CRT-D device therapy, similar to the existing Quality Standard 3 for pharmaceutical therapy.
7	Boston Scientific	General	The recently updated NICE technology appraisal guidance on implantable cardioverter defibrillators & cardiac resynchronisation therapy for arrhythmias & heart failure (TA314, June 2014) is missing from the draft Quality Standards for Chronic Heart Failure and is not referenced anywhere in the document. We recommend this reference is added.
8	Royal College of Physicians	General	We would like to formally endorse the response submitted by the British Society for Heart Failure (BSH).
9	Royal College of Physicians of Edinburgh	General	There are some concerns that the data source for these standards will be local data collection. There is already a national heart failure audit program run by University College London – National Institute for Cardiovascular Outcomes Research. Most trusts contribute partial data to this. This could be made compulsory / recommended as the national data source for quality assessment standards. They already publish a public 100 page report annually which is very helpful in comparing the quality of trusts. Proposing local data collection not only involves duplication but may make comparisons less valid.
10	Royal College of Physicians of Edinburgh	General	The quality statements define several key areas of merit in achieving optimum care for a high risk group of patients with chronic heart failure.

ID	Stakeholder	Statement Number	Comments
			The management pathways for CHF are established and well evidenced with clear algorithms for treatment initiation, titration and addition of extra agents linked with disease response and progression. The majority of this could be, and often is, effectively managed within primary care. A key obstacle is access to echocardiography in a timely fashion to help secure the diagnosis of impaired left ventricular systolic function, which would enable primary care physician to confidently follow CHF algorithms. It is less clear what the added value of a tightly time-defined access to specialist assessment is for the majority of cases if symptomatic presentation is supported by echocardiographic confirmation of the diagnosis alongside the role for serum natriuretic peptide. This proposed requirement could detrimentally affect access to specialist cardiology opinion for other priority cardiac conditions. It would be beneficial to provide greater clarity of expectation about where monitoring and review of chronic heart failure should occur, as primary care structures may continue to be better positioned for a patient centred approach to this chronic disease.
11	Medtronic Limited	General	Medtronic welcomes the draft quality statements in supporting uptake of Chronic Heart Failure Guidance and improving quality of patient care
12	Bayer Plc	General	The heart failure audit also shows that specialist input has a significant impact on prognosis and life expectancy. In 2012/13, the audit showed that on admission, around 80% of patients were seen by a heart failure specialist in some capacity, and that the 'majority' (66% on first admission and 70% on readmission) were seen by a member of a heart failure multidisciplinary team (MDT). On discharge 56% of patients were referred for a follow-up appointment with the heart failure MDT, indicating that 44% of heart failure patients were not referred to an MDT. As part of the topic engagement exercise, stakeholders highlighted their own experience that referral to heart failure teams is not available for all appropriate patients, as teams are not staffed or commissioned adequately according to the population needs and cited lack of specialist involvement as a suggested barrier to optimal medicines uptake. As there remains room to drive measurable improvements in this area we suggest that statement 6 from the

ID	Stakeholder	Statement Number	Comments
			current quality standard: “People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for the team,” should be retained in the updated quality standard.
13	British Cardiovascular Society (BCS)	General	I am in agreement with all of the standards
14	RCGP	General	Overall these standards seem reasonable from an evidence based and clinical perspective, however the key issue is that people with heart failure are often extremely frail, old or have multiple comorbidities. The QS must emphasise the need for clinical discretion or the evolving multi-morbidity perspective { BMJ 2015; 350 doi: http://dx.doi.org/10.1136/bmj.h176}; managing heart failure may not be the patient’s or carer’s key objective. The NICE multimorbidity guideline which is currently being developed will give a more detailed view in this perspective. (MJ)
15	British Association for Nursing in Cardiovascular Care (BANCC)	General	BANCC welcomes the statements for heart failure. In order for these standards to be measured robust audit tools are required. The national heart failure audit could be expanded to encompass these fields however with community services this may be challenging, extending the national heart failure audit to cover primary care would be beneficial.
16	Novartis Pharmaceuticals UK Ltd	General	**Appropriate discharge** It is important that heart failure patients are discharged from hospital only when their condition is stable and that the decision of when to discharge a patient should always be based on ensuring optimisation of care. The most recent National Heart Failure Audit indicates that patients who received specialist input into their management were more likely to receive optimal care and be more stable prior to discharge, which translates into better outcomes including fewer early readmissions to hospital and lower mortality rates.[7] We would therefore suggest that the decision to remove Quality Statement 12 included within the original CHF Quality Standard ‘People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge’ is reversed.
17	British Heart Foundation	General	We are concerned that the statement about access to palliative care services for people with chronic heart

ID	Stakeholder	Statement Number	Comments
			failure in the previous version of the quality standard has not been included in the draft updated standard. We recognise that (as per the briefing note) NICE has a separate quality standard on end of life care. However, there is a particular issue created by the uncertain prognosis for patients with heart failure that means they are less likely to be referred for specialist palliative care - or are referred too late for them to benefit. The quality standard on end of life care has been in place since 2011. Whilst we recognise that data from the National Heart Failure Audit only covers people that were admitted to hospital with heart failure, this shows that only 4% of these patients were referred for palliative care (although in some cases palliative care will also be part of the role of heart failure specialist nurses) The Department of Health's VOICES survey of bereaved people shows clear discrepancies in the experiences of people whose loved ones died from CVD compared to those who died from cancer. For example, 65% of relatives of people who died from cancer felt that the person had enough choice over their place of death, this compared to 44% of relatives of people that died from cardiovascular disease. We therefore recommend that a quality statement on referring patients with heart failure for palliative care is retained in the standard.
18	Association for Palliative Medicine	Question 1	We do not think that the draft quality standard accurately reflect the key areas for quality improvement. There must be inclusion of palliative care so that the patient's quality of life and symptomatic burden can be managed alongside cardiological management of their chronic heart failure.
19	RCGP	Question 1	Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement? The standards chosen are important areas. However additional standards should include: 1. patients with heart failure with stages C or D who need regular at least monthly follow up from community based specialist heart failure nurses 2. patients with heart failure with stages C or D who need advanced care planning. (MH)
20	Novartis Pharmaceuticals UK Ltd	Question 1	Heart failure, known to affect 550,000 people in the UK[1], represents a major and growing cost to the NHS and wider society. It is the leading cause of hospital admission in over 65s[2] and it is one of the five long term conditions responsible for 75% of unplanned hospital admissions.[3] Heart failure accounts for circa 1 million inpatient bed days and 5% of all emergency and medical admissions.[4] In total, the condition accounts for almost 2% of the entire NHS budget, equating to approximately £2.3bn every year.[5,6] Projections indicate that hospital admissions for heart failure are set to rise by 50% in the next 25 years due to an ageing population.[4]

ID	Stakeholder	Statement Number	Comments
			In light of the significant impact that heart failure has, it is important to ensure that this Quality Standard accurately reflects all the key areas for quality improvement for those with Chronic Heart Failure (CHF), thereby contributing to improving health outcomes for patients. This draft Quality Standard broadly reflects the key areas for quality improvement for chronic heart failure. We would suggest that the importance of providing specialist input into the care and management of patients with CHF should be better emphasised, whilst there is a need for the guidance to communicate the fact that patients admitted to hospital with heart failure are only discharged when appropriate. It is also important that Quality Statements 5 and 6 provide guidance for commissioners to make provisions for developments in new treatments for heart failure, to ensure patients can access these medicines at the appropriate time.
21	RCGP	Question 2	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? Yes GP clinical systems should be able to collect and collate this information. (MH)
22	Royal Devon & Exeter NHS Foundation Trust	Statement 1	This QS does not seem to reflect the recommendations and tone of the full guideline document. The main guideline recommends all patients with new suspected CHF and a natriuretic peptide level above a threshold level are referred for specialist assessment and imaging. QS 1 however is non-committal and leaves the referral decision very much to the GP. For a condition which has 30-40% 1 year mortality and 10% per year thereafter (from the QS introduction) should we not be recommending specialist assessment for all patients who want it?
23	Royal College of Physicians of Edinburgh	Statement 1	We agree that all patients with suspected heart failure have an echo and a cardiology specialist assessment. However, the denominator chosen may not represent the group of interest. A primary care physician may make a determination, for reasons of other comorbidities and functional status, not to refer a patient with suspected heart failure and elect to treat and review patient progress. This group of patients would not then be included in calculations.

ID	Stakeholder	Statement Number	Comments
			The denominator should therefore be defined as 'the number of adults with suspected heart failure'. With the current drafted denominator, the numerator and denominator are likely to be very similar given that the majority who are referred will undergo specialist assessment. The area of interest is the proportion of patients who would be amenable to specialist assessment and who are referred for this.
24	Barnsley Hospital NHS Foundation Trust	Statement 1	Can you please comment on 'specialist assessment' post echocardiogram and hitherto what it means for healthcare professional. We run a one-stop diagnostic heart failure clinic and the patient is seen by the specialist nurse after the echo. The patient doesn't see the Consultant cardiologist at this point and may only see in clinic at a later date if heart failure. Each patient is however is discussed with the Consultant after the clinic and a management plan sent to the GP. Is this ok and appropriate? Thank you
25	RCGP	Statement 1	(Adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and specialist assessment.) This standard does not allow for clinical discretion- many patient with heart failure are extremely frail and house bound/ nursing home bound so specialist referral is impracticable. (MJ)
26	RCGP	Statement 1	(echocardiography component) An echo is a non-ambulatory investigation so can be impossible to organise for frail house bound patients. Many GPs still don't to have direct access to echocardiography, so rely on specialists to request and then report any finding of an ECHO in clinic letters, which anecdotally is often poorly done.
27	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 1	BANCC agree with the rationale for the statement, especially with the need to determine the underlying aetiology and to be seen by a specialist following echo. A specified time by which an echo & being reviewed by specialist would be desirable. It is anticipated that obtaining an echo is going to become increasingly challenging due to a shortage in cardiac physiologists.
28	British Heart Foundation	Statement 1	We strongly agree with this statement that adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and specialist assessment. The Heart Failure Audit suggests that patient outcomes are improved where there is specialist input to care.
29	British Society for Heart	Statement 1	Key area for quality improvement but should specify heart failure specialist assessment.

ID	Stakeholder	Statement Number	Comments
	Failure	Question 1	
30	British Society for Heart Failure	Statement 1 Question 2	Denominator for 'suspected heart failure' is difficult to measure.
31	RCGP	Statement 1 Question 2	If measurement is to be done for this standard using primary care data (consultation Q2) then this standard will be poorly attained (evidence from QoF 9.2% HF exception reporting in 2013/14 the highest of all the CV domain). (MJ)
32	Royal College of Physicians of Edinburgh	Statement 2	"Those with NT ProBNP >2000 should be seen within 2 weeks of referral". This is currently difficult to achieve. Even a 4 week target would be very challenging, requiring a substantial investment and additional resources for heart failure and cardiology services. In a financially constrained health system, creation of an artificially defined 2 week referral requirement has the potential to displace timely access to cardiology opinion for other conditions, for which rapid assessment and treatment also has prognostic impact. For example, patients presenting with ischaemic heart disease symptoms, symptomatic valvular heart disease, or arrhythmia, may be unable to access a cardiology opinion in a clinically appropriate timescale due to the demand generated by this quality standard. We are unclear as to what additional prognostic benefit has been demonstrated by access to a specialist opinion within this 2 week timeframe compared with initiation of treatment by a primary care physician who suspects the diagnosis. Primary care physicians who make a diagnosis of heart failure are able to initiate appropriate treatments for heart failure using established NICE algorithms. Additionally, if factors such as previous MI or high levels of serum natriuretic peptide are identified, treatment is indicated and should be commenced within primary care. The diagnosis of chronic heart failure is supported by echocardiographic information. Given that Quality Statement 1 recognises this through the requirement for adults to have both an echocardiogram and a specialist assessment, Quality Statement 2 requiring specialist assessment within 2 weeks of the suspected diagnosis would not provide an opportunity for patients to undergo echocardiography. Therefore, it may be more appropriate to define a timescale by which a patient with suspected chronic heart failure accesses echocardiographic assessment of their ventricular function, rather than defining the access

ID	Stakeholder	Statement Number	Comments
			time to specialist opinion. There are then clear and structured treatment pathways for chronic heart failure which could be initiated and monitored by a primary care physician for a patient in whom there is echocardiographic evidence of left ventricular systolic dysfunction.
33	Royal College of Physicians of Edinburgh	Statement 2	If the quality statement is judging the effectiveness and rapidity of access to specialist assessment, mortality due to heart failure should be compared between groups receiving specialist assessment versus those not accessing specialist assessment.
34	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 2	Having a 2 week target is beneficial for high risk patients.
35	British Heart Foundation	Statement 2	We think that the rationale for this statement should be amended to cover the fact that starting on the appropriate medication will alleviate symptomology and help to reduce hospital admissions, and in the longer term help to reduce mortality.
36	British Society for Heart Failure	Statement 2 Question 1	Two week pathway is a key area for quality improvement but requires an additional statement: Adults with suspected heart failure should have serum natriuretic peptide tested. This QS has been removed (QS2 of 2011 Chronic HF Quality Standards) but remains a key area for quality improvement in many regions.
37	British Society for Heart Failure	Statement 2 Question 2	This data is measurable.
38	Royal Devon & Exeter NHS Foundation Trust	Statement 3	This statement is rather vague and does not provide any timeline or sense that this should be performed gradually but progressively over a few months (not years). Local community heart failure services should report time to full titration as well as absolute numbers.
39	Boston Scientific	Statement 3	We are concerned that these Quality Statements may be misleading – in some cases, the disease may not be well controlled despite optimal pharmacological treatment and the patient may need to be considered for a cardiac rhythm device. These Quality Statements make no reference to such considerations and we are concerned that eligible patients may not be considered for these if people are not aware of this treatment

ID	Stakeholder	Statement Number	Comments
			option. As above, we would recommend that an additional Quality Standard is added to reference the consideration of CRT-P/CRT-D device therapy for eligible patients, similar to the existing Quality Standard 3 for pharmaceutical therapy.
40	Royal College of Physicians of Edinburgh	Statement 3	We are surprised that only ACE inhibitors and beta-blockers are mentioned for quality standards and not the MRA (mineralocorticoid receptor antagonists) spironolactone and eplerenone which reduce mortality in heart failure and are routinely prescribed.
41	Royal College of Physicians of Edinburgh	Statement 3	It is unclear how respondents would be able to collect data associated with the structure being proposed. Are the data to indicate that a structure is in place to review the medication of all patients with confirmed chronic heart failure due to left ventricular systolic dysfunction? Is this to be a primary or secondary care structure?
42	Royal College of Physicians of Edinburgh	Statement 3	It is unclear how 'optimal titration' will be defined. Is this to be a clinician judgement recorded in notes that dose has been increased within patient tolerance or side effects, or based on a proportion of patients achieving maximal recommended medication dose for each agent prescribed? For patients on multiple agents for chronic heart failure, what mechanism is proposed to define 'optimal titration'? Greater specificity is required to define the variable in the denominator. Is low-dose medication to be defined as commencing any agent with an evidence base in CHF, or specific medications such as ACE inhibitors or beta blockers?
43	Bayer Plc	Statement 3	During the topic engagement exercise on the current standard, several stakeholders suggested that aldosterone antagonists (MRAs) should be incorporated into the quality statement. Stakeholders commented that outcomes data from the NICOR National Heart Failure Audit show patients discharged from hospital on all 3 drugs (angiotensin-converting enzyme inhibitors (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with angiotensin-converting enzyme inhibitors), beta-blockers and MRAs) have better outcomes than those discharged on other combinations, improving life expectancy and reducing hospitalisations. Stakeholders also emphasised their own experience of suboptimal medication uptake, with a suggested barrier to uptake being fragmented care pathways and lack of specialist involvement. We are concerned that the new draft statement (3) does not reflect the need to add additional treatments if

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			a patient remains symptomatic despite optimal therapy with and ACE inhibitor and a beta-blocker, and appears to focus more on the titration of medication. We suggest that an additional quality statement should be included to reflect the recommendation from the NICE clinical guideline on chronic heart failure regarding second line treatment, which is a key priority for implementation. **Suggested quality statement:** People with chronic heart failure due to left ventricular systolic dysfunction who remain symptomatic despite optimal therapy with an ACE inhibitor and a beta-blocker are offered one of the following: an aldosterone antagonist licensed for heart failure, an angiotensin II receptor antagonist (ARB) licensed for heart failure, or hydralazine in combination with nitrate.
44	RCGP	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.) A multi-morbidity perspective must be applied here eg "where clinically appropriate" this measure is not for someone with palliative care needs eg end stage heart failure, very poor renal function, low blood pressure etc. Did this review include the very elderly or those with comorbidities –as these people are often excluded from trials? (doi: 10.3399/bjgp14X682309). (MJ)
45	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 3	BANCC feel that all heart failure patients should be referred to a heart failure specialist nurse in order to achieve titration of medication.
46	Novartis Pharmaceuticals UK Ltd	Statement 3	**Importance of medicines optimisation** In relation to the proposed Quality Statement 3, it is important that the supporting Statement guidance takes into account the development of new treatments for heart failure to ensure patients can access these medicines at the appropriate time. For instance, Quality Statement 3 could include reference to angiotensin receptor-neprilysin inhibitors. In addition, NICE have started a technology appraisal for sacubitril/valsartan for the treatment of chronic heart failure (ID822). Sacubitril/valsartan has been granted Promising Innovative Medicine (PIM) status and has also received a positive scientific opinion under the Medicines and Healthcare products Regulatory Agency (MHRA) Early Access to Medicines Scheme (EAMS) for patients with significant unmet medical need.

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47	British Heart Foundation	Statement 3	We think it would be helpful to list the recommended medication in the quality statement rather than the rationale.
48	British Society for Heart Failure	Statement 3 Question 1	This QS is vague and replaces the 2011 QS 7 which specified ACE inhibitors/ARBs and betablockers. We recommend the following: Adults with chronic heart failure due to left ventricular systolic dysfunction are started on low-dose evidence-based medication that is gradually increased until the optimal tolerated or target dose is reached.
49	British Society for Heart Failure	Statement 3 Question 2	Not measurable as lacking a specific denominator.
50	Royal Devon & Exeter NHS Foundation Trust	Statement 4	I agree with the parameters for review except those following a change in amiodarone dose. For amiodarone, testing should be performed before starting. Repeat testing approximately 3 months later and then 6 monthly is generally recommended. Repeat testing of thyroid function and/or liver function after only 2 weeks is unlikely to be informative unless there has been a clinical change. Can the word 'type' of amiodarone by deleted as it is generic?
51	Boston Scientific	Statement 4	We are concerned that these Quality Statements may be misleading – in some cases, the disease may not be well controlled despite optimal pharmacological treatment and the patient may need to be considered for a cardiac rhythm device. These Quality Statements make no reference to such considerations and we are concerned that eligible patients may not be considered for these if people are not aware of this treatment option. As above, we would recommend that an additional Quality Standard is added to reference the consideration of CRT-P/CRT-D device therapy for eligible patients, similar to the existing Quality Standard 3 for pharmaceutical therapy.
52	Royal College of Physicians of Edinburgh	Statement 4	Achieving a review within two weeks of a dose titration is unrealistic, as many patients will require multiple dose titrations eg perhaps 6-7.
53	Royal College of Physicians of Edinburgh	Statement 4	Renal impairment is one of a number of factors which may impact on clinician ability to maximally titrate ACE inhibitor, ARB or diuretic therapy for heart failure. However, using renal impairment as an outcome measure is non-specific. Other conditions and comorbidities could be causative for renal impairment. For example, how would causality be attributed to CHF treatments? How would pre-existing renal impairment be accounted for? How are other adverse reactions to CHF treatments to be reported, e.g. significant bradycardias, orthostatic hypotension, and falls secondary to other agents such as beta blockers?

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54	RCGP	Statement 4	Can the heart failure medication review be done by any modality (eg phone review)? It would be more likely to occur if it were not done just face to face. This would allow clinical discretion to be used to identify which patients would benefit most from a face to face review. (MJ)
55	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 4	In order for this outcome to be measured services need to have robust audit tools. Titration will often occur in community settings not covered by the national heart failure audit.
56	British Heart Foundation	Statement 4	We think that the timing of a review following a change in medication will be very dependent on individual patient circumstances. Some patients tolerate changes in medication very well, but others – often older patients with co-morbidities – need re-assessment earlier than two weeks, to avoid adverse drug reactions, particularly dehydration during an acute intercurrent illness. We would also query whether the denominator for this statement should be the number of patients who have a change in their chronic heart failure medication, rather than the number to a dose or type of chronic heart failure medication, as this may be difficult to ascertain.
57	British Society for Heart Failure	Statement 4 Question 1	The BSH supports this QS as a key area for quality improvement.
58	British Society for Heart Failure	Statement 4 Question 2	Lack of specification about who is responsible for this review affects measurability.
59	Royal College of Physicians of Edinburgh	Statement 5	We agree that adults with chronic heart failure should have a review of their condition at least every 6 months.
60	Royal College of Physicians of Edinburgh	Statement 5	Would mortality secondary to CHF be the primary outcome to consider in relation to effectiveness of regular review? What quality of life (QOL) scoring tool is to be used? CHF disease specific QOL measures or a more generic QOL score which may reflect other comorbidities? Obtaining and recording QOL scores in patients in a clinical setting is time consuming and labour intensive even in a research context. Does the advisory committee have evidence to indicate these data can be reliably and comprehensively collated in routine clinical practice?

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61	Medtronic Limited	Statement 5	Medtronic welcomes this draft quality statement to “have a review of their condition at least every sixth months. This will allow the healthcare professional to assess where there has been any deterioration in their condition, if their medication should be changed and if other procedures (such as cardiac resynchronisation therapy) should be considered and whether referral to another member of the multidisciplinary team is needed”. This quality statement will assist in bridging the knowledge gap for this treatment option in primary care as well as inequity in access to cardiac resynchronisation therapy devices which was highlighted in the briefing document.
62	RCGP	Statement 5	This standard of a 6 month review has very real resource issues - it must be worded “if appropriate”. If the patient has stable CCF as many patients do (as laid out in NICE’s own introduction to these standards), then this is an inefficient use of resource. This burden will inevitably fall on over stretched primary care. (MJ)
63	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 5	Reviewing heart failure patients 6 monthly will help to maintain stable care. However unless the review is undertaken by a member of the cardiology MDT then appropriate referral criteria for further interventions may not be known. ECG should be undertaken to detect any abnormalities or indication for further intervention such as device therapy, cardiac rhythm assessment is too vague and a simple pulse check will not capture that information. All patients with heart failure should specifically be referred to a heart failure nurse as the evidence suggests that this improves adherence and readmissions due to heart failure and is cost effective.
64	Novartis Pharmaceuticals UK Ltd	Statement 5	**The importance of specialist input** Whilst the outcomes for people diagnosed with heart failure have often been compared to those of the worst cancers, the National Heart Failure Audit suggests that patients receiving specialist input through a multidisciplinary team set-up “can do much better”.[7] Evidence suggests that ensuring that every heart failure patient has access to a multidisciplinary heart failure team led by a specialist can be an important means of improving clinical management, patient outcomes and reducing the burden of hospital readmission rates.[8] The most recent National Heart Failure Audit also indicates that patients who received specialist input into their management were more likely to receive optimal care and be more stable prior to discharge, which translates into better outcomes including fewer early readmissions to hospital and lower mortality rates.[7]

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			We note that Quality Statement 6 from the original Quality Standard for CHF has been removed from the updated guidance ('People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for them'). In light of the significant benefits that specialist input can provide in terms of patient management and improved outcomes, it is important that the remaining Quality Statements clearly make this case, in the context of service providers, healthcare professionals and commissioners. In particular, we suggest that Quality Statement 5 should include the phrase 'by a member of the multidisciplinary specialist team' within the Statement wording.
65	British Heart Foundation	Statement 5	We agree with this statement. We think that the definition of the review should include the patient's weight.
66	British Society for Heart Failure	Statement 5 Question 1	The BSH supports this QS as a key area for quality improvement.
67	British Society for Heart Failure	Statement 5 Question 2	Lack of specification about who is responsible for this review affects measurability.
68	Association for Palliative Medicine	Statement 6	Says "Health care 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. This is the only mention of palliative care that we can see, and it seems a strange place to include it when it hasn't been mentioned elsewhere. There is a wide body of literature supporting access to palliative care for patients with heart failure. Not all patients would need to see palliative care – they should be referred according to symptom burden, or if they have complex advance care planning needs, as outlined above.
69	Association of Chartered Physiotherapists in Cardiac Rehabilitation	Statement 6	Add: 'Cardiac rehabilitation has also been shown to reduce re-admission rates (Davies et al. Cochrane Database Syst Rev 2010)'
70	Association of Chartered Physiotherapists in	Statement 6	Is this aimed at newly diagnosed who have not yet participated in CR so their suitability for cardiac rehab is reviewed and for anyone who has had a step change in their HF condition and functioning. Or is this for all

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	Cardiac Rehabilitation		adults with stable chronic heart failure for the rest of their lives? The latter would put a huge strain on CR resources if all HF patients were able to be re-referred back to CR every 6 months.
71	Association of Chartered Physiotherapists in Cardiac Rehabilitation	Statement 6	**Data collection:** Currently the national audit of cardiac rehabilitation (NACR) captures the number of heart failure patients referred to an individual cardiac rehabilitation programme plus outcome measures for quality of life (Dartmouth coop and Minnesotta LHFQ) but the database does not record changes in self management of symptoms.
72	Association of Chartered Physiotherapists in Cardiac Rehabilitation	Statement 6	There are no standard systems in place to record 6 monthly discussion of cardiac rehabilitation by health professionals or for measuring hospital inpatient stays, re-admission rates or mortality rates in relation to cardiac rehabilitation participation.
73	Royal College of Physicians of Edinburgh	Statement 6	We agree with the overall statement although it may not be necessary to offer rehabilitation services every 6 months.
74	Royal College of Physicians of Edinburgh	Statement 6	We would like to see more information on how this would be measured – again, which QOL tool will be used and will this be undertaken by patient or clinician? The same comments around consumption of time and resource pertain.
75	British Association for Nursing in Cardiovascular Care (BANCC)	Statement 6	Despite stating that cardiac rehabilitation should be open to all the quality statement only offers group rehabilitation and no home programmes for housebound patients. A more specific content rather than a psychological component is required, such as access to counselling & clinical psychologist as required. All patients should have 6 monthly anxiety & depression screening. Data source – Self management. There needs to be specific indicators for evidence of self management as this term is ambiguous. Discussing with patients every 6 months their desire to be referred to rehab is too frequent. Would patients who have undertaken rehab be excluded from the need for repeat review in the data collection process?
76	Novartis Pharmaceuticals UK Ltd	Statement 6	**Empowering patients** In light of the proposed removal of Quality Statement 10 included within the original CHF Quality Standard 'People admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP' we suggest that the revised Quality Standard could be improved by more clearly emphasising the importance of empowering patients and their carers to better manage their condition.

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			In particular, the rationale included within Quality Statement 6 'cardiac rehabilitation programme' should make reference to the need for cardiac rehabilitation programmes to empower patients to help manage their condition. Utilising the Quality Standard to help empower heart failure patients would also align it with a key ambition set out in the NHS Five Year Forward View, that of helping patients to make informed choices of treatment, managing long-term conditions and staying healthy.[9] Evidence indicates that better understanding of care instructions is associated with improved patient outcomes and reduced readmission rates.[10] Patients who do not adhere to recommended clinical guidelines in terms of managing their symptoms and wider lifestyle risk factors are more likely to have decreased time to readmission.[11]One of the most positive actions a heart failure patient can make in regards to improving their outcomes is identifying how they can manage their symptoms and keep their condition under control.[12]
77	British Heart Foundation	Statement 6	We support the inclusion of a statement in this quality standard on adults with chronic heart failure being offered a cardiac rehabilitation programme. However, we think the rationale for the statement should be expanded from people having 'greater opportunities to return to work' to also cover other activities, which could include hobbies, physical activity, volunteering etc, given that heart failure patients are likely to be older.
78	British Society for Heart Failure	Statement 6 Question 1	The BSH supports this QS as a key area for quality improvement.
79	British Society for Heart Failure	Statement 6 Question 2	Baseline data for this item could be collected through QOF.
80	NHS England	No comments	Thank you for the opportunity to comment on the above Quality Standard. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
81	Department of Health	No comments	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
82	Royal College of Nursing	No comments	This is to inform you that the Royal College of Nursing have no comments to submit to inform on the above draft quality standard consultation at this time.

Registered stakeholders who submitted comments at consultation

The following stakeholders submitted comments in response to the consultation:

- Association for Palliative Medicine
- Association of Chartered Physiotherapists in Cardiac Rehabilitation
- Barnsley Hospital NHS Foundation Trust
- Bayer plc
- Boston Scientific
- British Association for Nursing in Cardiovascular Care
- British Cardiovascular Society
- British Heart Foundation
- British Society for Heart Failure
- Department of Health
- Medtronic Limited
- NHS England
- Novartis Pharmaceuticals UK Ltd
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Physicians

- Royal College of Physicians of Edinburgh
- Royal Devon & Exeter NHS Foundation Trust