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Quality standards

Consultation summary report: Chronic heart failure in adults (update)

Quality Standards Advisory Committee post-consultation meeting: 19 October 2022

1. Introduction

The draft quality standard for chronic heart failure was made available on the NICE website for a 4-week public consultation period between 18 July and 19 August 2022. 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.

Comments were received from 16 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.

1. 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. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Stakeholders were also invited to respond to the following statement-specific questions:

Statement 5: Could the population for this statement be written as ‘adults with chronic heart failure?

Statement 6: Could the population for this statement be written as ‘adults with chronic heart failure’?

1. General comments

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

* There was general support for the quality improvement areas and agreement that they are relevant, including comments on improving patient access to treatment such as N-terminal pro-B-type natriuretic peptide (NT-proBNP) testing and cardiac rehabilitation, and cost, resource and efficiency savings from NT-proBNP testing in primary care and conducting the test before echocardiography.
* Stakeholders flagged that there have been changes in current practice regarding treatment options for heart failure with reduced ejection fraction (HFrEF) since the last update of the source guideline, and that these are reflected in some non-NICE guidance.
* Stakeholders raised that there were no specific statements for patients with heart failure with preserved ejection fraction (HFpEF), and that greater emphasis should be given to those patients.
* There was some concern that merging existing quality standards 1 and 2 (updated as draft statement 2) will result in loss of clarity on where quality improvement needs to happen in the care pathway.

### Consultation comments on data collection

* There were concerns about the quality of coding in heart failure.
* There were comments outlining that additional or modified systems may need to be used for local data collection, for example for collecting data on when NT-proBNP testing is used, auditing routine reviews, and auditing referral and uptake of cardiac rehabilitation.
* Data sources such as NHS Cardiac Pathways Improvement Programme, Hospital Episode Statistics (HES), National Audits including National Institute for Cardiovascular Outcomes Research (NICOR) and CV Prevent, and NACR were suggested for inclusion.
* There were general comments about the ability of primary and secondary care systems to share data.

### Consultation comments on resource impact

* There were comments on the capacity of the workforce to carry out the quality statements and undertake data collection, though it was noted there are systems in place to do so.
* There were comments on variation in access to NT-pro-BNP across the country, including that this was not likely to significantly improve in the short term.
* There was concern about the capacity of primary and secondary care to meet some of the statements in general terms, and reference to high waiting list numbers, including those waiting over a year. This includes meeting 2 week timescales to refer for specialist assessment and transthoracic echocardiography, capacity to conduct reviews of medication, capacity to conduct 6 monthly reviews of stable chronic heart failure (CHF), and capacity to deliver cardiac rehabilitation.
* It was raised that some services such as heart failure multi-disciplinary teams (MDTs) and cardiac rehabilitation aren’t always locally commissioned to provide care for HFpEF.
* Lack of staff and capacity in certain roles, with variation across the country, was highlighted, particularly for heart failure specialist nurses, cardiac physiologists, sonographers to carry out echocardiography and advanced care practitioners.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT‑proBNP) measured. **[new 2022]**

### Consultation comments

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

* There was strong support from stakeholders for this statement as an area for quality improvement.
* There was some concern over the degree of knowledge of symptoms of heart failure in primary care.
* It was suggested to clarify that the target population for the statement would not have an existing diagnosis of heart failure.
* There was a suggestion to specify that the measurement should be urgent.
* There was a suggestion to change the wording of the process measure to ‘the number of adults diagnosed with heart failure by specialist assessment and echocardiography’.

### Issues for consideration

#### For discussion:

* Do we need to add any more information to the definitions or audience descriptors?
* Should the denominator for the process measure specify that diagnosis was by specialist assessment and echocardiography.

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 2

Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. **[2011, updated 2022]**

### Consultation comments

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

* There was general support for this statement being a measurable and auditable area for quality improvement in heart failure care, and mention of the measures being appropriate for that purpose.
* There was a concern that waiting times of up to a month for access to the NT‑proBNP blood test will delay access to specialist assessment and transthoracic echocardiography.
* It was suggested that the specialist assessment and the transthoracic echocardiography should occur concurrently.
* It was suggested to highlight that all suspected heart failure patients should be referred even if not prioritised due to NT‑proBNP level.
* There was a suggestion to reference the definitions of high and very high NT-proBNP within the statement.
* There was a suggestion to specify that a comprehensive geriatric assessment should be part of the specialist assessment.
* There were requests to retain the definition of specialist that is currently included in statement 2 based on recommendation 1.1.1. in NG106.
* There was a suggestion to clarify that the statement is for adults with suspected heart failure presenting in primary care.

### Issues for consideration

#### For discussion:

* Do we need to confirm that all patients with suspected heart failure should be referred even if not prioritised due to NT‑proBNP level?
* Is there risk that waiting times for NT‑proBNP level results before referral could lead to delays in accessing specialist assessment and transthoracic echocardiography?
* Should the statement specify that the adults with suspected heart failure are presenting in primary care?
* Should we define specialist?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 3

Adults with chronic heart failure who have reduced ejection fraction receive all appropriate medication at target or optimal tolerated doses. **[2011, updated 2022]**

### Consultation comments

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

* Stakeholders indicated that early intervention is important and that sodium-glucose cotransporter-2 inhibitor (SGLT2i) medication should be introduced alongside angiotensin-converting enzyme inhibitor (ACEi), angiotensin II receptor blocker (ARB), beta-blocker and mineralocorticoid receptor antagonist (MRA) treatments (four pillars), prior to optimisation of dose.
* Stakeholders suggested that the focus on gradually increasing medication dose is inappropriate and it is preferable to optimise relevant medication as soon as possible.
* Stakeholders queried why angiotensin receptor-neprilysin inhibitor (ARNI) medication was not included in the definition of appropriate medication.
* The statement should include people with HFpEF as medicines are becoming available for this population.
* It was suggested that detail on how the medication should be optimised should be included within the supporting information
* There was a suggestion to specify that process measures exclude those with a contraindication to each medication.
* It was suggested that the rationale should mention management of co-morbidities, remote optimisation, personalised care and support planning.

### Issues for consideration

#### For discussion:

* The draft statement reflects current NICE guidance. Is it helpful in the current context? What is our rationale?
* How should the statement approach optimisation of medication?
* Which medications should be included in the definition?
* Which factors should we note when explaining that achievement of the process measures is not expected to be 100%?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 4

Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication. **[2016]**

### Consultation comments

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

* Stakeholders suggested that the medications included in reviews should be specified, as SGLT2i do not routinely require a review, and in some cases may affect test results in ways that cause concern.
* The focus should be on optimisation of medication rather than ‘change’ or ‘review’ of medication.
* It was suggested that remote and digital monitoring could be used in achievement of this statement.
* It was highlighted that the statement should include change in diuretics dose and prognostic medication.
* There were concerns that data measuring may be difficult for the statement due to recording of changes in medication and reviews when patients present with multiple conditions.

### Issues for consideration

#### For discussion:

* Do we need to define medication?
* Do we need to include remote and digital monitoring?
* Are the measures feasible?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 5

Adults with stable chronic heart failure have a review of their condition at least every 6 months. **[2011, updated 2016]**

### Consultation comments

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

* There was general support from stakeholders for this statement as an area for quality improvement, and feedback that it is measurable through QOF and primary care data.
* Stakeholders highlighted the importance of people self-monitoring their condition.
* It was raised that people may not be monitored by heart failure multi-disciplinary teams if their condition is stable, and therefore the review may need to be carried out by primary care.
* The definition of review should include optimising their medication.
* The importance of mental health support was highlighted.
* The role of the reviews as opportunities for identifying new interventions or referral to specialists should be highlighted.
* It was suggested that review of frailty, end of life care needs and care plans be included in the definition of a review of people with stable CHF.

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

* The majority of stakeholders were in favour of changing the statement wording to be written as ‘adults with chronic heart failure’.

### Issues for consideration

#### For discussion:

* Should the statement wording be changed to ‘adults with chronic heart failure’?
* Should the definition of ‘review’ be amended?

#### For decision:

* Should this quality statement remain in the quality standard?
  1. Draft statement 6

Adults with stable chronic heart failure are offered a personalised programme of cardiac rehabilitation. **[2011, updated 2022]**

### Consultation comments

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

* There was general support from stakeholders for this statement as an area for quality improvement, and feedback that it is measurable through the National Audit of Cardiac Rehabilitation (NACR) and NICOR audits.
* Stakeholders suggested that virtual rehabilitation is referenced. This was tried in a pre-consultation draft however there aren’t appropriate recommendations available.

### Consultation question 4

Stakeholders made the following comments in relation to consultation question 4:

* The majority of stakeholders were in favour of changing the statement wording to be written as ‘adults with chronic heart failure’.

### Issues for consideration

#### For discussion:

* Should the statement wording be changed to ‘adults with chronic heart failure’?
* Is there anything that we should add about virtual rehabilitation?

#### For decision:

* Should this quality statement remain in the quality standard?

1. Suggestions for additional statements

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

* Access to palliative care (palliative care provision included as an additional area at prioritisation, NICE quality standards on [end of life care for adults (QS13)](https://www.nice.org.uk/guidance/qs13) and [care of dying adults in the last days of life (QS144)](https://www.nice.org.uk/guidance/qs144) cover this area)
* Access to advanced heart failure management in patients with HFrEF that is not responding to optimised treatments (not discussed at prioritisation stage, NG106 section 1.10 contains relevant statements)
* Device therapy (NG106 section 1.8 contains relevant statements)
* Time to organise a referral from primary to secondary care when heart failure is suspected or confirmed. (There are no recommendations on timescales for referring suspected heart failure patients from primary to secondary care when heart failure is suspected or confirmed in NG106)
* Early identification and care planning for patients who are frail or are approaching end of life (There are no recommendations on care planning specific to frailty or end of life in NG106)
* Management of exacerbation of the condition (There are no recommendations on management of the condition specific to exacerbation in NG106)
* Management post-discharge from hospital (NG106 recommendations 1.1.5 and 1.1.6 are relevant to this suggestion)
* Statements on HFpEF including access to a specialist, loop diuretic treatment, and management of co-morbidities (HFpEF loop diuretics and specialist advice was not progressed at prioritisation, NG106 recommendation 1.6.2 is relevant to this suggestion)
* Multidisciplinary care assessment and management of an older person with heart failure (MDTs were not progressed at prioritisation, NG106 recommendation 1.1.3 is relevant to this suggestion)

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# Appendix 1: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
|  | Alliance for Heart Failure | General | The Alliance broadly supports the statements and rationale of the quality standards. We believe they will see more patients given access to NTproBNP (N-terminal (NT)-pro hormone BNP) testing and cardiac rehabilitation. These are the two areas of care we prioritised in our 2021 Call to Action report.  However, there are some areas in which we have concerns. Firstly, the Alliance believes that the quality standard should closer reflect the clinical guideline, which includes the latest recommended treatments such as ARNI (Angiotensin Receptor-Neprilysin Inhibitor) as per UK and international guidelines. At present, the proposed QS omits any reference to ARNI which is incongruent with the guideline that underpins it (NG106).  Furthermore, there are some statements we believe could be better worded to optimise heart failure treatment and better serve available resources. We have proposed these alterations below. |
|  | AstraZeneca | General | **Summary**  The draft NICE Quality Standard for Chronic Heart Failure (HF) in Adults reflects the recommendations made in the NICE clinical guideline Chronic HF in adults: diagnosis and management (NG106) which was last updated in 2018. Since then, there have been significant changes to the treatment landscape with respect to both newly NICE recommended therapies for the treatment of HF with reduced ejection fraction (HFrEF) and updated guidelines from major professional cardiology organisations including ESC and AHA/ACC/HFSA which have introduced and endorsed the four-pillars of care for HFrEF as the gold standard management strategy, which includes the addition of an SGLT2i.[[1]](#endnote-1),[[2]](#endnote-2) Furthermore, NG106 was developed before recent advancements in the treatment landscape for patients with HF with left ventricular ejection fraction (LVEF) >40% (mildly reduced ejection fraction [HFmrEF] or preserved ejection fraction [HFpEF]).  The current draft quality standard therefore fails to capture many of the areas of best practice, advancement and innovation within HF which have evolved across the last 4 years, making it **regressive compared with current practice in many regions which are early adopters of the four-pillars approach**, and **not aspirational enough** for those which are yet to transition. |
|  | Boehringer Ingelheim | General | BI recognises the progression of QS to reflect advances in HF treatment and management have been captured. |
|  | British Geriatrics Society | General | **The BGS recommends a multidisciplinary integrated care approach to older people with heart disease.**  It is imperative that we address the need for a collaborative multidisciplinary approach to the assessment and management of an older person with heart failure. There is strong evidence to suggest that patients who have a multidisciplinary assessment will have better outcomes.  Optimal management of older adults with cardiac conditions involves integrating pertinent guideline recommendations with each unique patient’s personal preferences using a process of shared decision-making (<https://www.bgs.org.uk/resources/silver-book-ii-holistic-assessment-of-older-people>). Shared decision making to generate a management plan that best fits the individualised personal goal and has the best balance of added value versus risks and burden.  The older cohort of patients frequently display age-related physiological impairments, multimorbidity and geriatric syndromes such as frailty, sarcopenia, functional and cognitive impairment.  Targets:   * Comprehensive geriatric assessment (a multi-dimensional interdisciplinary approach to determine the medical, psychological, and functional needs of older patients in order to develop a coordinated and integrated plan for treatment and long term management) * Multidisciplinary “Heart Failure” approach * Assess for degree of frailty (Clinical Frailty Scale) to predict outcome, aid decision making and individualised management plans. Frailty has consistently been shown to significantly predict mortality and postoperative outcomes. We suggest the use of a standard measure, such as the Clinical Frailty Scale (CFS). * Individualised management plans * Maintain independence, reduce harm, reduce treatment burden, lengthen, improve quality of life * Database and regular data review for heart failure in older people * Further research into heart failure in older people   S Conroy. Silver Book II: Quality urgent care for older people (2021) <https://www.bgs.org.uk/resources/silver-book-ii-holistic-assessment-of-older-people>  Ellis G, et al. “Comprehensive geriatric assessment for older adults admitted to hospital.” The Cochrane database of systematic reviews vol. 9,9 CD006211. 12 Sep. 2017, doi:10.1002/14651858.CD006211.pub3  S G Parker, P McCue, K Phelps, A McCleod, S Arora, K Nockels, S Kennedy, H Roberts, S Conroy, What is Comprehensive Geriatric Assessment (CGA)? An umbrella review, Age and Ageing, Volume 47, Issue 1, January 2018, Pages 149–155, <https://doi.org/10.1093/ageing/afx166>  Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ. 2005;173(5):489-495. doi:10.1503/cmaj.050051  Van Grooten B, Jeuris A, Jonckers M et al. Geriatric co-management for cardiology patients in the hospital: A quasi-experimental study. Journal of the American Geriatrics Society 2021;69 (3) |
|  | NHSE | General | 1. the consultation and the proposed changes. 2. There are current and ongoing negotiations to revise an existing heart failure QOF indicator to ensure people with suspected heart failure receive the appropriate diagnostic tests and diagnosis prior the entering the register. The outcomes of the NICE consultation should be aligned to any changes with QOF and vice versa.   To support the equality and health inequalities impact assessment, we highlight the components of the [Comprehensive Model for Personalised Care](https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf). A personalised care approach should be considered within the further information of the quality statements. A personalised care approach includes supported self-management, personalised care and support planning, advance care planning and shared decision making. Health and care professionals should tailor their approaches to working with people based on the person’s level of health literacy, individual assets, needs and preferences, as well as taking into account inequalities and barriers to access. This is important when in the context of patient choice and delivering care closer to home. |
|  | NHS Surrey Heartlands ICB | General | N/A |
|  | Novartis Pharmaceuticals UK Ltd | General | In general, we support and welcome the overall updates to QS9. We particularly welcome the explicit clarifications made to the diagnostic statements (1 & 2) on use of NT-proBNP testing in primary care and the sequencing of the test before further investigations are ordered using echocardiography. This represents an area of cost, resource and efficiency saving for the NHS. Some questions remain around the degree to which NT-proBNP tests are accessible to HCPs through local commissioning structures depending on geography (particularly in primary care), as well as the role of the newly forming Community Diagnostic Centres in improving access to the blood test.  We do have some concerns that the Quality Statement still does not include reference to angiotensin receptor-neprilysin inhibitors (ARNI) in the treatment mix for heart failure, despite clear NICE guidance recommending its use (see comments against Q1 below). Additionally, we believe there is scope to clarify the role of medicines optimisation within the Quality Standard (statements 4 & 5) by emphasising optimisation of medication rather than ‘change’ or ‘review’ of medication.  Finally, the healthcare system faces challenging workforce conditions which may impact local services (including data collection), particularly in the primary care setting, where resources and capacity are particularly stretched. We welcome the ambition set out in the NHS Long Term Plan to increase the number of heart failure specialist nurses and other specialists to support the implementation of the statements set out in this updated Quality Standard. |
|  | Primary Care Cardiovascular Society | General | In general the sentiments underpinning the draft QS for Heart failure but have significant reservations related to some as indicated below. |
|  | Royal College of Nursing | General | The QS is reflective of core ambitions within the NICE HF guidance |
|  | Royal College of Nursing | General | There are systems in place to gather the appropriate data |
|  | Royal College of Nursing | General | We would like to highlight that workforce continues to be a challenge in primary care and whether these recommendations are achievable in that context. |
|  | Sussex Health & Care Partnership | General | Regarding the way the standard is worded potentially changes the timeline or the diagnosis or exclusion of heart failure.  Linking the 2 week and 6-week targets for echo to the result of the NTproBNP potentially prolongs the time to diagnosis.  The guidelines initially required an echo within 2 weeks or 6 weeks of suspecting heart failure; now it is dependent on the time to phlebotomy and analysis of the test.  Previously when carrying out education sessions on NP it was apparent that some people can wait up to a month for the NP blood test. |
|  | UKCPA | Overall | The standards are heavily focused towards HFrEF, due to the majority of treatment evidence being in this type of heart failure. Greater emphasis is needed for the HFpEF population if they are to have equal access to services. |
|  | University Hospitals Birmingham | General | There is no mention of sacubitril valsartan. In current practice, we are switching all patients on ACE/ARAs to ARNI |
|  | Alliance for Heart Failure | Question 1 | We disagree with the statement that proposal one and two be merged. Keeping the statements separate would ensure those with a very high level of NTproBNP are referred urgently for echocardiogram and specialist care. Merging the statements would result in a loss of transparency over where in the diagnostic pathway improvements should be made. |
|  | AstraZeneca | Question 1 | [***Statement 1***](#_Quality_statement_2:) ***Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT‑proBNP) measured. [new 2022]***  AstraZeneca support this statement; the early, proactive recognition and testing of patients with suspected HF using natriuretic peptides is appropriate and of high importance, particularly for primary care physicians. We understand that despite the high importance of NT-proBNP testing as the first step to diagnosis after clinical suspicions are recognised, that testing rates remain highly variable throughout England and the UK. Access to, and commissioning of testing is also reportedly nonuniform across the country which poses inequality of care concerns. Encouraging best practice with respect to NT-proBNP testing in conjunction with earlier access to a specialist (statement 2) is therefore a positive step towards earlier diagnosis and appropriate management for all patients with HF.  The proposal to merge statements one and two is not supported by AstraZeneca. Keeping the statements separate increases the emphasis on patients with very high levels of NTpropBNP being referred urgently for echocardiogram and specialist care. Merging the statements may reduce transparency and clarity on where in the diagnostic pathway improvements should be made.  **------------------------------------------------------------------------------------------------------------------------------------------**  [***Statement 2***](#_Quality_statement_2:_1) ***Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]***  AstraZeneca support this statement; the focus on early referral for specialist assessment and transthoracic echocardiography linked to the results of NT-proBNP levels supports early diagnosis of HF which is of high importance. It is important to note that best practice entails access to a specialist ***at the same time*** as early echocardiography, and that delays between the echo and contact with a specialist should be avoided.  Whilst statements 1 and 2 are helpful in instilling best practice around early identification and diagnosis of patients with HF, the next step in the process of optimising and driving efficiencies in HF care is currently omitted, namely ***early initiation*** and ***optimisation*** of therapies. As discussed below in response to statement 3, the four-pillars approach to treating HFrEF advocates for the early introduction of 4 cornerstone disease modifying agents, angiotensin-converting enzyme inhibitors (ACEi) / angiotensin receptor-neprilysin inhibitors (ARNI), beta-blockers, mineralocorticoid receptor antagonists (MRAs) and sodium-glucose cotransporter 2 Inhibitors (SGLT2is), with this approach now globally recognised to offer mortality and morbidity benefit.1,2  ***Suggested changes based on comments above:***  **Current:** “Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]”  **With proposed changes:** “Adults with suspected heart failure have ***concurrent*** specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]”  **------------------------------------------------------------------------------------------------------------------------------------------**  [***Statement 3***](#_Quality_statement_3:) ***Adults with chronic heart failure who have reduced ejection fraction have their medication gradually increased until the target or optimal tolerated doses are reached. [2011, updated 2022]***  This statement is not appropriate in its current format for three reasons summarised below:   1. These standards aim to optimise uptake of recommendations made in NG106, and as mentioned above, this guideline does not appropriately incorporate recommendations for all NICE recommended treatments for HFrEF which now constitute standard of care (SoC), such as the recommendations set out in NICE TA6793 and TA773.4 2. The focus on gradual increase of medication dosage is misaligned with the current best practice approach outlined in the 2021 ESC1 and the 2022 AHA/ACC/HFSA2 guidelines as part of the four pillars approach. 3. The exclusion of recommendations for patients with HF with LVEF ≥40% does not reflect the rapidly evolving treatment landscape for this underserved population with no disease modifying treatment options until 3 months ago.   **Further evidence and rationale for each area of concern**   1. **NG106 does not adequately include recommendations for all SoC HFrEF therapies**   As mentioned above, since these guidelines were developed, NICE has appraised and provided positive recommendations for the use of two SGLT-2is for the treatment of patients with HFrEF, namely dapagliflozin (TA679; 2021)[[3]](#endnote-3) and empagliflozin (TA773; 2022).[[4]](#endnote-4) Both the 2021 ESC1 and the 2022 AHA/ACC/HFSA2 guidelines for the management of chronic HF provide the highest level of recommendation (A1) for the use of dapagliflozin and empagliflozin in patients with HFrEF. Currently, NG106 briefly references these technology appraisals at the start of section 1.4 ‘Treating HF with reduced ejection fraction’, but no recommendations are provided in the body of the guideline. AstraZeneca note that this contrasts to the approach taken for sacubitril valsartan and ivabradine when NG106 was last updated, when the recommendations for their use made in TA388 and TA267, respectively, were copied directly into the guideline, without further modification or evidence assessment. This is one of several ways that NG106 is now out of date and why statement 3 in this quality standard cannot be expected to drive best practice.  NG106 requires updating to align with SoC management, particularly with respect to the pharmacological treatment sections. Recognising that a full GL update is time and resource intensive, and in line with NICE’s commitment to developing ‘living guidelines on priority topics’ laid out in the NICE 5-year strategic plan,[[5]](#endnote-5) AstraZeneca suggest that the recommendations made by NICE for dapagliflozin and empagliflozin for the treatment of HFrEF in their respective TAs are reflected directly in the guideline until a full guideline update is undertaken. Since this would require no evidence review or consultation, as with sacubitril valsartan and ivabradine, this change could be considered editorial in nature with the purpose of better alignment and consistency between NICE guidance documents, whilst ensuring that statement 3 works to optimise treatment with all appropriate medicines.   1. **The focus on ‘gradual’ increase of medication dosage is misaligned with the current best practice four pillars approach**   The guidance provided in NG106 and reflected in this quality standard doesn’t match current evidence and consensus on treatment course. The rationale provided for statement 3 includes the following statement:  *“People taking these medicines should be started on low doses, and have the doses gradually increased where appropriate, with regular checks to monitor any side effects, until the target or optimal tolerated doses are reached”.*  This statement reflects recommendations in NG106 with respect to titration of ACEi, ARB, beta-blocker and MRA treatments, which are based on the previous and now outdated clinical guidance and opinion which also recommended HF treatments should be initiated in a sequence that follows the chronological order in which trials were conducted.6 However, there is now increasing evidence that patients should be optimised rapidly on all of the four-pillar HFrEF treatments in order to gain the maximum possible benefit.[[6]](#endnote-6) The 2022 AHA/ACC/HFSA guidelines state that *“Initiation and titration should be individualized and optimized without delay”* and that *“simultaneous initiation or sequencing, and order of guideline-directed medications are usually individualized…//... and does not necessarily need to be done according to the sequence of trial publications and should not be delayed”.*  A recent study modelled the accelerated up-titration schedule and optimised ordering of four-pillars treatments using data from 6 pivotal trials in HFrEF.6 The results indicate the most effective treatment sequences were those starting either with an SGLT2i or an MRA, owing to SGLT2is being administered in a single fixed dose and MRAs have a maximum of two dose steps standard which allowed a reduction in total up-titration duration from 24 weeks with standard practice to 12 weeks. On this accelerated 12-week up-titration schedule initiating treatments in the following order: SGLT2i à MRA à beta-blockerà ARNI could avoid at least 14 deaths from any cause and 47 patients experiencing HF hospitalisation or cardiovascular death per 1000 treated over the first 12 months of treatment. This research strongly indicates that historic treatment guidance on dose optimisation may not lead to the best treatment outcomes in patients with HFrEF and that substantial health improvements as well as cost savings could be realised with alternative approaches. Given this new evidence and the revised international cardiology guidelines, this is another element of NG106 which requires urgent update to reflect current best practice and we would urge NICE to take this opportunity to reflect this in the quality standards update.   1. **Recommendations should be adapted to incorporate patients with HF with LVEF ≥40%**   At the time of the 2018 Guidelines there were no medications licensed for use in HFpEF. This cohort of patients may represent up to 50% of HF patients overall and is likely to increase further in the future.[[7]](#endnote-7) The quality of life in patients with HFpEF is poor and often worse than patients with HFrEF,[[8]](#endnote-8) and their 5-year survival is just 35%, which is worse than many cancers.[[9]](#endnote-9) Until this year (2022), this group of patients have experienced the highest level of unmet need, with no disease modifying treatment available, and management consisting of symptom control and treatment of comorbidities. Given the recent and imminent MHRA licenses being granted for SGLT2is empagliflozin and dapagliflozin to cover the treatment of patients with a LVEF >40%, and with reimbursement for these therapies expected next year, it is appropriate to expand the wording of this statement to cover treatment optimisation in all patients with HF across the continuum of LVEF.  ***Suggested changes based on comments above:***  **Current:** “Adults with chronic heart failure who have reduced ejection fraction receive all appropriate medication at target or optimal tolerated doses. **[2011, updated 2022]**”  **With proposed changes:** “Adults with chronic heart failure receive early intervention with all evidence-based medications, with timely optimisation to target or optimal tolerated doses. **[2011, updated 2022]**”  **------------------------------------------------------------------------------------------------------------------------------------------**  [***Statement 4***](#_Quality_statement_4:) ***Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication. [2016]***  SGLT2-inhibitors do not routinely require a review following initiation and, in some cases, this may actually be detrimental depending on what follow up tests are conducted.[[10]](#endnote-10) The mechanism of action of SGLT2is cause an initial drop in eGFR due to a reduction in glomerular pressure following vasoconstriction in the afferent arteriole induced by SGLT2 inhibition. eGFR subsequently increases again over several months and henceforth the SGLT2i treatment slows progressive eGFR decline as compared with individuals not taking SGLT2 inhibitors. Conducting an eGFR test in the weeks following SGLT2i initiation is not informative and may cause unnecessary concern that could result in termination of treatment if the healthcare professional isn’t aware of the mechanism of action for this drug class. This concern was also raised by multiple stakeholders during the consultation on the NICE CKD guidelines (CG182, with recommendations on SGLT2is now included in NG28) which resulted in additional text being added to the final guideline clarifying that monitoring requirements for SGLT2is differ from RAASi therapies. Importantly, in recognition of this risk the UK Kidney Association guidelines on the management of chronic kidney disease recommend that testing is not required following initiation of an SGLT2i.[[11]](#endnote-11)  AstraZeneca suggest that this statement should explicitly name the medications for which monitoring is thought to be essential, such as for RAASi therapies where monitoring for hyperkalaemia for example is required. This will ensure that patients and the healthcare system are not being unduly burdened with unnecessary appointments, will optimise opportunity costs and will help to mitigate against clinical inertia in the up-titration of evidence-based medications.  ***Suggested changes based on comments above:***  **Current:** “Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication**. [2016]**”  **With proposed changes:** “Adults with chronic heart failure started on ACEi/ARB/ARNI or MRA have a review within 2 weeks of any change in the dose or following a change to or addition of any of these medications**. [2016]**”  **------------------------------------------------------------------------------------------------------------------------------------------**  [Statement 5](#_Quality_statement_5:) Adults with stable chronic heart failure have a review of their condition at least every 6 months. **[2011, updated 2016]**  AstraZeneca supports this statement and believes it to be appropriate and important.  **------------------------------------------------------------------------------------------------------------------------------------------**  [Statement 6](#_Quality_statement_6:) Adults with stable chronic heart failure are offered a personalised programme of cardiac rehabilitation. **[2011, updated 2022]**  AstraZeneca supports this statement and believes it to be appropriate and important. |
|  | Boehringer Ingelheim | Question 1 | Rewarding to see quality standards relating to HFREF however 50% of HF patients have HF with a Preserved ejection fraction. We believe that a separate quality standard should be introduced to ensure that these patients get a good quality of care which could include access to a specialist, loop diuretic treatment and management of co-morbidities.  Furthermore, NICE are currently reviewing the cost effectiveness of the first class of medication to have prognostic benefit in this population and following that guidance we would hope for a timely inclusion of this important treatment option |
|  | British Cardiovascular Society | Question 1 | Yes, although lacks specifics on how exactly medications are to be optimised. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Question 1 | Yes |
|  | British Society for Heart Failure | Question 1 | All areas covered are relevant. However, additional elements that should also be considered for inclusion…  • A statement on palliative care/ advanced HF management in patients with HFrEF not responding to optimised treatments.  • Statement on consideration of device therapy. |
|  | NHSE | Question 1 | 4. We agree the current quality statements remain key areas for quality improvement in chronic heart failure.  5. Other key areas for quality improvement to be considered include, (1) co-morbidity optimisation in patients with heart failure with for example diabetes, chronic kidney disease etc. and (2) early identification of patients with frailty or at end of life and ensuring care plans are put in place.  Yes - draft quality standards accurately reflect the key area for quality improvement. |
|  | NHS Surrey Heartlands ICB | Question 1 | No- it covers the main areas of diagnosis; up titration and management; referral for cardiac rehab; ongoing six monthly review; it does not cover exacerbation management or post discharge from hospital management focusing instead on new diagnosis and not existing caseloads.  Yes, the quality standards accurately reflect the key areas for quality improvement |
|  | Novartis Pharmaceuticals UK Ltd | Question 1 | The updated Quality Standard makes welcome incremental improvements on the previous iteration of the document. The explicit addition of Statement 1 on NT-proBNP measurement is particularly welcome. As is the clarity applied to the appropriate sequencing of NT-proBNP testing before the use of more costly and resource intensive echocardiography, in Statement 2. A question mark remains around the non-universality of access to NT-proBNP testing (geographic disparity resulting in a ‘postcode lottery’ for access) and how this will be addressed to ensure equity of access to the blood test across the whole country, in efforts to eradicate health inequalities. For example, the role of the newly established Community Diagnostic Centres (see response to question 3) is unclear with regards to improving access to and availability of NT-proBNP testing but represents an area of high potential and promise to address inequity of access.  We have concerns that Quality Standard Statement 3 fails to reflect the latest clinical guidance and best practice. QS3 states that “Adults with chronic heart failure who have reduced ejection fraction are started on low-dose angiotensin-converting enzyme (ACE) inhibitor and beta-blocker medications that are gradually increased until the target or optimal tolerated doses are reached. [2011, updated 2016]”; however, this still does not reflect more recent advances in best practice treatment options for adults with chronic heart failure (CHF) who have reduced ejection fraction.  The Quality Statement should be updated to specifically include the initiation (where appropriate) of angiotensin receptor-neprilysin inhibitors (ARNI) alongside beta-blocker (BB), mineralocorticoid receptor antagonist (MRA) and sodium-glucose co-transporter 2 inhibitors (SGLT2i) medications. (ACEi or ARB may be used as an alternative if ARNI is not suitable/appropriate). Doing so would bring the Quality Statement in line with the best available evidence, as reflected in the most recent UK and international guidelines set out below.  The CaReMe 2021 HF Algorithm guidance from the British Cardiovascular Society, Renal Association and Association of British Clinical Diabetologists, which has been modified from the NICE guideline for Chronic Heart Failure (NG106), recommends ARNI as first line treatment option for patients with ejection fraction <35%. The 2021 ESC Guidelines also consider ARNI as first line treatment for CHF patients, as a replacement for ACEi. The AHA/ACC/HFSA 2022 Guideline for the Management of Heart Failure recommends ARNI first line for NYHA class II -III patients with ejection fraction<40%.  The PARADIGM-HF trial by McMurray JJV, Packer M, Desai AS, et al. 20141 showed that a combination of sacubitril-valsartan (ARNI) was superior to Enalapril (ACEi) in preventing cardiovascular deaths or hospitalisation for heart failure and reducing all-cause mortality.  Reference  1. McMurray JJV, Packer M, Desai AS, et al. 2014; N Engl J Med 2014;371:993-1004 |
|  | Primary Care Cardiovascular Society | Question 1 | I think this document reflects some of the key areas with other areas highlighted in our response to the individual statements e.g urgent referral of all suspected HF with raised NT-proBNP (over 400ng/L) and HF specialist triage. |
|  | UKCPA | Question 1 | Mostly, all areas are relevant to heart failure but the QS are missing some important elements of care. Heart Failure is a long term condition with poor outcomes where 40% of patient will die within 1 year of diagnosis(1) and a poorer prognosis than most cancers.(2) It is important to ensure that patients with heart failure have equivalent access to palliative care as with other condition with poor prognosis such as cancer.  Access to palliative care or inclusion in palliative care registers should be included in the quality standards.  Complex devices are also used to improve patient outcomes and quality of life as per national and international guidelines. Ensuring patients are considered for such devices should also reflected in the standards. |
|  | Alliance for Heart Failure | Question 2 | The impact of diagnostic hubs on waiting times for echocardiography is not clear. Better data needs to be gathered on the provision of echocardiography services. |
|  | AstraZeneca | Question 2 | Diagnostic and management pathways are well-established within the National Health Service (NHS), however there are significant capacity issues in terms of echocardiography diagnostics,13 and secondary cardiac care, which can lead to long waiting times and delays to diagnosis.  Coding in HF is widely recognised to be poor. AstraZeneca believe that case-finding coupled with more accurate coding, review and optimisation should be prioritised in order to ensure patients are identified, assessed and optimally treated. |
|  | Boehringer Ingelheim | Question 2 | We recognise the challenge of collecting data on the existing stretched workforce so we would recommend that where possible data sources should include routinely collected data such as HES, National Audits (NICOR, CV Prevent), dashboards within integrated datasets. |
|  | British Cardiovascular Society | Question 2 | Most areas have systems in place to collect data for the national heart failure audit but this covers mainly care during and after an acute episode. Data to quantify outpatient quality metrics are harder to capture and will sit across primary and secondary care. This will mean the accuracy of the data collected may not be as good as would be desired. |
|  | British Society for Heart Failure | Question 2 | QOF targets for HF are outdated in relation to disease modifying medicines and stable patient review frequency (assuming stable review is intended to be done by primary care).  Other outcomes will be dependent on each area’s own auditing processes and access to technology.  NACR data will be useful in relation to statement 6. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Question 2 | No. Care is shared between the two sectors but there is no link between data collected in primary and secondary care. Different IT systems will make it very difficult to put these in place |
|  | NHSE | Question 2 | 6. The NHS Cardiac Pathways Improvement Programme has several metrics which are used to monitor programme and Cardiac Network activity against agreed programme priorities. Metrics are available to cardiac networks and their partners, at trust and ICS level, on the Model Health System.  7. Data collections that can support the quality measures include the Quality Outcomes Framework (QOF) incentives, the National Heart Failure Audit and the National Audit for Cardiac Rehabilitation. However, it can be difficult to collect data on when NT-proBNP testing is used in relation to symptoms of heart failure. It is feasible to develop a system in GP electronic patient records.  It may be hard to measure quality of cardiac rehabilitation programmes (statement 6) due to multiple variables included in the standard – it may be achievable if monitored exercise and life style changes were separated from psychological support and education. |
|  | NHS Surrey Heartlands ICB | Question 2 | No – no centralised dashboard across east Surrey place; PCNs will hold their own data and First Community holds its own but not specifically on the date being requested; systems would need to be added to manage the specific detail such as auditing referrals to ensure Bnp is recorded; auditing echo waiting times for urgent and standard echos; auditing review times post adjustment of medication; auditing routine reviews; auditing referral and uptake of cardiac rehabilitation (currently this is a service commissioned for consultant referrals from the acute trust); EQ collects data on whether patient has been seen by HF specialist within 2 weeks.  Some systems may need to be put in place, see further comments below |
|  | Novartis Pharmaceuticals UK Ltd | Question 2 | Heart failure data sets and measurement tools do exist both nationally and locally, including the National Institute for Cardiovascular Outcomes Research (NICOR) which collects clinical information from UK hospitals into secure registries established by the cardiovascular specialist societies to improve quality of care. At a local level the Quality and Outcomes Framework (QOF) and the CCG Outcome Indicator Set (CCGOIS) provide outcomes and incentive measures for primary and secondary care.  However, gaps exist in local data collection systems/structures to measure the successful implementation of the proposed quality statements. This includes the primary care Quality & Outcomes Framework (QOF) which does not contain an indicator to capture use of NT-proBNP testing, despite inclusion in the NICE guideline for chronic heart failure (NG106) and in this updated Quality Standard. It is both feasible and desirable to include an indicator measuring NT-proBNP testing (for both diagnosis and ongoing management) in the QOF indicator menu for heart failure to accurately reflect the assay’s status as an exclusion test for heart failure, before further investigations (i.e. echocardiography) are conducted. The inclusion of such a QOF indicator would add consistency to the diagnostic framework outlined in the NICE guideline NG106 and the updated QS9, while incentivising local data capture of QS Statements 1 & 2.  Given the recent formation of Integrated Care Systems (ICS) following the move away from CCGs as the primary local commissioning authorities, a question remains about how local/regional heart failure data will be collected under regional systems in future. The future use of the existing CCG Outcome Indicator Set (which includes heart failure mortality measures) within the new ICS structure is unclear and may represent an additional emerging data collection gap. |
|  | Primary Care Cardiovascular Society | Question 2 | There are not currently systems and structures in place to collect the relevant data for the draft quality statements and this would require significant investment to achieve |
|  | UKCPA | Question 2 | Some Local systems may be in place to measure the quality standards, but this is unlikely to be commonplace.  Standard 1. Measured in primary care – potentially thorough electronic systems searches but only where appropriate coding has been used.  Standard 2. Measured in secondary care. Trusts should have systems in place to monitor this outcome where heart failure services exist. This will be easier where electronic systems are in place. Early diagnosis is crucial to patient outcomes therefore, needs to be treated with the same urgency and a cancer 2 week referral. Outcomes for heart failure are worse than most cancers. (3)  Standard 3. This will depend on who is completing the gradual increase in medication and optimal will differ between for each patient. Data could be done in primary care, such information will be difficult to collect and extra resources may be required to do so.  Standard 4. This will be time consuming and difficult to measure and require extra resource to complete.  Standard 5. This could be measure from primary care systems through appropriate coding. We know that coding for heart failure in primary care is poor. Extra resource to code and collect the data would be required.  Standard 6. Currently measured in NHFA at the point of discharge from hospital. Heart failure services providing cardiac rehab or Rehab services should be able to collect data on numbers referred where rehabilitation services exist. However, those attending or completing rehab would be a better measure than those referred. |
|  | Alliance for Heart Failure | Question 3 | Clear capacity and innovation within the diagnostic space needs to be increased to ensure those most at risk of mortality from heart failure receive the best treatment at the earliest possible opportunity. |
|  | AstraZeneca | Question 3 | Based on feedback from clinicians across care settings, the lack of direct financial incentivisation associated with the NICE quality standards reduces the motivation to prioritise and meet the recommendations unless they are aligned to Quality Outcomes Framework (QOF) or Direct Enhanced Service (DES) indicators. This is likely to be especially true in current UK landscape which is still managing a Covid backlog whilst navigating a recent NHS structural reform into 42 new Integrated Care System (ICS) structures, each with common as well as unique priorities depending on their population.  With specific reference to:  Statement 2 Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]  NHS England data suggest that in December 2021, nearly half of all patients were not receiving their echocardiogram within the six-week window, and that these lists continue to grow in size. Based on this it’s clear that capacity and innovation within the diagnostics space needs to increase and improve to ensure that those at highest risk, namely untreated HF, move rapidly through diagnosis pathways and obtain access to evidence-based medications at the earliest possible opportunity.  Primary and secondary care providers cannot meet these requirements without input from HF specialist nurses, the number of which varies considerably across the UK resulting in inequitable service provision. Increasing prevalence of HF is likely to further burden specialist care centres which are already struggling with Covid backlogs. Increasing capacity and confidence across both primary and secondary care and the wider multi-disciplinary team should be prioritised.  As discussed above, potential systems-based cost-savings could be achieved by ensuring that evidence-based therapies are introduced and optimised as early as possible within the pathway6 and that monitoring post-medication changes are personalised for the patient and the medication to avoid unnecessary monitoring costs. |
|  | Boehringer Ingelheim | Question 3 | We have included responses within the statement responses below. |
|  | British Cardiovascular Society | Question 3 | Yes, although not all areas have access to NT BNP assay yet. Some still use BNP. This relates to wider procurement of biochemical tests in a region and will likely only change over the medium term (years). Heart failure is an increasing burden on society, so increasing numbers of heart failure professionals, especially specialist nurses or pharmacists, will be needed to maintain current performance against these targets, never mind improve on them. It does not seem likely that the QS will lead to any cost savings, although in theory better and quicker adherence to it might prevent HF hospitalisations. Given the progressive nature of the disease though and the overall growth in prevalence, overall HF admissions are likely to keep rising even if the QS is implemented thoroughly.  There is a national lack of echocardiographer staffing which limits capacity growth. NTproBNP is not very specific and so a wide range of patents will have an NTproBNP between 400-1999 which does prove a capacity challenge for heart failure services. |
|  | British Society for Heart Failure | Question 3 | • Significant workforce issues across the board. Access to primary care, heart failure specialist nurses/ pharmacists/ consultants and cardiac physiologists, will reduce ability to meet all standards. The fact that some of these statements have been in place since 2011 and are not being routinely met, demonstrates the clear need for an aligning workforce plan for heart failure.  • Some services are only just restoring post pandemic.  • Waiting lists for consultations and investigations are high.  • Lack of awareness of heart failure symptoms, leading to people not presenting in primary care but instead with an acute admission.  • HFpEF: the introduction highlights that these standards apply to HFpEF as well as HFrEF. Assuming this applies to all standards except statement 3 (which specifies HFrEF), this has significant resource issues. In many localities heart failure teams and cardiac rehabilitation teams are not commissioned to provide care for HFpEF. Implementing the standards is likely to require significant uplift in staff.  • Wording of the document in comparison to last draft:  The previous edition had a definition of the HF MDT and the ‘specialists’ within it. In the proposed edition this is gone. The inclusion of the definition of specialists within the MDT is useful in designing appropriate pathways of care and formulary guidance for specialist prescribing. It would be useful to continue to include this. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Question 3 | No. Currently there are insufficient staff to implement Statement 3 and therefore 4. There are insufficient specialists confident in titrating medication given recent evidence of the benefits of ARNi and SGLT2 for this cohort of patients. Evidence also suggests this is most successful if achieved within 3 months and currently insufficient resource to achieve this. Statement 2 will be limited by access to echocardiography given current national shortage of trained sonographers. Many areas do not provide funding for heart failure rehabilitation limiting access. |
|  | NHSE | Question 3 | 8. There is a significant shortfall in the number of echocardiographers to support diagnostics services and similarly with heart failure specialist nurses and advanced care practitioners who are essential for the day-to-day delivery of cardiac services. This shortfall will have an impact on achievability in the short and medium term and will likely impact on patient reviews including ensure a person is reviewed within 2 weeks of a change to dose or type of medicine.  9. There is an opportunity to optimise patient care with co-morbidities, lifestyle changes, medication optimisation and frailty and end of life care planning. This works towards reducing avoidable admissions and improving quality of life.  10. Resource requirements should consider the wider role of the multidisciplinary team and signposting to education resources and toolkits to support upskilling of existing clinical staff for example on the appropriate use of NT-proBNP testing.  Statement 6 related to rehabilitation programmes will be difficult to achieve due to variability of the provision of rehabilitation programmes. It may be possible to progress towards achievement if local government and social care organisations were involved. |
|  | NHS Surrey Heartlands ICB | Question 3 | **Statement 1** - Yes – primary care achievable; responsibility of primary care  **Statement 2** – 6 weeks is achievable and we are currently achieving it; 2 weeks will be difficult to achieve due to the timings of clinics and these would need to be reviewed as they fall on a Monday and a bank holiday will mean the loss of a clinic; the clinics are not accessible five days a week with the current commissioned service; if there is leave taken by either the GPSI or Consultant cardiologist a clinic session is lost as there is no cover; there would need to be an increase funding for community HF establishment with only 2.08 WTE staff to cover sessions; patients sometimes choose not to attend the offered slot within two weeks; location can also be an issue as the clinics alternate between north and south of the borough and this can impact on the 2 weeks wait dependent on which clinic the patient agrees to attend  **Statement 3** - Yes – achieved  **Statement 4** - Achievable but not with current resources (see above 2.08 WTE); currently can only offer a telephone review; if a clinic slot is needed where a patient needs to be examined or blood taken then it can be three weeks and longer; additional clinic space and additional resources for the HF team would mean that this would be achievable consistently; can also be influenced by pts access to phlebotomy, etc.  **Statement 5** – If this sits with primary care then it would be for them to agree if achievable or not; we don’t have the resources to pull patients back in because of only 2.08 WTE staff in the team and a caseload currently of over 260; clinic venue capacity and additional admin support also needed as currently only 0.7 WTE admin  **Statement 6** - Achievable – discussed with all patients on the caseload; suitability to attend is assessed; patients are referred to cardiac rehab team if indicated but there is limited capacity available in the existing cardiac rehab to support if there was an increase in uptake of sessions.  All of the above is only in relation to LVSD and not right sided or valvular heart failure.  More resource would be needed for statement 4, 5 and 6 |
|  | Novartis Pharmaceuticals UK Ltd | Question 3 | Human resource remains the biggest challenge in optimally diagnosing and managing heart failure. Statements 1,2 & 5 have resourcing implications for primary care teams, which are under increasing workforce pressures. For example, for GPs and other primary care HCPs to order investigation with NT-proBNP testing, they must first recognise the signs and symptoms of heart failure (breathlessness, fatigue, oedema etc.). While recognising the systemic workforce challenges faced by primary care, it may be necessary to upskill primary care HCPs on the signs and symptoms of the condition to ensure early diagnosis with NT-proBNP is prioritised (leading to specialist assessment) and that patient reviews (including appropriate medicine optimisation) are conducted in a timely manner. Therefore, upskilling in the form of primary care education programmes/materials (particularly around use of NT-proBNP tests) are likely to be needed to improve early diagnosis of heart failure and to ensure the best chance of success for the new & updated diagnostic (1 & 2) and reviews (5) quality statements.  Finally, we note that the most efficient heart failure services, leading to better patient outcomes, are those where multi-disciplinary teams (MDT) are clearly defined and established. Conversely, those areas where MDTs are not established or where services are not adequately resourced with appropriately trained HCPs, tend to experience worse outcomes. Therefore, it is crucial that a sufficient cadre of heart failure specialists (including heart failure specialist nurses, cardiologists and GPs with special interest in heart failure) are prioritised in future NHS workforce and resource planning, in line with the ambitions of the NHS Long Term Plan. |
|  | Primary Care Cardiovascular Society | Question 3 | Currently statements 1and 4 are possibly achievable though see our comments regarding statement 4. The current lack of echo resource which is not going to be addressed in the short term with direct implications for statement 2. As indicated below statement 3 is not in keeping with the current direction of travel related to managing HFrEF. Statement 5 is achievable but not if the recommended QOF review remains at one year. Statement 6 is achievable in the long term but currently very few people with heart failure have cardiac rehab therefore there would have to be significant investment in services etc to achieve this. |
|  | UKCPA | Question 3 | Standard 1. Primary care indicator – There are still areas with no access to NT-pro-BNP in the UK. Access to NT-pro-BNP should be mandatory for all primary care services. Awareness of heart failure symptoms is key to this indicator.  Standard 2. There are currently huge resource issues across the UK with echocardiography services and physiologists with many services not able to meet the demand for echocardiogram. There needs to be a massive UK wide drive for recruitment and training to ensure capacity to meet 2 and 6-week targets.  Standard 3. Heart failure services are extremely under resourced with the increase in heart failure patients and the pressure to take on the care of patients with HFpEF. In many services there are waiting lists for up-titration of heart failure medications delaying vital heart failure treatment. Heart failure services need to be adequately resourced (3-4 nurses/AHPs per 100,000 population(3)) to ensure all heart failure patients have access to a heart failure nurse/AHP and appropriate treatment.  Standard 4. This will be difficult to achieve given the current pressures for heart failure services. Work force gaps will be the biggest barrier.  Standard 5. Heart failure service do not have the capacity to retain patients within their services indefinitely and once stable and/or on optimal therapy are discharge to primary care. Current QoF indicators for heart failure require 12-monthly follow up. 6-monthly follow up would require investment in resources either primary or secondary care, robust heart failure databases across primary/secondary care interface.  Standard 6. Cardiac rehabilitation services are not available in all localities therefore, significant investment will be required to ensure all patients have the option of cardiac rehab. |
|  | Boehringer Ingelheim | Question 4 | We are aware of a service in Wales who have been able to remotely manage patients to initiate the 4 pillars of treatment significantly quicker than routine practice - [NHS Wales: App helping keep heart patients out of hospital - BBC News](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bbc.co.uk%2Fnews%2Fuk-wales-62407984%3Ffbclid%3DIwAR0qLEua8OQE0K-aE6Y3wznB2q9pAxrSC8uR1_n2nQzH6IUgryy0ISZlIr8&data=05%7C01%7Cross.rotheram%40boehringer-ingelheim.com%7Cd58aab4fab3445e78d5a08da7939ccb2%7Ce1f8af86ee954718bd0d375b37366c83%7C0%7C0%7C637955586391105069%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=zd5nTyl3b7CFWsf5QAZ2jCMpvJ29e9OPBGlThr27dHM%3D&reserved=0) - with patient testimonial [https://f.io/vrgnffxD](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fscanmail.trustwave.com%2F%3Fc%3D261%26d%3DgfC44ruBcgttu27tIxnsfFuQrnwQJAvBVjgDCh_4AA%26u%3Dhttps%253a%252f%252ff.io%252fvrgnffxD&data=05%7C01%7Cross.rotheram%40boehringer.mail.onmicrosoft.com%7Cc6cfb7eea43949b18beb08da7f658059%7Ce1f8af86ee954718bd0d375b37366c83%7C0%7C0%7C637962371176120921%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=Mdv5oRASBDBjV5n4jv8Ylg52Knj1aJXMm8DrKqLJje0%3D&reserved=0) |
|  | British Cardiovascular Society | Question 4 | Yes the statements could be written in this way |
|  | British Society for Heart Failure | Question 4 | Statement 5: Could the population for this statement be written as ‘adults with chronic heart failure’?  Yes  Statement 6: Could the population for this statement be written as ‘adults with chronic heart failure’?  Yes |
|  | NHSE | Question 4 | 11. Agree it is reasonable for both statement 5 and 6 to be changed from ‘stable chronic heart failure’ to ‘chronic heart failure’  No |
|  | NHS Surrey Heartlands ICB | Question 4 | Capacity of team to provide this is an issue – see above.  No, the population should remain as “stable chronic heart failure” |
|  | Novartis Pharmaceuticals UK Ltd | Question 4 | We note that “stable” is not a definitive term in the context of chronic heart failure, given that patients with the condition are never “stable” per se, as symptoms can worsen without warning and decompensation can occur even in patients considered to be optimally managed. However, the term “stable” could be used to refer to patients no longer considered to be in the acute stage of heart failure i.e., those patients considered to be living with chronic heart failure. This distinction could therefore apply to both statements 5 & 6 with regards to the use (or not) of the word “stable” in this context. On balance, we are comfortable with removing the word ‘stable’ from the two statements in question. |
|  | Primary Care Cardiovascular Society | Question 4 | We would support the use of the phrase ADULTS with Chronic heart Failure thereby omitting the word stable as we feel that it is inappropriate to use the word “stable” in the context of chronic heart failure given the increased risk of sudden death and overall prognosis. |
|  | UKCPA | Question 4 | Yes, are heart failure patients ever truly stable? Could be changed, the word stable may prevent or delays cardiac rehab and regular review. Alternative the use of the word chronic could be defined for clarity. |
|  | AstraZeneca | Question 5 | With reference to:  Statement 2 Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]  Project OPERA is a joint working partnership programme between AstraZeneca and the NHS in Glasgow and Clyde. More than 700 people referred from the community for investigation of suspected HF have participated. The interventions included mapping the existing HF pathway and establishing dedicated consultant cardiologist led triage of HF referrals in-line with NICE quality standards 1 and 2, coupled with echocardiography enabled with artificial intelligence and machine learning capabilities. A clinical dashboard has been developed which presents all information relating to the patient’s treatment (including pre-appointment information collected directly from the patient) in a single display. As a consequence of the project wait times for investigations have reduced from almost 12 months to less than 12 weeks, and the corresponding commencement of treatment earlier in the patients disease has shown a reduction of hospitalisation episodes. This initiative is aligned with the AstraZeneca UK medical missions to eradicate unplanned admissions for HF and has demonstrates the potential to generate lasting practice change for community-based HF diagnosis in the UK. |
|  | British Cardiovascular Society | Question 5 | No |
|  | NHSE | Question 5 | 1. Local practice case studies include the Oxford Academic Health Science Network who have developed an excellence in heart failure toolkit: <https://docplayer.net/221234532-Excellence-in-heart-failure-toolkit-by-oxford-ahsn.html>   Clinical systems in primary care have provision to code Chronic Heart Failure as a diagnosis, and many patients can have well managed, stable heart failure, therefore, target population for Statement 5 and Statement 6 be written as ‘adults with chronic heart failure’. |
|  | NHS Surrey Heartlands ICB | Question 5 | 1. N/A |
|  | Novartis Pharmaceuticals UK Ltd | Question 5 | The NICE guideline for chronic heart failure (NG106) was published in 2018 and does not take into consideration the more recent evidence and guidelines around managing and treating chronic heart failure patients, specifically the ‘four pillars’ approach1 which is now broadly recognised to improve patient mortality and morbidity. Due to the recent evidence and guideline updates (mentioned above), there is a strong case to review and update this guidance, to ensure clinicians have the latest information and evidence to provide the best care for their heart failure patients.  Vaduganathan M et al. 20202 estimated the treatment effects of comprehensive disease-modifying pharmacological therapy (ARNI, β blocker, MRA, and SGLT2 inhibitor) versus conventional therapy (ACE inhibitor or ARB and β blocker) in patients with chronic HFrEF by making indirect comparisons of three pivotal trials, EMPHASIS-HF (n=2737), PARADIGM-HF (n=8399), and DAPA-HF (n=4744). They estimated that comprehensive therapy reduced the hazard of cardiovascular death or hospital admission for heart failure significantly (hazard ratio 0·38 [95% CI 0·30–0·47]) compared with conventional therapy. Depending on the age of therapeutic optimisation, treatment with comprehensive therapy was estimated to afford 1·4 to 6·3 additional years of survival and 2·7 to 8·3 additional years free from cardiovascular death or hospital admission for heart failure compared with treatment with ACE inhibitor or ARB and β blocker alone.  Reference  1. Straw S., McGinlay M., Witte KK., Open Heart 2021;8:e001585. doi:10.1136/openhrt-2021-001585   1. 2. Vaduganathan et al. 2020 Lancet 2020; 396: 121–28 |
|  | UKCPA | Question 5 | NA |
|  | Alliance for Heart Failure | Statement 1 | The quality standards (1 and 2) should go further in supporting early initiation and optimisation of disease modifying agents in HFrEF (Heart Failure With Reduced Ejection Fraction). |
|  | AstraZeneca | Statement 1 | No changes suggested |
|  | Boehringer Ingelheim | Statement 1 | We welcome the addition of NT pro-BNP as a quality standard. We believe that this has the potential to improve patient pathways and reduce first attendance at hospital. Prevention of inappropriate Echo use |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 1 | This is a basic requirement and standard reflects what should happen |
|  | British Society for Heart Failure | Statement 1 | Very relevant. Has not been readily available in all areas but recent NHS targeted funding on this so hopefully situation is hopefully improving. This statement should then support implementation and usage once test more readily available. |
|  | British Society for Heart Failure | Statement 1 | Auditing whether this is routinely used once available would need to go to primary care. Could it become a QOF? |
|  | British Society for Heart Failure | Statement 1 | Yes, provided access to assay available and clinicians well educated on referral pathways. |
|  | NHSE | Statement 1 | 13. Welcome this change. Ensuring patients have better access to investigations for HF and HVD in primary care, mainly NT-proBNP testing, will reduce the amount of testing in secondary care settings and will trigger earlier diagnosis and management, potentially reducing hospital admissions.  14. All community diagnostics centres (CDCs) should be able to measure NT-pro-BNP as well as secondary care settings who treat patients with suspected heart failure with clear links into echocardiography.  Under the process of the quality statement, we suggest clarifying the denominator of the quality measure to be ‘the number of adults diagnosed with heart failure by specialist assessment and echocardiography’ |
|  | NHS Surrey Heartlands ICB | Statement 1 | As above. It is a requirement on the referral form to the community HF team for patients with suspected LVSD. East Surrey HF team only cover left sided HF and do not see valvular or right sided.  The measures for this standard are appropriate |
|  | Primary Care Cardiovascular Society | Statement 1 | We would support the statement that “ Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT‑proBNP) measured “ with the caveat that the measurement of NT- pro BNP is in people who do not have an existing diagnosis of heart failure. |
|  | Sussex Health & Care Partnership | Statement 1 | Would like statement one to state that there is urgent measurement of NTproBNP . Although this would put pressure on primary care phlebotomy services, the diagnosis of heart failure is serious enough that it should be an urgent blood test.  It may not be popular but these quality standards should be aspirational despite the pressures within the system |
|  | UKCPA | Statement 1 | The measures for this standard are appropriate |
|  | AstraZeneca | Statement 2 | **Suggested changes:**  **Current:** “Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. [2011, updated 2022]”  **With proposed changes:** “Adults with suspected heart failure have ***concurrent*** specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have |
|  | Boehringer Ingelheim | Statement 2 | We recognise the challenge of measuring this. This stresses the importance of appropriately coding Echo using OPCS codes and a pragmatic approach about overall wait times regardless of NT-proBNP maybe more easily captured as a surrogate.  As reported by the BHF, there are long waits for key heart tests, such as echos, have contributed to the growing backlog of heart care for potentially life saving procedures. At the end of November 2021, there were over 280,000 people on an NHS cardiac waiting list, with 3,589 people waiting over a year. Such long waits for the treatment of conditions like coronary heart disease increase the risk of someone becoming more unwell or even dying while they wait for care. [british-heart-foundation-submission-to-hsc-workforce-consultation-final.pdf (bhf.org.uk)](https://www.bhf.org.uk/-/media/files/what-we-do/influencing-change/british-heart-foundation-submission-to-hsc-workforce-consultation-final.pdf?rev=8073ce2d20fc408c9245af46daabadc5&hash=983ECA59EFAF19EE15075DC5B781B9FE) |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 2 | Specialist assessment within 6 weeks of high levels of NTproBNP (400 – 2000) will be challenging due to current pressure on cardiology appointments across the country |
|  | British Society for Heart Failure | Statement 2 | Yes, this should continue to be a key standard in heart failure care. As people may briefly reference the statement wording rather than the full document, should there be reference to cut off levels? |
|  | British Society for Heart Failure | Statement 2 | Yes. Trusts should have documented referral pathways and be able to access waiting list metrics. Making this reportable and a key element of inspection or audit, may help gather organisational support for investments focussed on this area. This needs to be seen with the same urgency as the cancer 2 week wait referral target and currently does not seem to be. |
|  | British Society for Heart Failure | Statement 2 | Access to all members of the specialist workforce presents a significant barrier, but particularly cardiac physiologists. In the short-term commissioners should be encouraged to look at options such as insourcing if needs cannot be met. In the longer term, we need a workforce plan. Consideration could also be given to training other professional groups in the skill of echocardiography (however, given shortages across the board this may be counterproductive. |
|  | British Geriatrics Society | Statement 2 | BGS suggests that the Heart Failure MDT should directly involve a physician specialising in the care of the older person  The joint British Society consensus guidelines on heart failure multidisciplinary meetings (2022) recommends the inclusion of a care of the elderly consultant as an attendee of the heart failure MDT.  A comprehensive geriatric assessment (CGA) is recommended as part of the initial assessment in the context of a new diagnosis of heart failure. There is compelling evidence that identification of frailty can predict the mortality for patients, with Uchmanowicz I et al (2020) state that ‘frailty in chronic heart failure is associated with an average of 48% and 40% increase in the hazard of all cause mortality and hospitalisation, respectively’. It is therefore imperative that it is recognised and optimised in this patient cohort by a physician specialising in care of the older person. Although there is not a validated frailty assessment tool for use in heart failure, Kanenawa et al (2021) found that the Clinical Frailty Score ‘was successful in predicting the risk for all-cause death in patients with heart failure’, and BGS would recommend the use of the CFS in assessment and prognostication in older patients with heart failure.  Vitale et al (2018) suggest that by recognising patients with co-existing frailty and heart failure will lead to identification of ‘those who need early intervention and close monitoring. The recognition of frailty is the first step for an accurate risk stratification and planning a tailored therapeutic plan.’ We suggest that a specialist in the care of the older person should be involved in the initial assessment, care planning and ongoing management of older patients with heart failure.  Heart failure multidisciplinary meetings: joint British Society consensus guidelines for structure and function (2022) <https://www.bsh.org.uk/wp-content/uploads/2022/02/Heart-failure-MDM-final-revised-v2.pdf>  Uchmanowicz I, Lee CS, Vitale C, Manulik S, Denfeld QE, Uchmanowicz B, Rosinczuk J, Drozd M, Jaroch J, Jankowska EA. Frailty and the risk of all-ill-use mortality and hospitalisation in chronic heart failure: a meta-analysis. ESC Heart Fail 2020; 7 (6): 3427-3437  Kanenawa K, Isotani A, Yamaji K et al. The impact of frailty according the Clinical Frailty Scale on clinical outcome in patients with heart failure. ESC Heart Fail 2021; 8 (2): 1552-1561  Vitale C, Spoletini I, Rosano GMC. Frailty in heart failure: Implications for management. Card Fail Rev 2018; 4 (2): 104-106 |
|  | NHSE | Statement 2 | 15. Welcome this change. However, encourage NICE to maintain clarity and emphasis the levels (ng/l) of ‘very high’ or ‘high’ NT-proBNP levels within the statement itself as opposed to within the further information of definition of terms.  16. Patients with suspected heart failure and NT-proBNP 400-2,000ng/l should have specialist assessment and echocardiography within 6 weeks. Patients with suspected heart failure and NT-proBNP >2000ng/l should have specialist assessment and echocardiography within 2 weeks  17. Considering the information provided in ‘what the quality statement means for different audiences’, it is implied this standard is for primary care. This should be made explicit in the statement (adults presenting in primary care).  It is good to set a standard for assessment of patients in secondary care services following referral from primary care but it is not clear if there can be a time period applied for primary care to organise a referral to secondary care services after diagnosis of heart failure is suspected or confirmed |
|  | NHS Surrey Heartlands ICB | Statement 2 | As above Question 3. Not always achieved within 2 weeks even if urgent. Some delay due to patient choice (convenience of appointment). Also clinic capacity can delay. Once referral is received with pro NT-ProBNP sometimes further information / diagnostics are required prior to echo. Echo is achieved within 6 weeks. Provided by Inhealth and appointment made via central booking. Not within the control of the community HF team.  The measures for this standard are appropriate |
|  | Primary Care Cardiovascular Society | Statement 2 | I think there are several considerations here. It was the view of the NICE CHF guideline committee that a person with suspected heart failure should be referred urgently from primary care if there NT-proBNP was above 400 and you can see this in the NICE HF Diagnosis visual summary. We would support the use of NT-proBNP thresholds to prioritise people for echo/specialist assessment but just as importantly there should be HF specialist triage of all suspected HF referrals as there are various factors when should be considered when interpreting NT-proBNP levels not least if they have an atrial dysrhythmia which can considerably increase the natriuretic peptide level. |
|  | UKCPA | Statement 2 | The measures for this standard are appropriate |
|  | Alliance for Heart Failure | Statement 3 | There is increasing evidence that treatments should be optimised as quickly as possible in order to gain the maximum possible benefit.  We propose the following wording: ‘Adults with chronic heart failure receive early intervention with all evidence-based medications, with timely optimisations to target or optimal tolerated doses.’ |
|  | AstraZeneca | Statement 3 | **Suggested changes:**  **Current:** “Adults with chronic heart failure who have reduced ejection fraction receive all appropriate medication at target or optimal tolerated doses. **[2011, updated 2022]**”  **With proposed changes:** “Adults with chronic heart failure receive early intervention with all evidence-based medications, with timely optimisation to target or optimal tolerated doses. **[2011, updated 2022]** |
|  | Boehringer Ingelheim | Statement 3 | Suggest wording change in line with NICE guidance: **Service providers** (GP practices, hospitals and community providers) ensure that adults with (SYMPOMATIC) chronic heart failure who have reduced ejection fraction are prescribed ACE inhibitors (or ARBs) and beta blockers, plus MRA and SGLT2i if symptoms of heart failure continue  This is consistent with the establishment of SGLT2i being the fourth pillar for the treatment of HF REF patients. Empagliflozin has demonstrated cost effectiveness (<https://www.nice.org.uk/guidance/ta773>) in this population and has been cited as having no significant resource impact. <https://www.nice.org.uk/guidance/ta773/resources/resource-impact-statement-11008588141>  As per quality statement 4, the regular intervals with which we should aim to review our patients with HF should focus on high-value interactions for both patients and the heart failure service. Evidence shows that patients on the so-called “four pillars” of heart failure therapy benefit significantly more than patients who are not, and that getting patients on these therapies in a timely manner should be prioritised, followed by up-titration of doses once all therapies are commenced (Packer, McMurray 2021 - Rapid evidence-based sequencing of foundational drugs for heart failure and a reduced ejection fraction [**https://doi.org/10.1002/ejhf.2149**](https://doi.org/10.1002/ejhf.2149)). Clinical inertia and lack of capacity in the system often mean that patients can be on mono or dual therapy for many months with slow up titrations of doses that ultimately limit the benefit they could be getting from lower initial doses of all four drug classes.  In other developed nations data suggests that only a minority of patients receive the full suite of guideline directed therapies (Greene 2018 – The CHAMP-HF registry), further illustrating the clinical inertia that is apparent in HF services.  Consider rewording of *“They ensure that the medication (apart from SGLT2i) is given in increasing doses until the target or optimal tolerated doses are reached.”* As described above, ensuring patients are on all “four pillars” of therapy should be prioritised and this may leave room for misinterpretation from excluding SGLTi. Once patients are on all recommended therapies, up-titration of doses can commence, where applicable, until optimal tolerated doses reached. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 3 | Why is ARNi not included with ACE / ARB measurement in section a? Increasing numbers of patients are on this medication. There need to be clear local protocols as to which health care professionals are responsible medication optimisation and the system then resourced appropriately. |
|  | British Society for Heart Failure | Statement 3 | A key target and must be included. But …  • Could possibly be more direct around the need to optimise disease modifying medicines expediently (but safely). Gradually seems to suggest slowly and with no urgency. Could read something like…Adults diagnosed with heart failure with reduced ejection fraction, should have clear care plan in place to achieve safe but timely optimisation of guideline-based disease modifying treatments.  ARNI do not appear to be included in the detailed section around this statement? |
|  | British Society for Heart Failure | Statement 3 | No these are not in place. Primary care QOF process covers some but not all 4 pillars. Areas with electronic prescribing should be able to audit their prescribing practice. Medications on hospital discharge audited by NICOR. |
|  | British Society for Heart Failure | Statement 3 | To do this in a timely fashion, investment in specialist workforce required. HFSN and specialist pharmacists key to this target. Those working in HF specialist care need to be supported by employers to become prescribers, with this being seen as a key element of their role. Local formulary guidance can be a barrier in some areas – keeping in the definition of specialist HF MDT from last edition would help to support discussions around formulary and non-medical prescribing, |
|  | British Geriatrics Society | Statement 3 | BGS suggest that the denominator should be all those with HFrEF who do not have a documented contraindication  BGS suggests that a health technology assessment on the use of SGLT2 inhibitors would be helpful prior to publication  Given the evidence supporting use of SGLT2 inhibitors in HFpEF it would seem prudent to evaluate their role with a health technology assessment prior to publication of the Heart Failure QS. This HTA may lead to a further change to the quality standards and hence has the potential to directly impact the care of this patient group.  The EMPEROR-Preserved randomized controlled trial has proven that ‘SGLT2 inibitors can significantly reduce HF hospitalization with neutral effect on cardiovascular death’.  Nassif et al (2021) found that dapagliflozin significantly improved both patient reported symptoms and physical limitations as well as objectively measured exercise function.  Wagdy K, Nagy S. EMPEROR-Preserved: SGLT2 inhibitors breakthrough in the management of heart failure with preserved ejection fraction. Glob Cardiol Sci Pract 2021; (3)  Nassif ME, Windsor SL, Borlaug BA et al. The SGLT2 inhibitor dapagliflozin in heart failure with preserved ejection fraction: a multicenter randomized trial. Nature Medicine 2021; 27: 1954-1960 |
|  | NHSE | Statement 3 | 18. The statement should consider clarifying ‘gradually’ as part of medicines optimisation. NICE guidance states that the dose should be titrated upwards at short intervals (for example every 2 weeks) until the target dose, or the highest tolerated dose is reached, with monitoring of renal function and blood pressure.  19. The statement rationale should consider co-morbidity management of a patient and the role of the multidisciplinary team to ensure patients are receiving optimal treatment. This is particularly important for high-risk groups of people with existing comorbidities such as diabetes, heart valve disease, chronic kidney disease etc.  20. The statement rationale should consider the opportunities of remotely optimising patients and personalised care and support planning, which could also provide early indications of decompensation that, if addressed, could prevent heart failure hospitalisation. |
|  | NHS Surrey Heartlands ICB | Statement 3 | As above Question 3. Yes achieved – shared responsibility between GP and HF nurse specialist.  The measures for this standard are appropriate. The QOF indicators for HF in primary care will need updating to reflect this.  The numerators are very specific.  How would it be recorded if a particular medicine was not appropriate for a patient?  How would it be recorded that the optimal dose had been reached?  There is no routinely-collected data measure for MRA/SGLT2i prescribing. How easy would that be to set up, given that there are other indications for these meds and those indications may co-exist? I know that that will also apply to ACE-I etc but I don’t have an understanding of how that data is recorded in practices. |
|  | Primary Care Cardiovascular Society | Statement 3 | Evidence from recent HF trials (DAPA-HF as example) have shown statistically significant benefit after just 4 weeks of introducing the therapy and there is an increasing emphasis on introducing and optimising evidence based therapies ( four pillars of therapy in HFrEF) quickly. |
|  | UKCPA | Statement 3 | Angiotensin Receptor Neprilysin Inhibitors should be included alongside ACEI and ARB to ensure complete capture of drug therapy.  ‘Doses gradually increased’ may be worded more appropriately as ‘safe but timely increase’. |
|  | Alliance for Heart Failure | Statement 4 | Certain medications, for example SGLT2-inhibitors (Sodium-glucose co-transporter-2 inhibitors), do not meet the requirement for a two week review. Naming medicines where this is applicable will reduce unnecessary appointments and encourage more timely upwards titration of relevant treatments. |
|  | AstraZeneca | Statement 4 | **Suggested changes:**  **Current:** “Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication**. [2016]**”  **With proposed changes:** “Adults with chronic heart failure started on ACEi/ARB/ARNI or MRA have a review within 2 weeks of any change in the dose or following a change to or addition of any of these medications**. [2016]**” |
|  | Boehringer Ingelheim | Statement 4 | As recognised by the BHF, heart failure specialist nurses (HFSN) play a vital role in delivering the high-quality care these patients require. They often fulfil extended roles and have a range of responsibilities, including triaging patients, providing care across the heart failure pathway, supporting clinics and ward rounds, and prescribing  Although HFSN services are well established in many areas of the UK, there is significant regional variation in their provision something that the pandemic has further exacerbated. To meet demand and NHS Long Term Plan aspirations, GIRFT estimates that the number of heart failure specialist nurses should be doubled or in some cases quadrupled from 1 per 100,000 population to 2 - 4 per 100,000.  [british-heart-foundation-submission-to-hsc-workforce-consultation-final.pdf (bhf.org.uk)](https://www.bhf.org.uk/-/media/files/what-we-do/influencing-change/british-heart-foundation-submission-to-hsc-workforce-consultation-final.pdf?rev=8073ce2d20fc408c9245af46daabadc5&hash=983ECA59EFAF19EE15075DC5B781B9FE)  BI recognise that the management of HF is complex and requires specialist input often from these HFSNs and that capacity to deliver QS statement 4 will be a challenge in some areas especially given that there is increase in prevalence and the availability of newer medicines also increasing HF service  Therefore, ICSs will need to ensure that there are significant specialists available to manage HF and other workforce such as GP/PCN pharmacists are upskilled in the management of HF to ensure that patients are able to get the standard of quality outlined in the Quality Standards.  In view of the last 2 years, new approaches to medication optimisation and management have emerged, including the use of remote monitoring for HF patients. The limitation of numbers of HF nurses and combined with increased referral rates/diagnosis HF patients, has led to new approaches to managing caseloads of HF patients.  The practical outcome of which is where clinically necessary following a change in medication, a 2 week review of patient; either via remote communication (telehealth report/ patient owned Monitoring equipment) or, face to face if clinical interventions required (for eg if bloods required), following a change in heart failure medications is desired.  Whilst a face to face is optimum and 2 week interval is optimum, where the titration of medication such as betablockers is required, a remote monitoring with patient BP/HR monitor may be sufficient. In between face to face reviews, patient education on change of symptoms is key to this process. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 4 | Part of standard 3. |
|  | British Society for Heart Failure | Statement 4 | Very relevant and the detailed paragraph outlines the rationale well. |
|  | British Society for Heart Failure | Statement 4 | Nothing in place for routine monitoring of this statement. Big challenge to monitor as medications may be adjusted in a range of settings. |
|  | British Society for Heart Failure | Statement 4 | Workforce gaps are the main barrier. Digital technology may be of use for remote review. Education of non-HF specialists around this standard would have benefits. |
|  | NHSE | Statement 4 | 21. The statement rationale should consider co-morbidity management of a patient and the role of the multidisciplinary team to ensure patients are receiving optimal treatment. This is particularly important for high-risk groups of people with existing comorbidities such as diabetes, heart valve disease, chronic kidney disease etc.  It would be difficult to measure Statement 4 as due to difficulties of recording data following changes in medications and review of heart failure because patients in primary care can present with multiple problems. |
|  | NHS Surrey Heartlands ICB | Statement 4 | As above Question 3. For patients on active caseload with HF nurse specialist (pts with LVSD) this is achieved – would be telephone review. Limited capacity and clinic space means that team unable to see patient’s face to face.  This standard will be difficult to measure as the patient may receive follow up in either primary or secondary care, or a community-based team. More resource will be required to implement this statement.  The HF nurses are employed by CSH. If they code their reviews on emis, is the practice able to pick these up in a search (assuming that the practice would be doing these searches)? It’s not possible for us (hubs) to conduct cross-organisational searches on emis, so I’m guessing the same applies the other way around. |
|  | Primary Care Cardiovascular Society | Statement 4 | We would support this statement though given the comments we have shared in statement 3 we feel the introduction of therapies may mean altering doses and review at shorter intervals. .`A HF review can of course be face to face or virtual /by telephone. Some therapies may not require review at 2 weeks as there is no associated titration of dose. |
|  | UKCPA | Statement 4 | This standard needs to be clear that this includes the change of diuretics dose as well as prognostic medication. |
|  | Boehringer Ingelheim | Statement 5 | We would like to highlight the importance of patient self-monitoring in heart failure throughout their disease trajectory. During periods of stability, it is important for patients to know when to highlight certain signs and symptoms of deterioration such as changes in fatigue, changes to exercise tolerability (progressive shortness of breath) and oedema. Monitoring of large fluctuations of weight (indicative of fluid accumulation) and blood pressure may also be clinically useful parameters for patients to inform their clinicians. Importantly, these parameters are achievable and widely available to patients to self-monitor. Evidence in the heart failure literature also backs this up, as deteriorations in health status were indicative of future hospital events in the weeks and months prior to the hospitalisation in both HFrEF and HFpEF patients (Vaduganathan - Circulation. 2022;145:00–00. DOI: 10094)  Supporting patients with appropriate patient materials and signposting them to the relevant HF patient groups/charities could facilitate this – e.g. the British Heart Foundation, Pumping Marvelous. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 5 | If ‘stable’ this should be part of long term conditions monitoring in primary care and not necessarily for specialist heart failure teams. Criteria for transfer between specialist and LTC monitoring in primary care needs to be clear. |
|  | British Society for Heart Failure | Statement 5 | Yes relevant. Could be more specific in the statement itself around the purpose of this intervention for identifying those who need consideration for new interventions/ referral back to specialists. |
|  | British Society for Heart Failure | Statement 5 | Measurable through QOF and primary care data in areas where primary care responsible. |
|  | British Society for Heart Failure | Statement 5 | Workforce is a considerable issue both in primary care and specialist services. Needs to be clarity around who and where this is being carried out. |
|  | NHSE | Statement 5 | 22. We encourage NICE to add to the important of accessing mental health support as a rationale for regular reviews (6 monthly). Access to mental health and psychosocial support is important, recognising that sometimes people can suffer from anxiety and depression due to their heart failure diagnosis and ensuing symptoms they need to manage.  23. We encourage NICE to include a review of frailty and end of life care needs and ensuring care plans are developed as part of the minimum requirements of a ‘review for people with stable chronic heart failure’.  24. We encourage NICE to review the subheading for statement 5 to ensure references to “stable” chronic heart failure are removed in line with the reference to chronic heart failure in statement 5 and statement 6 (question 4 of the consultation). For example, the subheading ‘Review for people with stable chronic failure’ should be amended to ‘Review for people with chronic heart failure’ |
|  | NHS Surrey Heartlands ICB | Statement 5 | As above Question 3. HF nurse specialist – patients will have maximum of 3 monthly reviews when on active caseload. Once stable chronic heart failure the LVSD patients would be discharged back to GP with ability to self refer back into service. Discharged patients are not recalled by HF nurse service for routine reviews when stable as capacity does not allow this (2.08WTE nurses - active caseload 260 patients. In primary care annual reviews are maintained.  The measures for this standard are appropriate. |
|  | Primary Care Cardiovascular Society | Statement 5 | We would support this statement though the annual QOF requirements for review of people with heart failure is an annual review. |
|  | UKCPA | Statement 5 | The measures for this standard are appropriate |
|  | Alliance for Heart Failure | Statement 6 | We agree with the merging of statements six and seven. However, it should also serve the provision of remote or virtual rehabilitation.  Consider rewording to: Adults with stable chronic heart failure are offered a comprehensive programme of cardiac rehabilitation that includes exercise with the offer of sessions during and outside working hours, and the choice of undertaking the programme at home (remotely or virtually), in the community or in a hospital setting. |
|  | Boehringer Ingelheim | Statement 6 | BI suggest that commissioners are also aware that solutions are available to patients via digital apps. |
|  | British Association for Cardiovascular Prevention and Rehabilitation (BACPR) | Statement 6 | Change ‘cardiac rehabilitation nurses’ to cardiac rehabilitation **specialists.** CR teams are multidisciplinary.  Generally remove the emphasis on the exercise component to a more comprehensive offer  Suggest:  **Commissioners** (integrated care systems and local authorities) ensure that they commission services in which personalised cardiac rehabilitation programmes *that offer a monitored exercise, psychological and educational component, are offered to adults with stable chronic heart failure. Patients may not always access each component if it is going to be a personalised programme.*  **Personalised programme of cardiac rehabilitation**  *This is a programme of rehabilitation designed for people with heart failure that offers an exercise, psychological and educational component.* |
|  | British Society for Heart Failure | Statement 6 | Highly relevant yes. Appreciate the wording around ‘personalised’, but could more clearly outline the need for cardiac rehabilitation to be offered in a variety of formats. Also, that the benefits should be explained to patients. |
|  | British Society for Heart Failure | Statement 6 | Yes, should be measurable via NACR and NICOR audit process. |
|  | British Society for Heart Failure | Statement 6 | Again, workforce is a big issue and possibly other resources are too. Cardiac rehabilitation services have been hit hard by the pandemic and some are only just managing recovery. Many have lost staff as well as access to venues and equipment. However, there has also been some targeted investment and adoption of new methods, making this a key time for service improvement in this area. |
|  | NHSE | Statement 6 | 25. Existing quality statement 7 (developmental) is not included in this draft proposal – however it is important in the context of patient choice, accessibility and the menu of options locally available.    26. We encourage NICE to modify the new statement 6, to include the use of virtual or remote rehabilitation within the statement itself or further information of the statement, including outside working hours, undertaking the programme at home, virtually, in the community or in a hospital setting based.  27. There are several digital platforms supporting remote rehabilitation for adults with heart failure (such as Rehabilitation EnAblement in CHronic Heart Failure (REACH-HF)).  Due to variable provision of facilities and opportunities for some groups of patients, it would be difficult to achieve personalised programme of cardiac rehabilitation. |
|  | NHS Surrey Heartlands ICB | Statement 6 | As above Question 3. Cardiac rehab is discussed with all patients on the active heart failure caseload. Referral would be made once patient stabilised if they consent and if indicated. Limited capacity and limited venue timings within existing cardiac rehab programme.  The measures for this standard are appropriate. More resource will be required to implement this statement. |
|  | Primary Care Cardiovascular Society | Statement 6 | We would fully support this statement |
|  | Royal College of Nursing | Statement 6 | Adults with stable chronic heart failure are offered a personalised programme of cardiac rehabilitation. [2011, updated 2022] has been poorly adopted nationally. It is both necessary and important to promote rehabilitation and self-optimisation in HF to improve both QoL and longevity. Most HF nurses will deliver some rehab as part of their role but not as part of a programme i.e. REACH. The introduction of HF into cardiac rehabilitation will have a significant resource implication nationally. |
|  | UKCPA | Statement 6 | The measures for this standard are appropriate. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Alliance for Heart Failure
* AstraZeneca
* Boehringer Ingelheim
* British Association for Cardiovascular prevention and Rehabilitation (BACPR)
* British Cardiovascular Society (comments endorsed by Royal College of Physicians)
* British Geriatrics Society
* British Society for Heart Failure
* NHS Surrey Heartlands ICB
* NHSE
* Novartis Pharmaceuticals UK Ltd
* Primary Care Cardiovascular Society
* Royal College of Nursing
* Sussex Health and Care Partnership
* UKCPA
* University Hospitals Birmingham

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