NICE National Institute for Health and Care Excellence

Chronic heart failure quality standard

Issued: June 2011

NICE quality standard 9

guidance.nice.org.uk/qs9

Contents

Introduction and overview

This quality standard covers the assessment, diagnosis and management of chronic heart failure in adults.

Introduction

Heart failure is a complex clinical syndrome in which the heart's ability to pump blood around the body is reduced. It is caused by structural or functional abnormalities of the heart. The most common cause of heart failure in the UK is coronary heart disease, and many patients have had a myocardial infarction in the past.

Patients with chronic heart failure often experience a poor quality of life; symptoms include breathlessness, fatigue and ankle swelling and over one third of patients experience severe and prolonged depressive illness. Heart failure has a poor prognosis: 30–40% of patients diagnosed with heart failure die within 1 year; thereafter the mortality is less than 10% per year. Heart failure accounts for 2% of all NHS inpatient bed-days and 5% of all emergency medical admissions to hospital. Readmissions are common: about 1 in 4 patients are readmitted within 3 months.

Effective multidisciplinary specialist services for people with chronic heart failure can have a positive effect on patients' life expectancy and quality of life and evidence suggests they can help to reduce recurrent hospital stays by 30–50%.

This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with chronic heart failure in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The NHS Outcomes Framework 2011/12 is available from www.gov.uk.

Overview

The quality standard for chronic heart failure requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole chronic heart failure care pathway. An integrated approach to provision of services is fundamental to the delivery of high-quality care to adults with chronic heart failure.

List of statements

Statement 1. People presenting in primary care with suspected heart failure and previous myocardial infarction are referred urgently, to have specialist assessment including echocardiography within 2 weeks.

Statement 2. People presenting in primary care with suspected heart failure without previous myocardial infarction have their serum natriuretic peptides measured.

Statement 3. People referred for specialist assessment including echocardiography, either because of suspected heart failure and previous myocardial infarction or suspected heart failure and high serum natriuretic peptide levels, are seen by a specialist and have an echocardiogram within 2 weeks of referral.

Statement 4. People referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels are seen by a specialist and have an echocardiogram within 6 weeks of referral.

Statement 5. People with chronic heart failure are offered personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wish.

Statement 6. People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for the team.

Statement 7. People with chronic heart failure due to left ventricular systolic dysfunction are offered angiotensin-converting enzyme inhibitors (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with angiotensin-converting enzyme inhibitors) and beta-blockers licensed for heart failure, which are gradually increased up to the optimal tolerated or target dose with monitoring after each increase.

Statement 8. People with stable chronic heart failure and no precluding condition or device are offered a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Statement 9. People with stable chronic heart failure receive a clinical assessment at least every 6 months, including a review of medication and measurement of renal function.

Statement 10. People admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP.

Statement 11. People admitted to hospital because of heart failure receive input to their management plan from a multidisciplinary heart failure team.

Statement 12. People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Statement 13. People with moderate to severe chronic heart failure, and their carer(s), have access to a specialist in heart failure and a palliative care service.

In addition, quality standards that should also be considered when commissioning and providing a high-quality chronic heart failure service are listed in related NICE quality standards.

Quality statement 1: Urgent referral for people with previous myocardial infarction

Quality statement

People presenting in primary care with suspected heart failure and previous myocardial infarction are referred urgently, to have specialist assessment including echocardiography within 2 weeks.

Quality measure

Structure: Evidence of local arrangements to ensure that people presenting in primary care with suspected heart failure and previous myocardial infarction (MI) are referred urgently, to have specialist assessment including echocardiography within 2 weeks.

Process: Proportion of people presenting in primary care with suspected heart failure and previous MI who are referred urgently, to have specialist assessment including echocardiography, with the referral indicating previous MI.

Numerator – the number of people in the denominator who are referred urgently, to have specialist assessment including echocardiography, with the referral indicating previous MI.

Denominator – the number of people presenting in primary care with suspected heart failure and previous MI.

What the quality statement means for each audience

Service providers ensure systems are in place to refer urgently people with suspected heart failure and previous MI, to have specialist assessment including echocardiography within 2 weeks.

Healthcare professionals ensure they refer urgently people with suspected heart failure and previous MI, to have specialist assessment including echocardiography within 2 weeks.

Commissioners ensure that services refer urgently people with suspected heart failure and previous MI, to have specialist assessment including echocardiography within 2 weeks.

People who go to their GP with symptoms of heart failure and who have had a heart attack in the past are referred urgently for assessment by a heart specialist, including an echocardiogram (a test that uses ultrasound to view the heart), within 2 weeks.

Definitions

In NICE clinical guideline 108:

- Echocardiography is defined as transthoracic Doppler 2D echocardiography.
- The term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Ideally an echocardiogram should be performed at the same time as the specialist assessment.

Source guidance

NICE clinical guideline 108 recommendation 1.1.1.2 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 1.

GP practices collect data on patients with diagnosed heart failure having a confirmation echocardiogram or specialist assessment for QOF HF2 – 'The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment'. However this data does not examine whether the patient has had a previous MI or was referred urgently.

Quality statement 2: Measuring serum natriuretic peptides

Quality statement

People presenting in primary care with suspected heart failure without previous myocardial infarction have their serum natriuretic peptides measured.

Quality measure

Structure: Evidence of local arrangements to ensure serum natriuretic peptide measurement is available in primary care for people presenting with suspected heart failure without previous myocardial infarction (MI).

Process: Proportion of people presenting in primary care with suspected heart failure without previous MI who have their serum natriuretic peptides measured before referral for specialist assessment including echocardiography.

Numerator – the number of people in the denominator who have their serum natriuretic peptides measured before referral for specialist assessment including echocardiography.

Denominator – the number of people presenting in primary care with suspected heart failure without previous MI.

What the quality statement means for each audience

Service providers ensure systems are in place to measure serum natriuretic peptides in people presenting in primary care with suspected heart failure without previous MI before referral for specialist assessment including echocardiography.

Healthcare professionals ensure they measure serum natriuretic peptides in people presenting in primary care with suspected heart failure without previous MI before making a referral for specialist assessment including echocardiography.

Commissioners ensure serum natriuretic peptide measurement is available to primary care providers.

People who go to their GP with symptoms of heart failure but who haven't had a heart attack in the past are offered a blood test to measure levels of substances in the blood known as serum natriuretic peptides to find out whether they should see a heart specialist.

Definitions

In NICE clinical guideline 108 the term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Source guidance

NICE clinical guideline 108 recommendation 1.1.1.3 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 2.

Quality statement 3: 2-week assessment and diagnosis

Quality statement

People referred for specialist assessment including echocardiography, either because of suspected heart failure and previous myocardial infarction or suspected heart failure and high serum natriuretic peptide levels, are seen by a specialist and have an echocardiogram within 2 weeks of referral.

Quality measure

Structure: Evidence of local arrangements to ensure that people referred for specialist assessment including echocardiography, either because of suspected heart failure and previous myocardial infarction (MI) or suspected heart failure and high serum natriuretic peptide levels, are seen by a specialist and have an echocardiogram within 2 weeks of referral.

Process: Proportion of people referred for specialist assessment including echocardiography, either because of suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels, who are seen by a specialist and have an echocardiogram within 2 weeks of referral.

Numerator – the number of people in the denominator seen by a specialist and having an echocardiogram within 2 weeks of referral.

Denominator – the number of people referred for specialist assessment including echocardiography either because of suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels.

What the quality statement means for each audience

Service providers ensure systems are in place for people with suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels to be seen by a specialist and have an echocardiogram within 2 weeks of referral.

Healthcare professionals ensure people referred because of suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels are seen and have an echocardiogram within 2 weeks of referral.

Commissioners ensure they commission services to provide specialist assessment including echocardiography within 2 weeks of referral for people with suspected heart failure and previous MI or suspected heart failure and high serum natriuretic peptide levels.

People referred urgently to a heart specialist for assessment, including an echocardiogram because of suspected heart failure, who have either had a heart attack in the past or have high levels of serum natriuretic peptides, are seen by a heart specialist and have an echocardiogram within 2 weeks of referral.

Definitions

In NICE clinical guideline 108:

- Urgent specialist assessment and echocardiography within 2 weeks is recommended for people with suspected heart failure **and**
    - a previous MI **or**
    - high levels of serum natriuretic peptides – B-type natriuretic peptide (BNP) levels above 400 pg/ml (116 pmol/litre) or N-terminal pro-B-type natriuretic peptide (NTproBNP) levels above 2000 pg/ml (236 pmol/litre) in untreated patients. Lower natriuretic peptide thresholds should be considered for patients already on treatment appropriate for heart failure.
- Echocardiography is defined as transthoracic Doppler 2D echocardiography.
- The term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Ideally an echocardiogram should be performed at the same time as the specialist assessment.

Source guidance

NICE clinical guideline 108 recommendations 1.1.1.2 and 1.1.1.4 (key priorities for implementation).

Data source

Structure: Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 3.

Equality and diversity considerations

NICE clinical guideline 108 recommendation 1.1.1.6 advises healthcare practitioners to be aware that:

- obesity or treatment with diuretics, angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, angiotensin II receptor antagonists (ARBs) and aldosterone antagonists can reduce levels of serum natriuretic peptides
- high levels of serum natriuretic peptides can have causes other than heart failure (for example, left ventricular hypertrophy, ischaemia, tachycardia, right ventricular overload, hypoxaemia [including pulmonary embolism], renal dysfunction [GFR < 60 ml/minute], sepsis, chronic obstructive pulmonary disease [COPD], diabetes, age > 70 years and cirrhosis of the liver).

Quality statement 4: 6-week assessment and diagnosis

Quality statement

People referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels are seen by a specialist and have an echocardiogram within 6 weeks of referral.

Quality measure

Structure: Evidence of local arrangements to ensure that people referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels are seen by a specialist and have an echocardiogram within 6 weeks of referral.

Process: Proportion of people referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels, who are seen by a specialist and have an echocardiogram within 6 weeks of referral.

Numerator – the number of people in the denominator seen by a specialist and having an echocardiogram within 6 weeks of referral.

Denominator – the number of people referred for specialist assessment including echocardiography because of suspected heart failure and intermediate serum natriuretic peptide levels.

What the quality statement means for each audience

Service providers ensure systems are in place for people with suspected heart failure and intermediate serum natriuretic peptide levels to be seen by a specialist and have an echocardiogram within 6 weeks of referral.

Healthcare professionals ensure people with suspected heart failure and intermediate serum natriuretic peptide levels are seen by a specialist and have an echocardiogram within 6 weeks of referral.

Commissioners ensure they commission services to provide specialist assessment including echocardiography within 6 weeks of referral for people with suspected heart failure and intermediate serum natriuretic peptide levels.

People referred to a heart specialist for assessment, including an echocardiogram, because of suspected heart failure and raised levels of serum natriuretic peptides, are seen by a heart specialist and have an echocardiogram within 6 weeks.

Definitions

In NICE clinical guideline 108:

- Specialist assessment within 6 weeks is recommended for people with suspected heart failure and intermediate levels of serum natriuretic peptides, that is BNP levels between 100 and 400 pg/ml (29–116 pmol/litre) or NTproBNP levels between 400 and 2000 pg/ml (47–236 pmol/litre) in untreated patients. Lower natriuretic peptide thresholds should be considered for patients already on treatment appropriate for heart failure.
- Echocardiography is defined as transthoracic Doppler 2D echocardiography.
- The term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Ideally echocardiography should happen at the same time as the specialist assessment.

Source guidance

NICE clinical guideline 108 recommendation 1.1.1.5.

Data source

Structure: Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 4.

Equality and diversity considerations

NICE clinical guideline 108 recommendation 1.1.1.6 advises healthcare practitioners to be aware that:

- obesity or treatment with diuretics, angiotensin-converting enzyme (ACE) inhibitors, beta-blockers, angiotensin II receptor antagonists (ARBs) and aldosterone antagonists can reduce levels of serum natriuretic peptides.
- raised levels of serum natriuretic peptides can have causes other than heart failure (for example, left ventricular hypertrophy, ischaemia, tachycardia, right ventricular overload, hypoxaemia [including pulmonary embolism], renal dysfunction [GFR < 60 ml/minute], sepsis, chronic obstructive pulmonary disease [COPD], diabetes, age > 70 years and cirrhosis of the liver).

Quality statement 5: Education and self-management

Quality statement

People with chronic heart failure are offered personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wish.

Quality measure

Structure: Evidence of local arrangements to ensure people with chronic heart failure are offered personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wish.

Process:

a) Proportion of people with chronic heart failure receiving personalised information, education, support and opportunities to discuss their care.

Numerator – the number of people in the denominator receiving personalised information, education, support and opportunities to discuss their care.

Denominator – the number of people with chronic heart failure.

b) Evidence from experience surveys showing that people with chronic heart failure feel they have been provided with personalised information, education, support and opportunities for discussion throughout their care to help them understand their condition and be involved in its management, if they wished.

What the quality statement means for each audience

Service providers ensure systems are in place to provide people with chronic heart failure with personalised information, education, support and opportunities for discussion throughout their

care and to collect feedback from people with chronic heart failure on their experience of these systems.

Healthcare professionals ensure they offer personalised information, education, support and opportunities for discussion throughout the care of people with chronic heart failure.

Commissioners ensure they commission services that offer personalised information, education, support and opportunities for discussion throughout the care of people with chronic heart failure.

People with chronic heart failure are offered personalised information, education, support and opportunities for discussion throughout their care so they can understand their condition and be involved in its management, if they wish.

Source guidance

NICE clinical guideline 108 recommendations 1.4.1.4, 1.5.5.2, 1.5.5.3 and 1.5.5.6

Data source

Structure: Local data collection.

Process: a) and b) Local data collection.

Equality and diversity considerations

The information provided should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with chronic heart failure should have access to an interpreter or advocate if needed.

Quality statement 6: Multidisciplinary heart failure team

Quality statement

People with chronic heart failure are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care, and are given a single point of contact for the team.

Quality measure

Structure:

a) Evidence of a local multidisciplinary heart failure team led by a specialist and consisting of professionals with the appropriate competencies from primary and secondary care.

b) Evidence of local arrangements to ensure people with chronic heart failure are given a single point of contact for the multidisciplinary heart failure team.

Process:

a) Proportion of people with chronic heart failure who are cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with the appropriate competencies from primary and secondary care.

Numerator – the number of people in the denominator cared for by a multidisciplinary heart failure team led by a specialist and consisting of professionals with the appropriate competencies from primary and secondary care.

Denominator – the number of people with chronic heart failure.

b) Proportion of people with chronic heart failure given a single point of contact for the multidisciplinary heart failure team.

Numerator – the number of people in the denominator given a single point of contact for the multidisciplinary heart failure team.

Denominator – the number of people with chronic heart failure cared for by a multidisciplinary heart failure team.

What the quality statement means for each audience

Service providers ensure the multidisciplinary heart failure team is led by a specialist and consists of professionals with appropriate competencies from primary and secondary care, and that systems are in place to provide those cared for with a single point of contact for the team.

Healthcare professionals ensure that people with chronic heart failure are cared for by a multidisciplinary heart failure team and are given a single point of contact for the team.

Commissioners ensure they commission a multidisciplinary heart failure team led by a specialist and consisting of professionals with appropriate competencies from primary and secondary care.

People with chronic heart failure are cared for by a heart failure team and given a single person to contact from the team.

Definitions

In NICE clinical guideline 108 the term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Unless otherwise specified, within this quality standard, specialist assessment or management refers to assessment or management by a multidisciplinary heart failure team. The team will decide on the most appropriate member to address a particular clinical problem, which may mean the GP leading the care in consultation with other members of the team.

Source guidance

NICE clinical guideline 108 recommendation 1.5.3.1 and appendix D – practical notes.

Data sources

Structure: a) and b) Local data collection.

Process: a) and b) Local data collection. Access to heart failure liaison services is monitored by the National heart failure audit for people with an unplanned admission to hospital with heart failure.

Quality statement 7: Treatment with angiotensin-converting enzyme inhibitors, angiotensin II receptor antagonists and beta-blockers

Quality statement

People with chronic heart failure due to left ventricular systolic dysfunction are offered angiotensin-converting enzyme inhibitors (or angiotensin II receptor antagonists licensed for heart failure if there are intolerable side effects with angiotensin-converting enzyme inhibitors) and beta-blockers licensed for heart failure, which are gradually increased up to the optimal tolerated or target dose with monitoring after each increase.

Quality measure

Structure:

a) Evidence of local arrangements to ensure that people with chronic heart failure due to left ventricular systolic dysfunction (LVSD) are offered angiotensin-converting enzyme (ACE) inhibitors (or angiotensin II receptor antagonists [ARBs] licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure.

b) Evidence of local arrangements to review people with chronic heart failure due to LVSD after each increase up to the optimal tolerated or target dose of ACE inhibitors (or ARBs) and beta-blockers.

Process:

a) Proportion of people with chronic heart failure due to LVSD who are prescribed ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors).

Numerator – the number of people in the denominator prescribed ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors).

Denominator – the number of people with chronic heart failure due to LVSD.

b) Proportion of people with chronic heart failure due to LVSD who are prescribed beta-blockers licensed for heart failure.

Numerator – the number of people in the denominator prescribed beta-blockers licensed for heart failure.

Denominator – the number of people with chronic heart failure due to LVSD.

c) Proportion of people with chronic heart failure due to LVSD who are prescribed both ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure.

Numerator – the number of people in the denominator prescribed both ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure.

Denominator – the number of people with chronic heart failure due to LVSD.

d) Proportion of people with chronic heart failure due to LVSD prescribed either ACE inhibitors or ARBs licensed for heart failure who are prescribed ACE inhibitors.

Numerator – the number of people in the denominator prescribed ACE inhibitors.

Denominator – the number of people with chronic heart failure due to LVSD prescribed ACE inhibitors or ARBs licensed for heart failure.

e) Proportion of people with chronic heart failure due to LVSD who are prescribed ACE inhibitors (or ARBs licensed for heart failure) who reach the optimal tolerated or target dose.

Numerator – the number of people in the denominator who reach the optimal tolerated or target dose of ACE inhibitor or ARB.

Denominator – the number of people with chronic heart failure due to LVSD who are prescribed ACE inhibitors or ARBs licensed for heart failure.

f) Proportion of people with chronic heart failure due to LVSD who are prescribed beta blockers licensed for heart failure who reach the optimal tolerated or target dose.

Numerator – the number of people in the denominator who reach the optimal tolerated or target dose of beta blocker.

Denominator – the number of people with chronic heart failure due to LVSD who are prescribed beta blockers licensed for heart failure.

What the quality statement means for each audience

Service providers ensure systems are in place to offer ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure to people with chronic heart failure due to LVSD and ensure review after each increase in dose.

Healthcare professionals ensure they offer ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure to people with chronic heart failure due to LVSD and review after each increase in dose.

Commissioners ensure they commission services that offer ACE inhibitors (or ARBs licensed for heart failure if there are intolerable side effects with ACE inhibitors) and beta-blockers licensed for heart failure to people with chronic heart failure due to LVSD and review after each increase in dose.

People with chronic heart failure due to left ventricular systolic dysfunction (when the chamber that pumps blood around the body isn't working as well as it should) are offered drugs called ACE inhibitors and beta-blockers, and their symptoms are reviewed after each increase in dose. People who have intolerable side effects with ACE inhibitors are offered angiotensin II receptor antagonists (ARBs for short) instead of ACE inhibitors.

Source guidance

NICE clinical guideline 108 recommendations 1.2.2.2 (key priority for implementation), 1.2.2.5, 1.2.2.6, 1.2.2.7 (key priority for implementation) and 1.2.2.8.

Data source

Structure: a) and b) Local data collection.

Process:

a) QOF HF3 – 'The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who can tolerate therapy and for whom there is no contra-indication.'

b) Local data collection.

c) QOF HF4 – 'The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker, who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers.' Also contained within NICE clinical guideline 108 audit support, criterion 6.

Prescription of core treatments recommended by NICE guidance is monitored by the National heart failure audit for people with an unplanned admission to hospital with heart failure.

d) Local data collection.

e) Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 7.

f) Local data collection.

Equality and diversity considerations

NICE clinical guideline 108 recommendation 1.2.2.7 promotes equality by highlighting certain groups for whom the provision of beta-blockers has been poor in the past:

Offer beta-blockers licensed for heart failure to all patients with heart failure due to left ventricular systolic dysfunction, including:

- older adults **and**

- patients with:
    - peripheral vascular disease
    - erectile dysfunction
    - diabetes mellitus
    - interstitial pulmonary disease and
- chronic obstructive pulmonary disease (COPD) without reversibility.

Quality statement 8: Cardiac rehabilitation programme

Quality statement

People with stable chronic heart failure and no precluding condition or device are offered a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Quality measure

Structure: Evidence of local arrangements to ensure the availability of a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support for people with stable chronic heart failure.

Process:

a) Proportion of people with stable chronic heart failure and no precluding condition or device who attend a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Numerator – the number of people in the denominator attending a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Denominator – the number of people with stable chronic heart failure and no condition or device that precludes them from exercise-based cardiac rehabilitation.

b) Proportion of people with stable chronic heart failure and no precluding condition or device who complete a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Numerator – the number of people in the denominator completing a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Denominator – the number of people with stable chronic heart failure and no condition or device that precludes them from exercise-based cardiac rehabilitation.

What the quality statement means for each audience

Service providers ensure systems are in place for people with stable chronic heart failure and no precluding condition or device to attend a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Healthcare professionals ensure people with stable chronic heart failure and no precluding condition are offered a supervised group exercise-based cardiac rehabilitation programme that includes education and psychological support.

Commissioners ensure they commission supervised group exercise-based cardiac rehabilitation programmes for people with chronic heart failure that include education and psychological support.

People with chronic heart failure are offered a supervised group exercise-based rehabilitation programme that includes information and psychological support, if it is suitable for them.

Definitions

The Guideline Development Group for NICE clinical guideline 108 noted that 'the majority of programmes [reviewed in the evidence update] included group exercises which also provided the patients with support and educational opportunities, through formal counselling, as well as iterative learning about their condition and how to cope with it'.

NICE clinical guideline 108 states that the conditions and devices that may preclude an exercise-based rehabilitation programme include:

- uncontrolled ventricular response to atrial fibrillation
- uncontrolled hypertension
- high-energy pacing devices set to be activated at rates likely to be achieved during exercise.

Source guidance

NICE clinical guideline 108 recommendation 1.3.1.1 (key priority for implementation).

Data source

Structure: Local data collection. Information on exclusion policies and reasons for referral to cardiac rehabilitation programmes is monitored by the National audit of cardiac rehabilitation.

Process: a) and b) Local data collection.

Equality and diversity considerations

Consideration should be given to people with conditions or devices precluding exercise-based programmes. These preclusions may legitimately exclude some people from such rehabilitation programmes.

Quality statement 9: Monitoring stable chronic heart failure

Quality statement

People with stable chronic heart failure receive a clinical assessment at least every 6 months, including a review of medication and measurement of renal function.

Quality measure

Structure: Evidence of local arrangements to ensure people with stable chronic heart failure receive a clinical assessment at least every 6 months, including a review of medication and measurement of renal function.

Process: Proportion of people with chronic heart failure receiving a clinical assessment in the last 6 months, including a review of medication and measurement of renal function.

Numerator – the number of people in the denominator receiving a clinical assessment in the last 6 months, including a review of medication and measurement of renal function.

Denominator – the number of people with stable chronic heart failure.

What the quality statement means for each audience

Service providers ensure systems are in place for the clinical assessment of people with stable chronic heart failure at least every 6 months, including a review of medication and measurement of renal function.

Healthcare professionals ensure people with stable chronic heart failure have a clinical assessment at least every 6 months, including a review of medication and measurement of renal function.

Commissioners ensure they commission services that provide a clinical assessment for people with stable chronic heart failure at least every 6 months, including a review of medication and measurement of renal function.

People with stable chronic heart failure have a check-up at least every 6 months, including a review of their drug treatment and tests to make sure their kidneys are working properly.

Definitions

NICE clinical guideline 108 states:

'All patients with chronic heart failure require monitoring. This monitoring should include:

- a clinical assessment of functional capacity, fluid status, cardiac rhythm (minimum of examining the pulse), cognitive status and nutritional status
- a review of medication, including need for changes and possible side effects
- serum urea, electrolytes, creatinine and eGFR*.

*This is a minimum. Patients with comorbidities or co-prescribed medications will require further monitoring. Monitoring serum potassium is particularly important if a patient is taking digoxin or an aldosterone antagonist.'

Unless otherwise specified, within this quality standard, specialist assessment or management refers to assessment or management by a multidisciplinary heart failure team. The multidisciplinary heart failure team will decide on the most appropriate member to perform clinical reviews for people with stable chronic heart failure, which may mean the GP leading the care in consultation with other members of the team.

Source guidance

NICE clinical guideline 108 recommendations 1.4.1.1 and 1.4.1.3.

Data source

Structure: Local data collection.

Process: Local data collection. Contained within NICE clinical guideline 108 audit support, criterion 17.

Quality statement 10: Management plans for people admitted to hospital

Quality statement

People admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP.

Quality measure

Structure: Evidence of local arrangements to ensure that people admitted to hospital because of heart failure have a personalised management plan that is shared with them, their carer(s) and their GP.

Process:

a) Proportion of people admitted to hospital because of heart failure who have a personalised management plan when discharged.

Numerator – the number of people in the denominator with a personalised management plan when discharged.

Denominator – the number of people discharged after admission to hospital because of heart failure.

b) Proportion of people admitted to hospital because of heart failure who have a personalised management plan shared with them, or their carer(s), when discharged.

Numerator – the number of people in the denominator who have a personalised management plan shared with them, or their carer(s), when discharged.

Denominator – the number of people discharged after admission to hospital because of heart failure.

c) Proportion of people admitted to hospital because of heart failure whose GP is given their personalised management plan when discharged.

Numerator – the number of people in the denominator whose GP is given their personalised management plan.

Denominator – the number of people discharged after admission to hospital because of heart failure.

What the quality statement means for each audience

Service providers ensure systems are in place to share personalised management plans with people admitted to hospital because of heart failure, their carer(s) and their GP.

Healthcare professionals ensure personalised management plans are shared with people admitted to hospital because of heart failure, their carer(s) and their GP.

Commissioners ensure they commission services that share personalised management plans with people admitted to hospital because of heart failure, their carer(s) and their GP.

People admitted to hospital because of heart failure, their carer(s) and their GP are provided with a copy of their personalised management plan.

Definitions

The management plan should include:

- how to access advice
- the main contact in the multidisciplinary heart failure team
- information on medication
- information on physical activity
- information on managing fluid balance
- details of follow-up appointments.

Source guidance

NICE clinical guideline 108 recommendation 1.5.2.2.

Data source

Structure: Local data collection.

Process: a), b) and c) Local data collection.

Quality statement 11: Contribution of multidisciplinary heart failure team to management plans

Quality statement

People admitted to hospital because of heart failure receive input to their management plan from a multidisciplinary heart failure team.

Quality measure

Structure: Evidence of local arrangements providing access to a multidisciplinary heart failure team for advice on management plans for people admitted to hospital because of heart failure.

Process:

a) Proportion of people admitted to hospital because of heart failure whose management plan includes advice from a multidisciplinary heart failure team.

Numerator – the number of people in the denominator whose management plan includes advice from a multidisciplinary heart failure team.

Denominator – the number of people admitted to hospital because of heart failure.

b) Proportion of people admitted to hospital because of heart failure seen by a specialist in heart failure.

Numerator – the number of people in the denominator seen by a specialist in heart failure.

Denominator – the number of people admitted to hospital because of heart failure.

An audit standard of less than 100% is expected for process b) to account for local service arrangements and appropriate use of resources.

What the quality statement means for each audience

Service providers ensure systems are in place for hospital staff to have access to a multidisciplinary heart failure team for advice on management plans for people admitted to hospital because of heart failure.

Healthcare professionals ensure they contact a multidisciplinary heart failure team for advice on management plans for people admitted to hospital because of heart failure.

Commissioners ensure they commission services that give hospital staff access to a multidisciplinary heart failure team for advice on management plans for people admitted to hospital because of heart failure.

People admitted to hospital because of heart failure receive input from their heart failure team into their management plan.

Definitions

As a minimum, the term 'receive input' should include documented discussion with, or input from a member of, the multidisciplinary heart failure team.

In NICE clinical guideline 108 the term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care. The team will involve, where necessary, other services (such as rehabilitation, tertiary care and palliative care) in the care of individual patients.

Unless otherwise specified, within this quality standard, specialist assessment or management refers to assessment or management by a multidisciplinary heart failure team. The team will decide on the most appropriate member to address a particular clinical problem.

Source guidance

NICE clinical guideline 108 recommendation 1.4.1.5 (key priority for implementation).

Data source

Structure: Local data collection.

Process: a) and b) Local data collection.

Quality statement 12: Hospital discharge and follow-up care

Quality statement

People admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Quality measure

Structure: Evidence of local arrangements to ensure that people admitted to hospital because of heart failure are discharged only when stable and receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Process: Proportion of people admitted to hospital because of heart failure who receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Numerator – the number of people in the denominator receiving a clinical assessment by a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Denominator – the number of people discharged following an admission to hospital for heart failure.

Outcome: Re-admissions because of heart failure within 30 days for people with heart failure discharged from hospital following an admission to hospital for heart failure.

Numerator – the number of people in the denominator re-admitted to hospital because of heart failure within 30 days.

Denominator – the number of people discharged following an admission to hospital for heart failure.

What the quality statement means for each audience

Service providers ensure systems are in place so that people admitted to hospital for heart failure are discharged only when they are stable and that they receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Healthcare professionals ensure people admitted to hospital for heart failure are discharged only when stable and that they receive a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

Commissioners ensure they commission services that discharge people admitted to hospital for heart failure only when they are stable and provide a clinical assessment from a member of the multidisciplinary heart failure team within 2 weeks of discharge.

People admitted to hospital for heart failure leave hospital only when their condition is stable and receive an assessment from a member of the multidisciplinary heart failure team within 2 weeks of leaving hospital.

Definitions

Unless otherwise specified, within this quality standard, specialist assessment or management refers to assessment or management by a multidisciplinary heart failure team. Arrangements for ongoing care will be agreed between the multidisciplinary heart failure team and primary care clinicians.

Source guidance

NICE clinical guideline 108 recommendation 1.4.1.3 and 1.5.2.1 (key priority for implementation).

Data source

Structure: Local data collection.

Process: Local data collection.

Outcome: Local data collection. The admitted patient care commissioning datasets contain the data needed for calculating re-admissions for people admitted to hospital because of heart failure. More information is available at HES Online.

Information on re-admissions is monitored by the National heart failure audit for people who have an unplanned admission to hospital with heart failure.

Quality statement 13: Specialist and palliative care for people with moderate to severe chronic heart failure

Quality statement

People with moderate to severe chronic heart failure, and their carer(s), have access to a specialist in heart failure and a palliative care service.

Quality measure

Structure:

a) Evidence of local arrangements to provide people with moderate to severe chronic heart failure, and their carer(s), with access to a specialist in heart failure.

b) Evidence of local arrangements to provide people with moderate to severe chronic heart failure, and their carers(s), with access to a palliative care service.

Process:

a) Evidence from experience surveys that people with moderate to severe chronic heart failure, and their carer(s), felt they had access to a specialist in heart failure.

b) Evidence from experience surveys that people with moderate to severe chronic heart failure, and their carer(s), felt they had access to a palliative care service.

What the quality statement means for each audience

Service providers ensure systems are in place for people with moderate to severe chronic heart failure and their carer(s) to have access to a specialist in heart failure and a palliative care service.

Healthcare professionals ensure people with moderate to severe chronic heart failure and their carer(s) have access to a specialist in heart failure and a palliative care service.

Commissioners ensure they commission services providing people with moderate to severe chronic heart failure and their carer(s) with access to a specialist in heart failure and a palliative care service.

People with moderate to severe chronic heart failure and their carer(s) have access to support from a heart specialist and an end of life care (also called palliative care) service.

Definitions

Referrals to the specialist in heart failure or the palliative care service should only be made for appropriate patients who would benefit from the services. Moderate to severe chronic heart failure refers to people with chronic heart failure and moderate to severe symptoms (typically progressive NYHA classes III or IV).

In NICE clinical guideline 108 the term 'specialist' denotes a physician with subspecialty interest in heart failure (often a consultant cardiologist) who leads a specialist multidisciplinary heart failure team of professionals with appropriate competencies from primary and secondary care.

Source guidance

NICE clinical guideline 108 recommendations 1.5.1.1, 1.5.9.2 and 1.5.9.3.

Data source

Structure:

a) Local data collection.

b) Local data collection. GP practices collect data on the completeness of a palliative care register for QOF PC3 – 'the practice has a complete register available of all patients in need of palliative care/support irrespective of age'. GP practices also collect data on case review meetings for QOF PC2 – 'the practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed'.

Process: a) and b) Local data collection. Information on access to heart failure liaison services and palliative care is an outcome monitored by the National heart failure audit for people with an unplanned admission to hospital with heart failure.

Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the development sources section.

Commissioning support and information for patients

NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. Information for patients using the quality standard is also available on the NICE website. Full commissioning guides on services for people with heart failure and cardiac rehabilitation services, that support the local implementation of NICE guidance are also available.

Quality measures and national indicators

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so aspirational achievement levels are likely to be 100% (or 0% if the quality statement states that something should not be done). However, it is recognised that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the NHS Information Centre through their Indicators for Quality Improvement Programme. For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard.

Diversity, equality and language

During the development of this quality standard, equality issues were considered.

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

Development sources

Evidence sources

The documents below contain clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Chronic heart failure: management of chronic heart failure in adults in primary and secondary care. NICE clinical guideline 108 (2010; NHS Evidence accredited source).

Policy context

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

NHS Improvement Programme and NHS End of life care programme (2010) End of life care in heart failure.

NHS Heart Improvement Programme (2005) Heart failure: a quick guide to quality commissioning across the whole pathway of care.

Department of Health (2003) Developing services for heart failure.

Department of Health (2000) Coronary heart disease: national service framework for coronary heart disease.

Definitions and data sources

References included in the definitions and data sources sections can be found below:

Commissioning dataset definitions.

Hospital episodes statistics.

The National heart failure audit.

The National audit of cardiac rehabilitation.

New York Heart Association (NYHA) classification of heart failure symptoms revised by the American Heart Association (1994) Revisions to classification of functional capacity and objective assessment of patients with diseases of the heart.

Quality and Outcomes Framework indicators.

Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).

End of life care for adults. NICE quality standard 13 (2011).

The Topic Expert Group and NICE project team

Topic Expert Group

Dr Abdallah Al-Mohammad
Consultant Cardiologist, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Ivan Benett
General Practitioner, NHS Manchester

Dr Paul Collinson
Consultant in Chemical Pathology, st George's Hospital and Medical School

Professor Martin R Cowie
Professor of Cardiology, Imperial College London

Miss Jane Gilmour
Clinical Nurse Specialist Heart Failure, Luton and Dunstable NHS Trust

Dr Suzanna Hardman
Consultant Cardiologist with special interest in Community Cardiology, Whittington NHS Trust

Dr John Mackay
General Practitioner, Grangewood Surgery, Co Durham

Professor Jonathan Mant
Professor of Primary Care Research, General Practice and Primary Care Research Unit, University of Cambridge

Dr Hugh McIntyre (Chair)
Consultant Physician, East Sussex Hospital Trust

Mr Richard Mindham
Lay member

Mr John Soady
Public Health Principal, NHS Sheffield

NICE project team

Fergus Macbeth
Director

Nick Baillie
Associate Director

Tim Stokes
Consultant Clinical Adviser

Craig Grime
Lead Analyst

About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

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

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

We have produced a summary for patients and carers.

Changes after publication

April 2015: minor maintenance.

August 2013: minor maintenance.

April 2013: minor maintenance.

Copyright

Contact NICE

National Institute for Health and Clinical Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk
nice@nice.org.uk
0845 003 7780