NICE National Institute for Health and Care Excellence

NICE quality standard

Chronic heart failure in adults

Quality standard
Published: 29 June 2011
Last updated: 3 September 2025

www.nice.org.uk/guidance/qs9

Contents

This standard is based on NG106.

This standard should be read in conjunction with QS13, QS15, QS93, QS103, QS100, QS99, QS84, QS76, QS68, QS53, QS43, QS21, QS11, QS8, QS6, QS127, QS120, QS111, TA679 and TA773.

Quality statements

Statement 1 Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT-proBNP) measured. **[2023]**

Statement 2 Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high N-terminal pro-B-type natriuretic peptide (NT-proBNP) level, or 6 weeks if they have a high NT-proBNP level. **[2011, updated 2023]**

Statement 3 Adults with newly diagnosed and pre-existing chronic heart failure with reduced ejection fraction receive all appropriate medication at optimal tolerated doses. **[2011, updated 2025]**

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]**

Statement 5 Adults with chronic heart failure have a review of their condition at least every 6 months. **[2011, updated 2016]**

Statement 6 Adults with chronic heart failure receive a personalised programme of cardiac rehabilitation. **[2011, updated 2023]**

In 2023, this quality standard was updated and statements prioritised in 2011 and 2016 were updated (2011, updated 2023), remained unchanged (2016), or were replaced (2023). For more information, see update information.

The previous version of the quality standard for chronic heart failure in adults is available as a pdf.

Quality statement 1: N-terminal pro-B-type natriuretic peptide measurement

Quality statement

Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT-proBNP) measured. **[2023]**

Rationale

N-terminal pro-B-type natriuretic peptide measurement in primary care can confirm whether heart failure is likely when it is suspected and there is no existing diagnosis of heart failure. People can then be referred for specialist assessment and echocardiography, begin appropriate treatment at an earlier point in their illness, and lower their risk of hospitalisation and mortality.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adults diagnosed with heart failure by specialist assessment and echocardiography who had NT-proBNP measured before diagnosis.

Numerator – the number in the denominator who had NT-proBNP measured before diagnosis.

Denominator – the number of adults diagnosed with heart failure by specialist assessment and echocardiography.

Data source: No routinely collected national data for this measure has been identified.

Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Hospital admissions due to heart failure.

Data source: The National Heart Failure Audit contains data on hospital admission rates for heart failure.

What the quality statement means for different audiences

Service providers (primary care) ensure that systems are in place to measure NT-proBNP when heart failure is suspected in adults.

Healthcare professionals (such as GPs and practice nurses) ensure that when they suspect heart failure in adults, they arrange or carry out NT-proBNP measurement.

Commissioners (integrated care systems) ensure that NT-proBNP testing is available in primary care settings.

Adults with suspected heart failure have a blood test by their GP or practice nurse to find out how well their heart is working.

Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018, updated 2025), recommendation 1.2.2

Definitions of terms used in this quality statement

Adults with suspected heart failure

Adults may be suspected of having heart failure after being:

- Asked about symptoms:
  - breathlessness – on exertion, at rest, on lying flat (orthopnoea), nocturnal cough, or waking from sleep (paroxysmal nocturnal dyspnoea)
  - fluid retention (ankle swelling, bloated feeling, abdominal swelling, or weight gain)
  - fatigue, decreased exercise tolerance, or increased recovery time after exercise
  - light headedness or history of syncope (fainting).
- Asked about risk factors:
  - coronary artery disease including previous history of myocardial infarction, hypertension, atrial fibrillation and diabetes mellitus
  - drugs use, including alcohol
  - family history of heart failure or sudden cardiac death under the age of 40 years.
- And examined for:
  - tachycardia (heart rate over 100 beats per minute) and pulse rhythm
  - a laterally displaced apex beat, heart murmurs, and third or fourth heart sounds (gallop rhythm)
  - hypertension; for more information, see NICE's clinical knowledge summary on hypertension
  - raised jugular venous pressure
  - enlarged liver (due to engorgement)
  - respiratory signs such as tachypnoea, basal crepitations, and pleural effusions
  - dependent oedema (legs, sacrum), ascites
  - obesity; for more information, see NICE's clinical knowledge summary on obesity.

[Adapted from NICE's clinical knowledge summary on chronic heart failure]

Quality statement 2: Specialist assessment

Quality statement

Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high N-terminal pro-B-type natriuretic peptide (NT-proBNP) level, or 6 weeks if they have a high NT-proBNP level. **[2011, updated 2023]**

Rationale

Adults who have high (between 400 and 2,000 ng/litre) or very high levels (over 2,000 ng/litre) of NT-proBNP have a higher likelihood of heart failure and a poorer prognosis. Having transthoracic echocardiography concurrently with specialist assessment to confirm heart failure classification within 2 or 6 weeks of referral can help to ensure that the person is started on appropriate treatment to manage their condition.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local service pathways and written clinical protocols to ensure that adults with suspected heart failure who have been referred for diagnosis have transthoracic echocardiography and specialist assessment within 2 or 6 weeks based on their NT-proBNP level.

Data source: No routinely collected data for this measure has been identified. Data can be collected from information recorded locally by healthcare provider organisations, for example from service pathways or protocols.

Process

a) Proportion of adults with very high levels of NT-proBNP, who have been referred for diagnosis, who have transthoracic echocardiography and specialist assessment within 2 weeks of referral.

Numerator – the number in the denominator who have transthoracic echocardiography and specialist assessment within 2 weeks of referral.

Denominator – the number of adults with very high levels of NT-proBNP who have been referred for diagnosis.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of adults with high levels of NT-proBNP, who have been referred for diagnosis, who have transthoracic echocardiography and specialist assessment within 6 weeks of referral.

Numerator – the number in the denominator who have transthoracic echocardiography and specialist assessment within 6 weeks of referral.

Denominator – the number of adults with high levels of NT-proBNP who have been referred for diagnosis.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Hospital admissions due to heart failure.

Data source: The National Heart Failure Audit contains data on hospital admission rates for heart failure.

What the quality statement means for different audiences

Service providers (such as secondary care) ensure that systems such as referral pathways, as well as appropriate equipment and staff training, are in place for adults with suspected heart failure to have an echocardiogram and be seen by a specialist concurrently within 2 or 6 weeks of referral based on their levels of NT-proBNP.

Healthcare professionals (such as consultant cardiologists) ensure that adults with suspected heart failure have an echocardiogram and specialist assessment within 2 or 6 weeks of referral based on their levels of NT-proBNP.

Commissioners (integrated care systems) ensure that they commission services in which adults with suspected heart failure have an echocardiogram and specialist assessment concurrently within 2 or 6 weeks of referral based on their levels of NT-proBNP.

Adults with suspected heart failure who have been referred for diagnosis have a test called an echocardiogram and are seen by a heart specialist at the same time. This should happen within 2 weeks of being referred by their GP if a blood test shows very high levels of a substance (called an N-terminal pro-B-type natriuretic peptide) that suggests they may have heart failure needing urgent treatment. It should happen within 6 weeks if those levels are high. An echocardiogram is a test to check the structure of the heart and how well it is working. The specialist will carry out an assessment and confirm whether they have chronic heart failure. If chronic heart failure is diagnosed, the specialist will try to find the cause, offer treatment and talk to the person about how to manage the condition.

Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018, updated 2025), recommendations 1.2.3 and 1.2.4

Definitions of terms used in this quality statement

Specialist assessment

Specialist assessment includes tests to evaluate for possible aggravating factors and to

exclude other conditions with similar presentations, and confirm a diagnosis of heart failure, including the type of reduced or preserved ejection fraction. It also includes assessment for underlying causes where appropriate.

The assessment should be carried out by the specialist heart failure multidisciplinary team which should include:

- a lead physician with subspecialty training in heart failure (usually a consultant cardiologist) who is responsible for making the clinical diagnosis
- a specialist heart failure nurse
- a healthcare professional with expertise in specialist prescribing for heart failure, for example, a specialist heart failure pharmacist.

[Adapted from NICE's clinical knowledge summary on chronic heart failure and NICE's guideline on chronic heart failure in adults, recommendation 1.1.1]

Very high levels of NT-proBNP

Very high levels of NT-proBNP are defined as above 2,000 ng/litre (236 pmol/litre). [Adapted from NICE's guideline on chronic heart failure in adults, recommendation 1.2.3]

High levels of NT-proBNP

High levels of NT-proBNP are defined as between 400 and 2,000 ng/litre (47 to 236 pmol/litre). [Adapted from NICE's guideline on chronic heart failure in adults, recommendation 1.2.4]

Quality statement 3: Medication for newly diagnosed and pre-existing chronic heart failure with reduced ejection fraction

Quality statement

Adults with newly diagnosed and pre-existing chronic heart failure with reduced ejection fraction receive all appropriate medication at optimal tolerated doses. **[2011, updated 2025]**

Rationale

It is important that all adults with chronic heart failure with reduced ejection fraction are given all appropriate medications at an optimal tolerated dose to best manage their condition and provide the best outcome.

Adults with chronic heart failure with reduced ejection fraction should be offered the following treatment combination to reduce the likelihood of related hospitalisation and mortality:

- angiotensin-converting enzyme (ACE) inhibitor
  - or an angiotensin receptor-neprilysin inhibitor (ARNI)
  - or an angiotensin II receptor blocker (ARB)
- beta-blocker
- mineralocorticoid receptor antagonist (MRA)
- sodium-glucose cotransporter-2 (SGLT2) inhibitor.

People's medical history, findings from their clinical assessment, their frailty status, prognosis and preferences should be used when making decisions about these medicines. They should have regular checks to monitor any side effects, until optimal tolerated doses are reached.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of adults with chronic heart failure with reduced ejection fraction that are prescribed an ACE inhibitor, or ARNI or ARB.

Numerator – the number in the denominator that are prescribed an ACE inhibitor, or ARNI or ARB.

Denominator – the number of adults with chronic heart failure with reduced ejection fraction.

Data source: Data on general practice prescribing of ACE inhibitors or ARBs is available from the NHS Quality and Outcomes Framework (QOF; see QOF indicator HF003). Data on prescribing of ACE inhibitors (or ARBs or ARNIs) on discharge from hospital is available from the National Heart Failure Audit.

b) Proportion of adults with chronic heart failure with reduced ejection fraction that are prescribed a beta-blocker.

Numerator – the number in the denominator that are prescribed a beta-blocker.

Denominator – the number of adults with chronic heart failure with reduced ejection fraction.

Data source: Data on general practice prescribing of beta-blockers, is available from the NHS Quality and Outcomes Framework (QOF; see QOF indicator HF006). Data on prescribing of beta-blockers on discharge from hospital is available from the National Heart Failure Audit.

c) Proportion of adults with chronic heart failure with reduced ejection fraction that are prescribed an MRA.

Numerator – the number in the denominator that are prescribed an MRA.

Denominator – the number of adults with chronic heart failure with reduced ejection fraction.

Data source: Data on prescribing of MRAs on discharge from hospital is available from the National Heart Failure Audit.

d) Proportion of adults with chronic heart failure with reduced ejection fraction that are prescribed an SGLT2 inhibitor.

Numerator – the number in the denominator that are prescribed an SGLT2 inhibitor.

Denominator – the number of adults with chronic heart failure with reduced ejection fraction.

Data source: Data on prescribing of SGLT2 inhibitors on discharge from hospital is available from the National Heart Failure Audit.

e) Proportion of adults with chronic heart failure with reduced ejection fraction that are prescribed an ACE inhibitor, beta-blocker, MRA and SGLT2 inhibitor.

Numerator – the number in the denominator that are prescribed an ACE inhibitor, beta-blocker, MRA and SGLT2 inhibitor.

Denominator – the number of adults with chronic heart failure with reduced ejection fraction.

Data source: No routinely collected national data on general practice prescribing is available for all medicines in this treatment combination, but may be collected locally by healthcare professionals and provider organisations, for example from patient records. Data on prescribing of ACE inhibitors (or ARNIs or ARBs, beta-blockers, MRAs and SGLT2 inhibitors) on discharge from hospital is available from the National Heart Failure Audit.

The uptake of MRAs, SGLT2 inhibitors and ARNIs in general practice prescribing for people with chronic heart failure with reduced ejection fraction will need to be undertaken at a local level using any data available. This could include electronic medical records.

Outcome

a) Hospital admissions due to heart failure.

Data source: The National Heart Failure Audit contains data on hospital admission rates for heart failure.

b) Mortality due to heart failure with reduced ejection fraction.

Data source: No routinely collected national data for this measure has been identified. The National Heart Failure Audit contains mortality data for people 1 year after discharge who were admitted with heart failure.

What the quality statement means for different audiences

Service providers (GP practices, hospitals and community providers) ensure that adults with chronic heart failure with reduced ejection fraction are prescribed a combination of treatments in line with the latest NICE guidance.

Healthcare professionals (such as GPs, specialists in cardiac care, heart failure specialist nurses and clinical pharmacists) ensure that they prescribe appropriate medications in line with their marketing authorisation and relevant NICE guidance (including clinical guidelines and technology appraisal guidance).

They ensure that the medication is started and increased (when applicable) in accordance with individual health needs and, if the medication requires it, based on the advice of a heart failure specialist. They also make sure that there is monitoring for side effects and symptoms of heart failure after each increase in dose.

Commissioners (such as integrated care systems and NHS England) ensure that they commission services in which adults with chronic heart failure with reduced ejection fraction are prescribed appropriate medication.

Adults with chronic heart failure with reduced ejection fraction (when the part of the heart that pumps blood around the body is not squeezing the blood as well as it should) are prescribed appropriate medications for heart failure. The medication is started and

increased (when applicable) with check-ins for any changes in symptoms, side effects and, depending on the medication, based on input from their heart failure doctor.

Source guidance

- Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018, updated 2025), recommendations 1.4.1 to 1.4.4, 1.7.1 and 1.7.2
- Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction. NICE technology appraisal 388 (2016) recommendations 1.1 and 1.2
- Dapagliflozin for treating chronic heart failure with reduced ejection fraction. NICE technology appraisal guidance 679 (2021), recommendations 1.1 and 1.2
- Empagliflozin for treating chronic heart failure with reduced ejection fraction. NICE technology appraisal guidance 773 (2022), recommendations 1.1 and 1.2

Definitions of terms used in this quality statement

Heart failure with reduced ejection fraction

Heart failure with an ejection fraction below 40%. [NICE's guideline on chronic heart failure in adults]

Appropriate medication

ACE inhibitors, beta-blockers, MRAs and SGLT2 inhibitors are of proven benefit for people with chronic heart failure with reduced ejection fraction, and NICE recommends them as first-line treatment.

ARNIs licensed for heart failure should be considered as an alternative to an ACE inhibitor for people on the maximum tolerated dose of each of ACE inhibitors, beta-blockers, MRAs and SGLT2 inhibitors who continue to have symptoms of heart failure, and for people with chronic heart failure with reduced ejection fraction who have symptoms of intolerance to ACE inhibitors (other than angioedema). Primary care prescribers should consider seeking advice from a heart failure specialist before starting someone on a angiotensin receptor-neprilysin inhibitor (ARNI).

ARBs licensed for heart failure should be considered for people with angioedema after taking an ACE inhibitor, and should be considered for people who have symptoms of intolerance of ACE inhibitors and ARNIs.

Other specialist treatments may also be appropriate for some people and should be initiated by a heart failure specialist with access to a multidisciplinary heart failure team or after seeking specialist advice. These treatments include ivabradine, hydralazine in combination with nitrate (especially if the person is of African or Caribbean family origin and has moderate to severe heart failure with reduced ejection fraction) and digoxin.

People's medical history, findings from their clinical assessment, their frailty status, prognosis and preferences should be used when deciding:

- which specific medicines and medicine combinations to use
- the order and timing for introducing each medicine
- the initial dose of each medicine and any subsequent dose increments
- when and how to optimise the dose of each medicine.

[NICE's guideline on chronic heart failure in adults, recommendations 1.4.1 to 1.4.4, 1.4.8 to 1.4.12, 1.7.1 and 1.7.2 and NICE's technology appraisal guidance on ivabradine, sacubitril valsartan, dapagliflozin, and empagliflozin for treating chronic heart failure with reduced ejection fraction]

Equality and diversity considerations

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

Quality statement 4: Review after changes in medication

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of changes to dose or type of chronic heart failure medication in which the person is reviewed within 2 weeks of a change.

Numerator – the number in the denominator in which the person is reviewed within 2 weeks of the change to dose or type of medication.

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

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Hospital admissions due to heart failure.

Data source: The National Heart Failure Audit contains data on hospital admission rates for heart failure.

What the quality statement means for different audiences

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

Healthcare professionals (such as GPs, specialists in cardiac care, heart failure specialist nurses, specialist multidisciplinary heart failure teams, and clinical pharmacists with an interest in chronic heart failure) carry out a review for adults with chronic heart failure within 2 weeks of any change in the dose or type of their heart failure medication. The multidisciplinary heart failure team will decide who is the most appropriate team member to do this, for example, the GP may lead the care in consultation with other members of the team.

Commissioners (integrated care systems) ensure that they commission services in which adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication.

Adults with chronic heart failure are seen by the appropriate healthcare professional within 2 weeks of any change in the dose or type of medication they are taking for heart failure, to check for any problems and make sure that the medication is working.

Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018,

updated 2025), recommendations 1.8.1 and 1.8.3

Definitions of terms used in this quality statement

Review when medication is changed

Review should include as a minimum:

- clinical assessment of functional capacity, fluid status, cardiac rhythm (minimum of examining the pulse), cognitive status and nutritional status
- review of medication, including need for changes and possible side effects
- an assessment of renal function
- iron status and haemoglobin measurement.

Reviews may need to be adjusted based on the medication that has been introduced or changed, for example testing within 2 weeks of introduction of a sodium-glucose co-transporter 2 inhibitor may show irregular results for some tests. More detailed monitoring is needed if the person has significant comorbidity or if their condition has deteriorated since the previous review. [Adapted from NICE's guideline on chronic heart failure in adults, recommendations 1.8.1 and 1.8.2, and expert opinion]

Quality statement 5: Review of people with chronic heart failure

Quality statement

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

Rationale

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

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

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

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

Denominator – the number of adults with chronic heart failure.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Hospital admissions due to heart failure.

Data source: The National Heart Failure Audit contains data on hospital admission rates for heart failure.

What the quality statement means for different audiences

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

Healthcare professionals (GPs and specialist multidisciplinary heart failure team members) ensure that they review adults with chronic heart failure at least every 6 months. The multidisciplinary heart failure team will decide on the most appropriate member to do this, for example, the GP may lead care in consultation with other members of the team.

Commissioners (integrated care systems) ensure that they commission services in which adults with chronic heart failure have a review of their condition at least every 6 months.

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

Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018, updated 2025), recommendations 1.8.1 and 1.8.3

Definitions of terms used in this quality statement

Review of people with chronic heart failure

Reviews should include as a minimum:

- clinical assessment of functional capacity, fluid status, cardiac rhythm (minimum of examining the pulse), cognitive status and nutritional status
- review of medication, including need for changes and possible side effects
- an assessment of renal function
- iron status and haemoglobin measurement.

Every 6 months, the person should have their clinical record updated by their primary care team, and any changes should be understood and agreed by the person with heart failure and shared with the specialist heart failure multidisciplinary team.

Healthcare professionals involved in the review should have a copy of the person's care plan, which should include information on:

- diagnosis and aetiology
- medicines prescribed, monitoring of medicines, when medicines should be reviewed and any support the person needs to take the medicines
- functional abilities and any social care needs
- social circumstances, including carers' needs
- plans for managing the person's heart failure, including follow-up care, rehabilitation and access to social care
- symptoms to look out for in case of deterioration
- a process for any subsequent access to the specialist heart failure multidisciplinary team if needed
- contact details for:
    - a named healthcare coordinator (usually a specialist heart failure nurse)

  - alternative local heart failure specialist care providers, for urgent care or review

- additional sources of information for people with heart failure.

For people taking amiodarone the review should include liver and thyroid function tests, and a review of side effects.

For people with a cardioverter defibrillator, the review should consider benefits and potential harms of it remaining active.

More detailed monitoring should be provided if the person has significant comorbidity or if their condition has deteriorated since the previous review. Monitoring serum potassium is particularly important if a person is taking digoxin or a mineralocorticoid receptor antagonist.

People with heart failure who wish to be involved in the monitoring of their condition should be provided with sufficient education and support to do this, with clear guidelines as to what to do in the event of deterioration. [Adapted from the BNF treatment summary on chronic heart failure and NICE's guideline on chronic heart failure in adults, recommendations 1.1.4, 1.1.7 to 1.1.9, 1.8.1 to 1.8.4, 1.9.3, 1.9.4, and 1.10.5]

Quality statement 6: Cardiac rehabilitation

Quality statement

Adults with chronic heart failure receive a personalised programme of cardiac rehabilitation. **[2011, updated 2023]**

Rationale

A personalised programme of cardiac rehabilitation delivered by an appropriate method, preceded by an assessment to ensure that it is suitable, can help to extend and improve the quality of a person's life. Cardiac rehabilitation uses monitored exercise, psychological support and education about lifestyle changes to reduce the risks of further heart problems. It can also reduce uncertainty and anxiety about living with chronic heart failure. Through better management of their condition, the person may have greater opportunities to return to normal activities.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of adults with chronic heart failure who have a record of referral to a personalised programme of cardiac rehabilitation.

Numerator – the number in the denominator who have a record of referral to a personalised programme of cardiac rehabilitation.

Denominator – the number of adults with chronic heart failure.

Data source: The National Heart Failure Audit contains data on patients discharged alive after an admission with acute heart failure referred as an inpatient to cardiac rehabilitation.

b) Proportion of adults with chronic heart failure who receive a personalised programme of cardiac rehabilitation.

Numerator – the number in the denominator who receive a personalised programme of cardiac rehabilitation.

Denominator – the number of adults with chronic heart failure.

Data source: National data on the uptake of cardiac rehabilitation is available from the NHS National Audit of Cardiac Rehabilitation.

Outcome

a) Rates of people with chronic heart failure completing programmes of cardiac rehabilitation.

Data source: National data on the proportion of people with chronic heart failure completing cardiac rehabilitation are available from the NHS National Audit of Cardiac Rehabilitation.

b) Patient outcomes following programmes of cardiac rehabilitation.

Data source: National data on patient outcomes following cardiac rehabilitation such as physical activity, BMI, anxiety and depression are available from the NHS National Audit of Cardiac Rehabilitation.

What the quality statement means for different audiences

Service providers (GP practices, community nursing teams and hospitals) ensure that referral pathways to personalised programmes of cardiac rehabilitation that include a monitored exercise, a psychological component and an educational component are available for adults with chronic heart failure.

Healthcare professionals (such as GPs, cardiac rehabilitation nurses and specialists in cardiac care) ensure that they refer adults diagnosed with chronic heart failure to a personalised programme of cardiac rehabilitation, once they are well enough to take part.

Commissioners (integrated care systems and local authorities) ensure that they commission services in which personalised cardiac rehabilitation programmes that include a monitored exercise, a psychological component and an educational component are available for adults with chronic heart failure.

Adults with chronic heart failure are offered a personalised programme of cardiac rehabilitation if it is suitable for them, once they are well enough to take part. This programme includes help and support with taking exercise, help with understanding their condition, support with their thoughts and feelings around the condition, and help with how to look after themselves.

Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018, updated 2025), recommendation 1.11.1

Definitions of terms used in this quality statement

Personalised programme of cardiac rehabilitation

This is an exercise-based programme of rehabilitation designed for people with chronic heart failure that includes a psychological and educational component. It should be accompanied by information about support available from healthcare professionals. The information should be provided in a format and setting (at home, in the community or in the hospital) that is easily accessible. It should be suited to the person, their condition, and their needs. [Adapted from NICE's guideline on chronic heart failure in adults, recommendation 1.11.1]

Equality and diversity considerations

A programme of cardiac rehabilitation should be accessible for all adults with chronic heart failure, including those who may be housebound or in a nursing home. A range of formats

(for example, online, in person) and settings (at home, in the community or in the hospital) should be provided so that everyone has their needs met.

When conducting cardiac rehabilitation in the community or in hospital, measures such as providing transport for people to attend sessions and holding the sessions in different locations should be considered. Cardiac rehabilitation should be held in buildings that have access for disabled people.

Healthcare professionals should take into account the communication needs of people with chronic heart failure, including those with cognitive impairment, when delivering cardiac rehabilitation. All information should be culturally appropriate, and accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. If needed, people should have access to an interpreter or advocate as set out in NICE's guideline on advocacy services for adults with health and social care needs.

Update information

September 2025: Changes have been made to align this quality standard with the updated NICE guideline on chronic heart failure in adults. Statement 3 on medication for chronic heart failure with reduced ejection fraction has been updated to reflect changes to the guidance. Links, definitions and source guidance sections have also been updated throughout.

January 2023: This quality standard was updated, and statements prioritised in 2011 and 2016 were updated or replaced, with some statements from 2016 remaining unchanged. The topic was identified for update following the annual review of quality standards. The review identified:

- potential changes in the priority areas for improvement
- that there was potential for quality statements to be combined.

Statements are marked as:

- **[2023]** if the statement covers a new area for quality improvement
- **[2011, updated 2023]** if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated
- **[2016]** if the statement remains unchanged
- **[2011, updated 2016]** if the statement covers an area for quality improvement included in the 2011 quality standard and was updated in 2016.

The previous version of the quality standard for chronic heart failure in adults is available as a pdf.

About this quality standard

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

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the resource impact products from NICE's guideline on chronic heart failure in adults to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

ISBN: 978-1-4731-7175-6

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Alliance for Heart Failure
- The Pumping Marvellous Foundation
- British Society for Heart Failure
- British Association for Nursing in Cardiovascular Care (BANCC)
- British Cardiovascular Society