

# Chronic heart failure in adults

Quality standard

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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 and QS111.

## Introduction

This quality standard covers the assessment, diagnosis and management of chronic heart failure in adults (18 and older). The diagnosis and management of acute heart failure is covered by [NICE's quality standard on acute heart failure](#). For more information see the [chronic heart failure topic overview](#).

This quality standard has been updated. The topic was identified for update following the annual review of quality standards in 2014. The review identified that there had been changes in the areas for improvement for chronic heart failure in adults. For further information about the update, see [update information](#). Statements from the 2011 quality standard that are no longer national priorities for improvement but are still underpinned by current accredited guidance are included after the updated statements in the [list of quality statements](#).

This quality standard should be considered alongside other relevant NICE quality standards, such as the [NICE quality standard on end of life care for adults](#), which covers care provided by health and social care staff for adults approaching the end of life. It should also be read alongside the [NICE technology appraisal guidance for implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure](#). Additional quality standards relevant to this topic are listed in [related NICE quality standards](#).

## Why this quality standard is needed

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

quality statements in this quality standard relate to all causes of chronic heart failure unless stated otherwise.

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

The [British Heart Foundation's cardiovascular disease statistics \(2014\)](#) estimated that around 550,000 people in the UK were living with heart failure in 2013. Both the incidence and the prevalence of heart failure increase with age, with an average age at first diagnosis of 76 years ([Cowie MR, Wood DA, Coats AJ et al. \[1999\] Incidence and aetiology of heart failure; a population-based study](#)).

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

Heart failure has a poor prognosis: 30–40% of people diagnosed with heart failure die within 1 year, but thereafter the mortality is less than 10% per year. Patients on GP heart failure registers, representing prevalent cases of heart failure, have a 5-year survival rate of 58%, compared with 93% in the general population ([Cowie MR, Wood DA, Coats AJ et al. \[2000\] Survival of patients with a new diagnosis of heart failure: a population based study](#) and [Hobbs FD, Roalfe AK, Davis RC et al. \[2007\] Prognosis of all-cause heart failure and borderline left ventricular systolic dysfunction: 5 year mortality follow-up of the Echocardiographic Heart of England Screening Study](#)).

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

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

## How this quality standard supports delivery of outcome

## frameworks

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

- [NHS Outcomes Framework 2015 to 2016](#)
- [Public Health Outcomes Framework 2013 to 2016](#)
- [Adult Social Care Outcomes Framework 2015 to 2016](#).

## Patient experience and safety issues

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

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

## Coordinated services

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

## Training and competencies

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

## Role of families and carers

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



## List of quality statements

Statement 1 Adults with suspected chronic heart failure who have been referred for diagnosis have an echocardiogram and specialist assessment. [2011, updated 2016]

Statement 2 Adults with suspected chronic heart failure and very high levels of serum natriuretic peptides, who have been referred for diagnosis, have an echocardiogram and specialist assessment within 2 weeks. [2011, updated 2016]

Statement 3 Adults with chronic heart failure who have reduced ejection fraction are started on low-dose angiotensin-converting enzyme (ACE) inhibitor and beta-blocker medications that are gradually increased until the target or optimal tolerated doses are reached. [2011, updated 2016]

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. [new 2016]

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

Statement 6 Adults with stable chronic heart failure are offered an exercise-based programme of cardiac rehabilitation. [2011, updated 2016]

Statement 7 (developmental) Adults with chronic heart failure referred to a programme of cardiac rehabilitation are offered sessions during and outside working hours, and the choice of undertaking the programme at home, in the community or in a hospital setting. [new 2016]

In 2016 this quality standard was updated, and statements prioritised in 2011 were updated (2011, updated 2016) or replaced (new 2016). For more information, see [update information](#).

Statements from the 2011 quality standard for stroke in adults that are still supported by the evidence may still be useful at a local level:

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

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

The [2011 quality standard for chronic heart failure](#) is available as a pdf.

# Quality statement 1: Diagnosis by a specialist

## Quality statement

Adults with suspected chronic heart failure who have been referred for diagnosis have an echocardiogram and specialist assessment. [2011, updated 2016]

## Rationale

To ensure that the correct diagnosis is made, adults with suspected chronic heart failure who have been referred for diagnosis should have an echocardiogram and be seen by a specialist. The specialist should assess the person and review the echocardiogram results. The echocardiogram will show any valve disease and assess the function of the left ventricle. Specialist assessment is needed to confirm the diagnosis of heart failure, consider the possible causes, discuss the appropriate treatment and develop a management plan.

## Quality measures

### Structure

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

**Data source:** Local data collection.

### Process

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

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

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

**Data source:** Local data collection.

## What the quality statement means for different audiences

**Service providers** (such as hospitals) ensure that systems are in place so that adults with suspected chronic heart failure who have been referred for diagnosis have an echocardiogram and specialist assessment.

**Healthcare professionals** (such as doctors and specialists in cardiac care) ensure that adults with suspected chronic heart failure who have been referred for diagnosis have an echocardiogram and specialist assessment. Specialists in cardiac care should assess the person after they have had an echocardiogram.

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

**Adults with symptoms of heart failure** who have been referred for diagnosis have a test called an echocardiogram to check the structure of their heart and how well it is working. They are then seen by a heart specialist who 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 their condition.

## Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018), recommendations 1.2.2, 1.2.4 and 1.2.6

## Definitions of terms used in this quality statement

### Specialist

The core specialist heart failure multidisciplinary team includes:

- 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.

[Adapted from [NICE's guideline on chronic heart failure in adults](#), recommendation 1.1.1]

## Quality statement 2: Urgent specialist assessment within 2 weeks

### Quality statement

Adults with suspected chronic heart failure and very high levels of serum natriuretic peptides, who have been referred for diagnosis, have an echocardiogram and specialist assessment within 2 weeks. [2011, updated 2016]

### Rationale

Adults who have very high levels of serum natriuretic peptides have a higher likelihood of heart failure and a poorer prognosis. The time taken for diagnostic testing and assessment is particularly important for these patients. Having an echocardiogram and specialist assessment within 2 weeks of referral can help to ensure that the person is started on appropriate medication to reduce any further long-term damage to the heart.

### Quality measures

#### Structure

Evidence of local arrangements and written clinical protocols to ensure that adults with suspected chronic heart failure and very high levels of serum natriuretic peptides, who have been referred for diagnosis, have an echocardiogram and specialist assessment within 2 weeks.

**Data source:** Local data collection.

#### Process

Proportion of adults with suspected chronic heart failure and very high levels of serum natriuretic peptides, who have been referred for diagnosis, who have an echocardiogram and specialist assessment within 2 weeks of referral.

**Numerator** – the number in the denominator who have an echocardiogram and a specialist assessment within 2 weeks of referral.

Denominator – the number of adults referred for diagnosis with suspected chronic heart failure and very high levels of serum natriuretic peptides.

Data source: Local data collection.

## Outcome

a) Mortality due to heart failure.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions due to heart failure.

Data source: Local data collection.

## What the quality statement means for different audiences

**Service providers** (such as hospitals) ensure that systems are in place for adults with suspected chronic heart failure referred for diagnosis to have an echocardiogram and be seen by a specialist within 2 weeks of referral if they have very high levels of serum natriuretic peptides.

**Healthcare professionals** (such as specialists in cardiac care) ensure that adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and are seen within 2 weeks of referral if they have very high levels of serum natriuretic peptides.

**Commissioners** (such as clinical commissioning groups) ensure that they commission services in which adults with suspected chronic heart failure referred for diagnosis have an echocardiogram and are seen by a specialist within 2 weeks of referral if they have very high levels of serum natriuretic peptides.

**Adults with symptoms of chronic heart failure** who have been referred for diagnosis have a test called an echocardiogram and are seen by a heart specialist. This should happen within 2 weeks of being referred by their GP if a blood test shows high levels of a substance (called a 'serum natriuretic peptide') that suggests they may have heart failure needing urgent treatment. An echocardiogram is a test to check the structure of their 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 \(2018\), recommendation 1.2.3](#)

## Definitions of terms used in this quality statement

### Specialist

The core specialist heart failure multidisciplinary team includes:

- 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.

[Adapted from [NICE's guideline on chronic heart failure in adults](#), recommendation 1.1.1]

### Very high levels of serum natriuretic peptides

Levels of serum natriuretic peptides (N-terminal pro-B-type natriuretic peptide [NT-proBNP]) in the blood are raised in people with heart failure. Very high levels of serum natriuretic peptides are defined as a NT-proBNP level above 2,000 ng/litre (236 pmol/litre). [Adapted from [NICE's guideline on chronic heart failure in adults](#), recommendation 1.2.3]



# Quality statement 3: Medication for chronic heart failure with reduced ejection fraction

## Quality statement

Adults with chronic heart failure who have reduced ejection fraction are started on low-dose angiotensin-converting enzyme (ACE) inhibitor and beta-blocker medications that are gradually increased until the target or optimal tolerated doses are reached. [2011, updated 2016]

## Rationale

ACE inhibitors and beta-blockers are of proven benefit for people with chronic heart failure who have reduced ejection fraction, and taking them at the optimum dose will provide the best outcome. However, ACE inhibitors can cause low blood pressure and renal impairment, and beta-blockers can initially make heart failure symptoms worse and cause low blood pressure and a low heart rate. Therefore, people taking these medicines should be started on low doses, and the doses gradually increased, with regular checks to monitor any side effects, until the target or optimal tolerated doses are reached.

## Quality measures

### Structure

Evidence of local arrangements to ensure that adults with chronic heart failure who have reduced ejection fraction are started on low-dose ACE inhibitor and beta-blocker medications, which are gradually increased until the target or optimal tolerated doses are reached.

**Data source:** Local data collection.

### Process

a) Proportion of adults diagnosed with chronic heart failure who have reduced ejection fraction prescribed ACE inhibitor medication who are on a dose that is higher than the starting dose.

**Numerator** – The number in the denominator who are on a dose of ACE inhibitor medication that is higher than the starting dose.

Denominator – The number of adults diagnosed with chronic heart failure who have reduced ejection fraction who are prescribed ACE inhibitor medication.

b) Proportion of adults diagnosed with chronic heart failure who have reduced ejection fraction prescribed beta-blocker medication who are on a dose that is higher than the starting dose.

Numerator – The number in the denominator who are on a dose of beta-blocker medication that is higher than the starting dose.

Denominator – The number of adults diagnosed with chronic heart failure who have reduced ejection fraction who are prescribed beta-blocker medication.

Data source: Local data collection.

## Outcome

a) Mortality due to heart failure.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions due to heart failure.

Data source: Local data collection.

## What the quality statement means for different audiences

**Service providers** (such as GP practices, hospitals and community providers) ensure that adults with chronic heart failure who have reduced ejection fraction are started on low-dose ACE inhibitor and beta-blocker medications that are gradually increased until the target or optimal tolerated doses are reached, and that there is monitoring for side effects after each increase in dose.

**Healthcare professionals** (such as GPs, specialists in cardiac care and heart failure specialist nurses) ensure that when they prescribe ACE inhibitors and beta-blockers for adults with chronic heart failure who have reduced ejection fraction, they start with low doses and gradually increase them until the target or optimal tolerated doses are reached. They also ensure that they monitor as a minimum the person's serum urea, creatinine, electrolytes, eGFR (estimated glomerular filtration

rate), heart rate, blood pressure and clinical status after each increase in dose. The multidisciplinary heart failure team will decide on 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** (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with chronic heart failure who have reduced ejection fraction are started on low-dose ACE inhibitor and beta-blocker medications that are gradually increased until the target or optimal tolerated doses are reached, and are monitored for side effects after each increase in dose.

**Adults with chronic heart failure who have reduced ejection fraction** (when the part of the heart that pumps blood around the body isn't squeezing the blood as well as it should) are prescribed medications for heart failure and high blood pressure (called beta blockers and ACE inhibitors). These are given at low doses at first and increased gradually until the person is taking the ideal dose for their condition, or the highest dose their body can cope with.

## Source guidance

[Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 \(2018\), recommendations 1.4.1, 1.4.3, 1.4.4 and 1.4.13](#)

## 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](#)]

## 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. [new 2016]

## Rationale

Medication to treat chronic heart failure can cause significant side effects, including dehydration, low blood pressure, a low heart rate and renal impairment. Some may initially and temporarily make heart failure symptoms worse. When the dose or type of medication for chronic heart failure is changed, the person should have a review within 2 weeks to monitor the effects. 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

### Structure

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

**Data source:** Local data collection.

### 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 in medication.

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

Data source: Local data collection.

## Outcome

a) Renal impairment.

Data source: Local data collection.

b) Hospital admissions, inpatient hospital days and readmissions.

Data source: Local data collection.

## What the quality statement means for different audiences

**Service providers** (such as 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 and specialist multidisciplinary heart failure teams) ensure that they carry out a review for adults with chronic heart failure within 2 weeks of any change in the dose or type of 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** (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication.

**Adults with chronic heart failure** are seen by their healthcare professional within 2 weeks of any change in the dose or type of medication they are taking for heart failure, to 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 \(2018\)](#), recommendations 1.7.1 and 1.7.3

## 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.

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 1.7.1 and 1.7.2]

# Quality statement 5: Review of people with stable chronic heart failure

## Quality statement

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

## Rationale

Adults with stable 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

### Structure

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

**Data source:** Local data collection.

### Process

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

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

**Denominator** – the number of adults with stable chronic heart failure.

Data source: Local data collection.

## Outcome

a) Quality of life.

Data source: Local data collection.

b) Renal impairment.

Data source: Local data collection.

## What the quality statement means for different audiences

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

**Healthcare professionals** (such as GPs and specialist multidisciplinary heart failure team members) ensure that they review adults with stable 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** (such as clinical commissioning groups and NHS England) ensure that they commission services in which adults with stable chronic heart failure have a review of their condition at least every 6 months.

**Adults with chronic heart failure that isn't worsening** are seen at least every 6 months by their healthcare professional, who will check whether their condition has got better or worse, 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 \(2018\), recommendations 1.7.1 and 1.7.3](#)



## Definitions of terms used in this quality statement

### Review of people with stable chronic heart failure

This 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.

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

The review should also include a discussion about the suitability of a programme of cardiac rehabilitation.

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 1.6.5, 1.7.1 and 1.7.3]

# Quality statement 6: Programme of cardiac rehabilitation

## Quality statement

Adults with stable chronic heart failure are offered an exercise-based programme of cardiac rehabilitation. [2011, updated 2016]

## Rationale

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

## Quality measures

### Structure

Evidence of local arrangements to ensure that adults with stable chronic heart failure are offered an exercise-based programme of cardiac rehabilitation.

Data source: Local data collection.

### Process

Proportion of adults diagnosed with stable chronic heart failure who have been referred to an exercise-based programme of cardiac rehabilitation.

Numerator – the number in the denominator who have a record of referral to an exercise-based programme of cardiac rehabilitation.

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

Data source: Local data collection.

## Outcome

a) Rates of uptake of and adherence to programmes of cardiac rehabilitation.

Data source: Local data collection. National data on the uptake of cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](#).

b) Patient experience of programmes of cardiac rehabilitation.

Data source: Local data collection. National data on the uptake of cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](#).

## What the quality statement means for different audiences

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

**Healthcare professionals** (such as GPs, cardiac rehabilitation nurses and specialists in cardiac care) ensure that they offer adults diagnosed with stable chronic heart failure an exercise-based programme of cardiac rehabilitation, once they are well enough to attend.

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

**Adults with chronic heart failure that isn't worsening** are offered an exercise-based programme of cardiac rehabilitation that is designed for people with heart failure, if it is suitable for them and once they are well enough to attend. This programme will include help and support with taking exercise, understanding their condition and how to look after themselves.

## Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018), recommendation 1.9.1

## Definitions of terms used in this quality statement

### Programme of cardiac rehabilitation

This is an exercise-based programme of rehabilitation designed for people with heart failure that includes a psychological and educational component. [Adapted from [NICE's guideline on chronic heart failure in adults](#), recommendation 1.9.1]

### Equality and diversity considerations

A programme of cardiac rehabilitation should be available for all adults with stable chronic heart failure, including those who may be house-bound or in a nursing home. To ensure equality of access to rehabilitation programmes, 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 centres that have access for disabled people.

Healthcare professionals should take into account the communication needs of people with stable 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. People should have access to an interpreter or advocate if needed.

# Quality statement 7 (developmental): Options for cardiac rehabilitation

Developmental quality statements set out an emergent area of cutting-edge service delivery or technology currently found in a minority of providers and indicating outstanding performance. They will need specific, significant changes to be put in place, such as redesign of services or new equipment.

## Quality statement

Adults with chronic heart failure referred to a programme of cardiac rehabilitation are offered sessions during and outside working hours, and the choice of undertaking the programme at home, in the community or in a hospital setting. [new 2016]

## Rationale

Programmes of cardiac rehabilitation can improve clinical outcomes and quality of life for people with chronic heart failure. People with chronic heart failure are typically older, and may be frail or have comorbidities. This can make it difficult for them to attend group-based programmes at hospitals or clinics. Offering programmes of cardiac rehabilitation at different times of day and at different venues is likely to increase both uptake and adherence, and to improve patient experience.

## Quality measures

### Structure

Evidence of local arrangements to provide programmes of cardiac rehabilitation during and outside working hours, and the choice of undertaking programmes at home, in the community or in a hospital setting.

Data source: Local data collection.

### Process

Proportion of people referred to a programme of cardiac rehabilitation who are offered sessions

during and outside working hours, and the choice of undertaking the programme at home, in the community or in a hospital setting.

Numerator – the number in the denominator offered sessions during and outside working hours, and the choice of undertaking the programme at home, in the community or in a hospital setting.

Denominator – the number of adults with chronic heart failure referred to a programme of cardiac rehabilitation.

**Data source:** Local data collection.

## Outcome

a) Rates of uptake of and adherence to programmes of cardiac rehabilitation.

**Data source:** Local data collection. National data on the uptake of cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](#).

b) Patient experience of programmes of cardiac rehabilitation.

**Data source:** Local data collection. National data on the uptake of cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](#).

## What the quality statement means for different audiences

**Service providers** (such as GP practices, community nursing teams and hospitals) offer programmes of cardiac rehabilitation during and outside working hours, and the choice of undertaking the programme at home, in the community or in a hospital setting.

**Healthcare professionals** (such as GPs, cardiac rehabilitation nurses and specialists in cardiac care) offer adults referred to programmes of cardiac rehabilitation a choice of sessions during and outside working hours, and a choice of undertaking the programme at home, in the community or in a hospital setting.

**Commissioners** (such as clinical commissioning groups, local authorities and NHS England) commission cardiac rehabilitation services that have the capacity to provide programmes during and outside working hours, and a choice of undertaking the programme at home, in the community

or in a hospital setting.

**Adults with chronic heart failure** offered a rehabilitation programme can choose to have their sessions at a time and place that suits them, such as during or outside working hours, and at a hospital or venue in their local area, or at home. This can help people to take part and continue to attend a programme.

## Source guidance

Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 (2018), recommendation 1.9.1

## Definitions of terms used in this quality statement

### Programme of cardiac rehabilitation

This is an exercise-based programme of rehabilitation designed for people with heart failure that includes a psychological and educational component. [Adapted from [NICE's guideline on chronic heart failure in adults](#), recommendation 1.9.1]

### Equality and diversity considerations

A programme of cardiac rehabilitation should be available for all adults with chronic heart failure, including those who may be house-bound or in a nursing home. To ensure equality of access to rehabilitation programmes, 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 centres 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. People should have access to an interpreter or advocate if needed.

# Using the quality standard

## Quality measures

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

See [NICE's how to use quality standards](#) for further information, including advice on using quality measures.

## Levels of achievement

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

[NICE's quality standard service improvement template](#) helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement.

## Using other national guidance and policy documents

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



## Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments for this quality standard](#) are available.

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

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

## Development sources

Further explanation of the methodology used can be found in the [quality standards process guide](#).

## Evidence sources

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

[Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 \(2018\)](#)

## Policy context

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

- [Department of Health. Living well for longer: progress 1 year on \(2015\)](#)
- [Welsh Government. Together for health – a heart disease delivery plan \(2015\)](#)
- [British Heart Foundation. National Audit of Cardiac Rehabilitation \(2014\)](#)
- [Health Committee. Managing the care of people with long-term conditions – second report \(2014\)](#)
- [Department of Health. Living well for longer: national support for local action to reduce premature avoidable mortality \(2014\)](#)
- [National End of Life Care Programme. End of life care in heart failure: a framework for implementation \(2014\)](#)
- [Department of Health. Cardiovascular disease outcomes strategy: improving outcomes for people with or at risk of cardiovascular disease \(2013\)](#)
- [NHS Improvement. A guide for review and improvement of hospital based heart failure services \(2011\)](#)
- [The Health Foundation. Bridging the quality gap: heart failure \(2010\)](#)

## Definitions and data sources for the quality measures

- [Chronic heart failure in adults: diagnosis and management. NICE guideline NG106 \(2018\)](#)

## Related NICE quality standards

- [Obesity: clinical assessment and management. NICE quality standard 127 \(2016\)](#)
- [Medicines optimisation. NICE quality standard 120 \(2016\)](#)
- [Obesity in adults: prevention and lifestyle weight management programmes. NICE quality standard 111 \(2016\)](#)
- [Acute heart failure. NICE quality standard 103 \(2015\)](#)
- [Cardiovascular risk assessment and lipid modification. NICE quality standard 100 \(2015\)](#)
- [Secondary prevention after a myocardial infarction. NICE quality standard 99 \(2015\)](#)
- [Atrial fibrillation. NICE quality standard 93 \(2015, updated 2018\)](#)
- [Physical activity: for NHS staff, patients and carers. NICE quality standard 84 \(2015\)](#)
- [Acute kidney injury. NICE quality standard 76 \(2014\)](#)
- [Acute coronary syndromes in adults. NICE quality standard 68 \(2014\)](#)
- [Anxiety disorders. NICE quality standard 53 \(2014\)](#)
- [Smoking: supporting people to stop. NICE quality standard 43 \(2013\)](#)
- [Familial hypercholesterolaemia. NICE quality standard 41 \(2013\)](#)
- [Hypertension in adults. NICE quality standard 28 \(2013, updated 2015\)](#)
- [Stable angina. NICE quality standard 21 \(2012, updated 2017\)](#)
- [Patient experience in adult NHS services. NICE quality standard 15 \(2012, updated 2019\)](#)
- [End of life care for adults. NICE quality standard 13 \(2011, updated 2017\)](#)
- [Alcohol-use disorders: diagnosis and management. NICE quality standard 11 \(2011\)](#)
- [Depression in adults. NICE quality standard 8 \(2011\)](#)

# Quality Standards Advisory Committee and NICE project team

## Quality Standards Advisory Committee

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

**Mr Ben Anderson**

Consultant in public health, Public Health England

**Mr Barry Attwood**

Lay member

**Professor Gillian Baird**

Consultant developmental paediatrician, Guy's and St Thomas' NHS Foundation Trust, London

**Dr Ashok Bohra**

Consultant surgeon, Royal Derby Hospital

**Dr Guy Bradley-Smith**

Freelance GP and clinical commissioning lead for learning disability, North, East and West (NEW) Devon Clinical Commissioning Group

**Mrs Julie Clatworthy**

Governing body nurse, Gloucester Clinical Commissioning Group

**Mr Michael Fairbairn**

Quality manager, NHS Trust Development Authority

**Mr Derek Cruickshank**

Consultant gynaecological oncologist/chief of service, South Tees NHS Foundation Trust

**Mrs Jean Gaffin**

Lay member

**Dr Anjan Ghosh**

Consultant in public health, Public Health Merton, London

**Mr Jim Greer**

Principal lecturer, Teesside University

**Mr Malcolm Griffiths**

Consultant obstetrician and gynaecologist, Luton and Dunstable University Hospital NHS Foundation Trust

**Dr Ulrike Harrower**

Consultant in public health medicine, NHS Somerset

**Mr Gavin Lavery**

Clinical director, Public Health Agency

**Dr Tessa Lewis**

GP and medical adviser in therapeutics, Aneurin Bevan University Health Board

**Ms Robyn Noonan**

Area service manager learning disability, Oxfordshire County Council

**Dr Michael Rudolf (Chair)**

Hon. consultant physician, London North West Healthcare NHS Trust

**Dr Anita Sharma**

GP and clinical director of vascular and medicine optimisation, Oldham Clinical Commissioning Group

**Dr Amanda Smith**

Director of therapies, health service and governance, Powys Teaching Health Board

**Ms Ruth Studley**

Director of strategy and development, Healthcare Inspectorate Wales

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

**Dr Abdallah Al-Mohammad**

Consultant cardiologist, Sheffield Teaching Hospital

**Dr Ivan Benett**

GP, NHS Central Manchester Clinical Commissioning Group

**Professor Martin Cowie**

Professor of cardiology, Imperial College London

**Miss Jane Gilmour**

Heart failure nurse specialist, Luton and Dunstable Hospital

**Dr Hugh McIntyre**

Consultant physician, East Sussex Healthcare Trust

**Mr Richard Mindham**

Lay member

## **NICE project team**

**Nick Baillie**

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Technical analyst

**Esther Clifford**

Programme manager

**Jenny Mills**

Project manager

**Nicola Cunliffe**

Coordinator



## Update information

**September 2018:** Changes have been made to align this quality standard with the updated [NICE guideline on chronic heart failure in adults](#). Statements 2 and 3 were amended and the source guidance throughout has been updated.

**February 2016:** This quality standard was updated and statements prioritised in 2011 were replaced.

Statements are marked as [new 2016] or [2011, updated 2016]:

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

Statements 1, 3, 4, 7, 8, and 9 in the 2011 version have been updated and included in the 2016 quality standard, marked as [2011, updated 2016].

Statements from the 2011 version (numbered 2, 5, 6, 10, 11, 12 and 13) that may still be useful at a local level are included after the updated statements in the [list of quality statements](#) section.

The [2011 quality standard for chronic heart failure](#) 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 standard advisory committees](#) for details of standing committee 2 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

This quality standard has been included in the [NICE Pathway on chronic heart failure](#), which brings together everything we have said on a topic in an interactive flowchart.

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

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## 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.

- [British Heart Foundation](#)
- [British Society for Heart Failure](#)
- [The Pumping Marvellous Foundation](#)
- [Association of Chartered Physiotherapists in Cardiac Rehabilitation \(ACPICR\)](#)
- [Royal College of General Practitioners \(RCGP\)](#)