NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Chronic heart failure in adults (update)

NICE quality standard

Draft for consultation

29 June 2011

18 July 2022

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| **This quality standard covers** assessing, diagnosing and managing chronic heart failure in adults (aged 18 and over). It describes high-quality care in priority areas for improvement. Statements cover adults with chronic heart failure with reduced ejection fraction and adults with chronic heart failure with preserved ejection fraction, unless otherwise stated.  This quality standard will update and replace the existing quality standard on [QS9 Chronic heart failure in adults](https://www.nice.org.uk/guidance/qs9) (published June 2011). The topic was identified for update following the review of quality standards. The review identified:   * potential changes in the priority areas for improvement * that the quality statements on diagnosis and cardiac rehabilitation could be combined.   For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).  This is the draft quality standard for consultation (from 18 July to 12 August 2022). The final quality standard is expected to publish by January 2023. |

# Quality statements

[Statement 1](#_Quality_statement_2:) Adults presenting in primary care with suspected heart failure have their N-terminal pro-B-type natriuretic peptide (NT‑proBNP) measured. **[new 2022]**

[Statement 2](#_Quality_statement_2:_1) Adults with suspected heart failure have specialist assessment and transthoracic echocardiography within 2 weeks of referral if they have a very high NT‑proBNP level, or 6 weeks if they have a high NT‑proBNP level. **[2011, updated 2022]**

[Statement 3](#_Quality_statement_3:) Adults with chronic heart failure who have reduced ejection fraction have their medication gradually increased until the target or optimal tolerated doses are reached. **[2011, updated 2022]**

[Statement 4](#_Quality_statement_4:) Adults with chronic heart failure have a review within 2 weeks of any change in the dose or type of their heart failure medication. **[2016]**

[Statement 5](#_Quality_statement_5:) Adults with stable chronic heart failure have a review of their condition at least every 6 months. **[2011, updated 2016]**

[Statement 6](#_Quality_statement_6:) Adults with stable chronic heart failure are offered a personalised programme of cardiac rehabilitation. **[2011, updated 2022]**

In 2022 this quality standard was updated and statements prioritised in 2011 were updated (2011, updated 2022) or replaced (new 2022). For more information, see [update information](#_Update_information_2).

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  **Question 4** Questions about the individual quality statements:  Statement 5: Could the population for this statement be written as ‘adults with chronic heart failure’?  Statement 6: Could the population for this statement be written as ‘adults with chronic heart failure’? Local practice case studies **Question 5** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

# 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. **[new 2022]**

## Rationale

N-terminal pro-B-type natriuretic peptide measurement in primary care can confirm whether heart failure is likely when suspected. People can then be referred for specialist assessment, 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 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.

**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

a) Mortality due to 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.

b) Hospital admissions due to heart failure.

**Data source:**The [National Heart Failure Audit](https://www.hqip.org.uk/resource/national-heart-failure-audit-nhfa-2021-summary-report/) 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, 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 see how well their heart is working.

## Source guidance

[Chronic heart failure in adults: diagnosis and management. NICE guideline NG106](https://www.nice.org.uk/guidance/ng106) (2018), 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 the [CKS topic on hypertension](https://cks.nice.org.uk/topics/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 the [CKS topic on obesity](https://cks.nice.org.uk/topics/obesity/).

[Adapted from [NICE’s clinical knowledge summary on chronic heart failure](https://cks.nice.org.uk/topics/heart-failure-chronic/)]

# 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 2022]**

## Rationale

Adults who have high or very high levels of NT-proBNP have a higher likelihood of heart failure and a poorer prognosis. Having transthoracic echocardiography and specialist assessment with heart failure classification within 2 or 6 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

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

a) Evidence of local service pathways and written clinical protocols to ensure that adults with suspected heart failure and very high levels of NT-proBNP, who have been referred for diagnosis, have transthoracic echocardiography and specialist assessment within 2 weeks.

**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.

b) Evidence of local service pathways and written clinical protocols to ensure that adults with suspected heart failure and high levels of NT-proBNP, who have been referred for diagnosis, have transthoracic echocardiography and specialist assessment within 6 weeks.

**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 a specialist assessment within 2 weeks of referral.

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

**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 a specialist assessment within 6 weeks of referral.

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

**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

a) Mortality due to 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.

b) Hospital admissions due to heart failure.

**Data source:**The [National Heart Failure Audit](https://www.hqip.org.uk/resource/national-heart-failure-audit-nhfa-2021-summary-report/) contains data on hospital admission rates for heart failure.

## What the quality statement means for different audiences

**Service providers** (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 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 are seen within 2 or 6 weeks of 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 are seen by a specialist 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. This should happen within 2 weeks of being referred by their GP if a blood test shows very high levels of a substance (called a 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](https://www.nice.org.uk/guidance/ng106) (2018), 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. It should be led by a consultant cardiologist.

[Adapted from [NICE’s clinical knowledge summary on chronic heart failure](https://cks.nice.org.uk/topics/heart-failure-chronic/)]

### Very high levels of NT-proBNP

Very high levels of NT-proBNP are defined as a level above 2,000 ng/litre (236 pmol/litre).

[Adapted from [NICE's guideline on chronic heart failure in adults](https://www.nice.org.uk/guidance/ng106), recommendation 1.2.3]

### High levels of NT-proBNP

High levels of NT-proBNP are defined as a level between 400 and 2,000 ng/litre (47 to 236 pmol/litre)

[Adapted from [NICE's guideline on chronic heart failure in adults](https://www.nice.org.uk/guidance/ng106), recommendation 1.2.4]

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

## Quality statement

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

## Rationale

It is important that adults with chronic heart failure who have reduced ejection fraction are given all appropriate medications at an optimal tolerated dose to best manage their condition and provide the best outcome. People taking these medicines should be started on low doses, and have the doses gradually increased where appropriate, with regular checks to monitor any side effects, until the target or optimal tolerated doses are reached.

## 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 diagnosed with chronic heart failure who have reduced ejection fraction prescribed angiotensin‑converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs).

Numerator – the number in the denominator who are prescribed ACE inhibitors or angiotensin II receptor blockers (ARBs).

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

**Data source:** [NHS Quality Outcomes Framework](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data) indicator HF003 records annual data on the percentage of patients with left ventricular systolic dysfunction who are currently treated with an ACE inhibitor or ARB.

b) Proportion of adults diagnosed with chronic heart failure who have reduced ejection fraction prescribed beta blockers.

Numerator – the number in the denominator who are prescribed beta blockers.

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

**Data source:** [NHS Quality Outcomes Framework](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data) indicator HF006 records annual data on the percentage of patients with left ventricular systolic dysfunction who are currently treated with a beta blocker.

c) Proportion of adults diagnosed with chronic heart failure who have reduced ejection fraction prescribed mineralocorticoid receptor antagonists (MRA).

Numerator – the number in the denominator who are prescribed MRA.

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

**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.

d) Proportion of adults diagnosed with chronic heart failure who have reduced ejection fraction prescribed sodium-glucose co-transporter-2 inhibitor (SGLT2i).

Numerator – the number in the denominator who are prescribed SGLT2i.

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

**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

a) Mortality due to 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.

b) Hospital admissions due to heart failure.

**Data source:**The [National Heart Failure Audit](https://www.hqip.org.uk/resource/national-heart-failure-audit-nhfa-2021-summary-report/) 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 adults with chronic heart failure who have reduced ejection fraction are prescribed ACE inhibitors (or ARBs) and beta blockers, plus MRA and SGLT2i if symptoms of heart failure continue. They ensure that the medication (apart from SGLT2i) is given in increasing doses until the target or optimal tolerated doses are reached. They also make sure that there is monitoring for side effects after each increase in dose.

**Healthcare professionals** (such as GPs, specialists in cardiac care, heart failure specialist nurses and clinical pharmacists with an interest in heart failure) ensure that they prescribe ACE inhibitors (or ARBs) and beta‑blockers, plus MRA and SGLT2i if symptoms of heart failure continue, to adults with chronic heart failure who have reduced ejection fraction. They ensure that the medication (apart from SGLT2i) is given in increasing doses until the target or optimal tolerated doses are reached. They also make sure that there is monitoring for side effects 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 who have reduced ejection fraction are prescribed ACE inhibitors (or ARBs) and beta‑blockers, plus MRA and SGLT2i if symptoms of heart failure continue. They ensure that the medication (apart from SGLT2i) is given in increasing doses until the target or optimal tolerated doses are reached. They also make sure that there is monitoring 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. (These are called ACE inhibitors, ARBs, beta-blockers, MRA and SGLT2i). Apart from SGLT2i, 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](https://www.nice.org.uk/guidance/ng106) (2018), recommendations 1.4.1, 1.4.3, 1.4.13 and 1.4.15

[Dapagliflozin for treating chronic heart failure with reduced ejection fraction. NICE technology appraisal guidance TA679](https://www.nice.org.uk/guidance/ta679) (2021), recommendations 1.1 and 1.2

[Empagliflozin for treating chronic heart failure with reduced ejection fraction. NICE technology appraisal guidance TA773](https://www.nice.org.uk/guidance/ta773) (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](https://www.nice.org.uk/guidance/ng106)]

### Appropriate medication

ACE inhibitors and beta blockers are of proven benefit for people with chronic heart failure who have reduced ejection fraction, and they are recommended as first-line treatment. ARBs licensed for heart failure should be considered as an alternative to an ACE inhibitor for people who have heart failure with reduced ejection fraction and intolerable side effects with ACE inhibitors. MRA and SGLT2i have also been shown to benefit people with chronic heart failure who have reduced ejection fraction. MRA should be added to ACE inhibitors and beta blockers if symptoms of heart failure continue, and SGLT2i may be added to optimised standard care with ACE inhibitors, beta blockers and MRA. Specialist treatments may also be appropriate for some people.

[[NICE's guideline on chronic heart failure in adults](https://www.nice.org.uk/guidance/ng106), NICE’s technology appraisals on [dapagliflozin](https://www.nice.org.uk/guidance/ta679) and [empagliflozin](https://www.nice.org.uk/guidance/ta773) 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.

### Structure

Evidence of local arrangements, including appropriate sharing of information, 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:** 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

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 (NHFA)](https://www.hqip.org.uk/resource/national-heart-failure-audit-nhfa-2021-summary-report/) 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 interest in chronic heart failure) 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** (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 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](https://www.nice.org.uk/guidance/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](https://www.nice.org.uk/guidance/ng106), 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

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 arrangements, including protocols for patient invitations, to ensure that adults with stable chronic heart failure have a review of their condition at least every 6 months.

**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

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

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

Denominator – the number of adults with stable 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

Quality of life.

**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 surveys.

## 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 stable 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 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** (integrated care systems) 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 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](https://www.nice.org.uk/guidance/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

Heart failure is considered to be stable when symptoms remain unchanged for at least one month despite optimal management. 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.

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 is needed 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 an MRA. [Adapted from [NICE’s BNF Treatment summary on chronic heart failure](https://bnf.nice.org.uk/treatment-summaries/chronic-heart-failure/) and [NICE's guideline on chronic heart failure in adults](https://www.nice.org.uk/guidance/ng106), recommendations 1.6.5, 1.6.6, 1.7.1 and 1.7.3, 1.8.4]

**Question for consultation**

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

# Quality statement 6: Cardiac rehabilitation

## Quality statement

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

## Rationale

A personalised programme of cardiac rehabilitation, 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.

### Structure

Evidence of local arrangements, including referral pathways and commissioning of relevant services, to ensure that adults with stable chronic heart failure are offered a personalised programme of cardiac rehabilitation.

**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

Proportion of adults with stable chronic heart failure who 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 stable 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

a) Rates of uptake of programmes of cardiac rehabilitation.

**Data source:**National data on the uptake of cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](http://www.cardiacrehabilitation.org.uk/nacr/index.htm).

b) Rates of patients completing programmes of cardiac rehabilitation.

**Data source:**National data on the proportion of patients completing cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](http://www.cardiacrehabilitation.org.uk/nacr/index.htm).

c) Patient outcomes following programmes of cardiac rehabilitation.

**Data source:**National data on patient outcomes cardiac rehabilitation are available from the [British Heart Foundation National Audit of Cardiac Rehabilitation](http://www.cardiacrehabilitation.org.uk/nacr/index.htm).

## What the quality statement means for different audiences

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

**Adults with chronic heart failure that isn’t worsening** are offered a personalised programme of cardiac rehabilitation, if it is suitable for them and once they are well enough to take part. This programme will include help and support with taking exercise, understanding their condition , support with their thoughts and feelings around the condition, and how to look after themselves.

## Source guidance

[Chronic heart failure in adults: diagnosis and management. NICE guideline NG106](https://www.nice.org.uk/guidance/ng106) (2018), recommendation 1.9.1

## 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 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](https://www.nice.org.uk/guidance/ng106), recommendation 1.9.1]

## Equality and diversity considerations

A programme of cardiac rehabilitation should be accessible for all adults with stable 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 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.

**Question for consultation**

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

# Update information

**July 2022:** This quality standard was updated and statements prioritised in 2011 were replaced. The topic was identified for update following the annual review of quality standards. The review identified:

* changes in the priority areas for improvement

Statements are marked as:

* **[2016]** if the statement remains unchanged
* **[new 2022]** 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 2011 quality standard and was updated in 2016.
* **[2011, updated 2022]** if the statement covers an area for quality improvement included in the 2011 quality standard and has been updated.

# 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](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) 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](https://www.nice.org.uk/guidance/indevelopment/gid-qs10152/documents)[.

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) 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](https://www.nice.org.uk/guidance/ng106/resources) for the source guidance to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10152/documents) 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:

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