Table 1

NICE quality standard for chronic heart failure

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

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

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

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

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

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

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

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

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

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

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

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

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