



Provider line of sight table on report recommendations for submission to the funders						
Please can the provider complete the following details to allow for ease of access and rapid review						
Project and Title of report		National Heart Failure Audit 2023 Summary Report (2021/22)				
1. What is the report looking at/what is the project measuring?		The quality of the care of people admitted to hospital with acute heart failure, and its improvement or other changes over time.				
2. What countries are covered?		England and Wales				
3. The number of previous projects (e.g. whether it is the 4 th project or if it is a continuous project)		15 th report				
4. The date the data is related to (please include the start and end points – e.g. from 1 January 2016 to 1 October 2016)		1 st April 2021 to 31 st March 2022				
5. Any links to NHS England/NHS Improvement objectives or professional work-plans (only if you are aware of any)						
Please can the provider complete the below for each recommendation in the report						
No.	Recommendation	Evidence in the report which underpins the recommendation	Current national audit benchmarking standard if there is one	Associated NHS payment levers or incentives'	Guidance available (for example, NICE guideline)	% project result if the question previously asked by the project (date asked and result). If not asked before please denote N/A. This is so that there is an indication of whether the result has increased or decreased and over what period of time



<p>Rec 1</p>	<p>Hospitals not achieving the recommended standard for the use of in-patient echocardiography for patients with acute heart failure (HF) should urgently review their clinical pathways and ensure that echocardiography is performed, ideally within the first 48 hours of admission.</p>	<p>NHFA report, section 3.1.</p> <p>Aggregate data shows only 85% of patients undergo echocardiography, a figure unchanged from the 2020/21 cycle.</p> <p>Patients admitted to cardiology wards were more likely to have echocardiography than those admitted to general medical wards (92% versus 82%). Patients receiving specialist input to their care, no matter where they are admitted, have lower echocardiography rates at 89%, but better than the 67% rate for patients not receiving any input from the HF specialist team. The echocardiography rate is less good in older patients, aged ≥ 75, at 83%, and overall women fare less well than men with rates of 83% and 86%, respectively.</p>	<p>$\geq 90\%$</p>	<p>N/A</p>	<p>NICE AHF guideline HF CG187</p>	<p>Echocardiography rates have steadily decreased from 90% reported in the 2014/15 audit cycle to 85% in 2020/21 and has remained at that level for the current 2021/22 cycle, for aggregate data.</p> <p>Only 51% of hospitals met the $\geq 90\%$ audit target for this key diagnostic tool a 3% increase from last year.</p>
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		<p>Only 51% of hospitals achieved an echocardiography rate of 90%, or more, for this audit cycle, a 3% increase from last year, and with considerable variation between hospitals.</p> <p>See Figures 3.1 – 3.3</p>				
Rec 2	<p>High-risk cardiac patients, including those with heart failure, should have access to a cardiology ward.</p>	<p>NHFA report, section 3.2.</p> <p>In this audit cycle, only 47% were admitted to cardiology wards (aggregate data), a figure similar to the 48% reported in the 2020/21 audit cycle. Whilst the low figure may reflect a fixed number of cardiology beds being available in most hospitals, there is an enormous variation in the number admitted to cardiology (0-100%) between hospitals within the audit. If there is no or inadequate access to a cardiology ward this needs to be addressed locally as a matter of</p>	<p>Audit standard is that $\geq 60\%$ of HF patients should be managed in a cardiology ward.</p>	N/A	<p>NICE AHF guideline HF CG187</p>	<p>There has been little change in the percentage access to cardiology beds at 47% compared with last year at 48% (2020/21), in the context of a reduction in overall HF admissions, over these last two cycles reflecting COVID-19 and other pressures.</p>

		<p>urgency. COVID-19 has demonstrated an ability to reorganise services and the learning from this could be applied to improve HF care including cardiology bed access for HF patients.</p> <p>Only 15% of hospitals met the 60%, or above, target in this cycle compared with 13% in the 2020/21 cycle.</p> <p>See Figure 3.4</p>				
Rec 3	<p>Hospitals not achieving the standards for ensuring that a patient with acute HF is seen by a HF team should review their pathways of care and consider a quality improvement programme to improve their performance.</p> <p>Hospitals without a clinical lead for heart failure should appoint one (ideally a consultant cardiologist with sub-specialty training in HF). The lack of a named lead should feature on their risk register.</p>	<p>NHFA report, section 3.3.</p> <p>Eighty-two per cent of patients were seen by a HF specialist during the admission, similar to the 81% of cycle 2020/21.</p> <p>For those on cardiology wards, 99% (unchanged) were seen by specialists, 92% were seen by a consultant cardiologist, a substantial improvement from the 83% of the previous cycle, and 52%</p>	<p>At least 80% of patients should be seen by a member of the specialist HF team.</p>	<p>Best Practice Tariff set at 60%</p>	<p>NICE AHF guideline HF CG187</p> <p>NICE CG 187 is explicit</p> <ul style="list-style-type: none"> All hospitals admitting people with suspected acute heart failure should provide a specialist heart failure team that is based on a 	<p>During this cycle aggregate data shows 82% of patients were seen by a HF Specialist, which is very similar to the 81% from the previous cycle. However, only 119, or 61% of hospitals met the audit target of 80%, a 4% decrease on the 2020/21 cycle.</p> <p>These findings may reflect variable provision, and protection of HF staff in different hospitals in the</p>

	<p>Hospitals without access to specialist HF nurses in their hospital team or in the community should urgently seek to appoint them.</p>	<p>were seen by HF nurses, a figure that has not changed.</p> <p>Overall, only 72% of patients on General Medical wards were seen by 'Any HF specialist', with 51% seeing a specialist HF nurse compared with 46% last year.</p> <p>Only 61% of hospitals achieved the Audit specialist review target of $\geq 80\%$, compared with 65% in the 2020/21 cycle. Again, there was marked variation between hospitals.</p> <p>See Figures 3.5 and 3.6.</p>			<p>cardiology ward and provides outreach services</p> <ul style="list-style-type: none"> • Ensure that all people being admitted to hospital with suspected acute heart failure have early and continuing input from a dedicated specialist heart failure team. 	<p>aftermath of COVID-19 and in response to other NHS pressures.</p>
Rec 4	<p>All patients with HFrEF should receive best-practice disease-modifying drugs unless there is a contra-indication. Treatment is improved by patients being managed on cardiology wards or being seen by a HF specialist team, early during an admission, and ensuring patients are not prematurely</p>	<p>NHFA report, section 3.4.</p> <p>High aggregate standards were again achieved with now 87% of patients being discharged on an ACEI/ARB/ARNI (audit target not met) and 90% on a beta-blocker (audit target met) compared with</p>	<p>$\geq 90\%$ for ACEI/ARB/ARNI</p> <p>$\geq 90\%$ for BB</p> <p>$\geq 60\%$ for MRA</p> <p>$\geq 60\%$ for all three drug groups</p>	N/A	<p>NICE CHF guideline NG106</p> <p>NICE AHF guideline HF CG187</p> <p>ESC 2021 Heart Failure Guideline.</p>	<p>The prescribing of these three drug classes (ACEI/ARB/ARNI, BB, MRA) was improved or stable for aggregate data, including for their combined prescribing.</p> <p>The inter-hospital prescribing variance</p>



	<p>discharged from hospital. Those hospitals not meeting the expected standards should perform a clinical pathway review to investigate where improvements can be made.</p> <p>Hospitals should make every effort to record all medications at discharge and avoid entering 'unknowns' in their audit submissions.</p>	<p>86% on an ACEI/ARB and 91% on a beta-blocker in the 2020/21 cycle. Similarly, improvements were seen in MRA prescribing now at 63% (audit target met) compared with 61% in the 2020/21 audit cycle.</p> <p>The combined aggregate prescribing of ACEI/ARB/ARNI + BB + MRA (in those without contraindications) has also increased to 56% in this cycle compared with 54% in 2020/21.</p> <p>This audit cycle again finds with increasing age from the 55-64 group onwards, there is a persistent age-related fall off in prescribing of these drugs. Nonetheless, for those aged ≥ 85 beta-blocker prescribing is relatively well maintained at 84.1% in this age group.</p>				<p>persists with fewer hospitals meeting the Audit prescribing targets for BB (which is intentionally set at a high level and relatively preserved in the older patients). In contrast the hospital target for ACEI and ARB now includes ARNI and has increased when compared with numbers for ARB and ACEI in the 2020/21 cycle.</p> <p>There is also a decrease in the number of hospitals achieving the benchmark for MRA prescribing, compared with the 2020/21 cycle.</p> <p>These findings may reflect variable provision, and protection of HF staff in different hospitals in the aftermath of COVID-19 and in response to other NHS pressures.</p>
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		<p>The <i>inter-hospital variation</i> in percentage prescription of these drugs demonstrates that many hospitals still fall far short of the benchmarks set. The proportion achieving the ACEI/ARB/ARNI target is 48%, compared with 44% for ACEI/ARB in the last audit cycle. The proportion achieving the beta-blocker benchmark is decreased at only 61% compared with 65% in the 2020/21 audit cycle. The proportion achieving the target for MRAs was also down at 56% compared with 60% in the 2020/21 audit cycle.</p> <p>See Table 3.1 and Figures 3.7 – 3.13</p>				
Rec 5	Patients should be referred for Cardiology and Specialist HF Nurse follow-up, ideally leaving hospital with their first appointment.	<p>NHFA report, section 3.5.</p> <p>Only 32% of those leaving hospital after a HF admission have cardiology follow-up (down a further</p>	The standard should be 100% for specialist follow-up within two-weeks.	N/A	<p>NICE CHF guideline NG 106</p> <p>NICE AHF guideline HF CG187</p>	Trends for both cardiology and HF nurse follow-up were decreased in the COVID-19 pressured audit cycle of 2020/21,



	<p>Hospitals should review their pathways for referral to cardiac rehabilitation to allow greater access and uptake for HF patients.</p>	<p>7% from the 2020/21 cycle). In contrast 58% have HF specialist nurse appointments post discharge (up 11% from 2020/21).</p> <p>Just under 10% of patients are referred for cardiac rehabilitation (down 3% from last year). Rates are higher for those cared for in cardiology wards at 15% (but down 3% from last year), compared to a 6% referral rate for those on general medical wards (a decrease of 2%).</p> <p>Essential follow up services appear to have been especially vulnerable to staff redeployment and other pressures during and in the aftermath of COVID-19. Whilst HF specialist nurse follow-up improvement suggests that the redeployment of HF specialist nurses during the pandemic has largely</p>			<p>NICE AHF Quality standard QS103</p>	<p>when compared with the previous cycle.</p> <p>This audit cycle (2021/22) shows a further drop of 7% so that only 32% had cardiology follow up.</p> <p>The improvement of 11% since last year in timely HF specialist nurse follow up to 58% is positive but does not compensate for the lack of cardiology follow up.</p> <p>Timely follow up in this cycle overall fell to 40%, from 43% in the 2020/21 cycle.</p> <p>Cardiac rehabilitation referral rates have also dropped a further 3% in this audit cycle compared with last year, to 9.6%.</p> <p>As with all other aspects of good HF care, timely follow up is better following an admission to</p>
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		<p>been reversed, elsewhere the downward trend persists with services resetting more slowly, emphasising the need to ensure Cardiology specialist HF services are protected within the hospital.</p> <p>See Figure 3.14</p>				<p>cardiology wards than elsewhere.</p>
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