

# Secondary prevention after a myocardial infarction

Quality standard

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This standard is based on NG185.

This standard should be read in conjunction with QS103, QS100, QS88, QS84, QS82, QS80, QS68, QS53, QS52, QS43, QS41, QS28, QS21, QS11, QS9, QS8, QS6 and QS5.

## Introduction

This quality standard covers secondary prevention after a myocardial infarction (MI), including cardiac rehabilitation, in adults (aged 18 years and over). It does not cover the diagnosis and management of myocardial infarction, which is covered by [NICE's quality standard on acute coronary syndromes in adults](#). For more information see the [secondary prevention after a myocardial infarction topic overview](#).

In addition to the areas covered by this quality standard, the Quality Standards Advisory Committee identified the prescribing of high-dose high-intensity statins for secondary prevention as an area for quality improvement. [NICE's quality standard on cardiovascular risk assessment and lipid modification](#) has a statement about this, which should be referred to for full details. Coronary revascularisation was also identified as an area for quality improvement; this area is covered in [NICE's quality standard on acute coronary syndromes in adults](#).

## Why this quality standard is needed

MI is one of the most severe presentations of coronary heart disease (CHD). It is usually caused by blockage of a coronary artery that results in tissue death and is commonly referred to as a heart attack. People who have had an MI benefit from treatment to reduce the risk of another MI and to slow the progression of CHD; this is known as secondary prevention. Examples of secondary prevention for people who have had an MI include the following:

- Drug treatment such as anti-platelet drugs, beta-blockers, angiotensin-converting enzyme (ACE) inhibitors and statins.
- Changes in lifestyle such as healthy eating, regular exercise and stopping smoking, which are key components of cardiac rehabilitation programmes.

MI is a preventable complication of CHD. The death rate from CHD has been falling since the early 1970s; for people under 75, the death rate fell by almost 25% between 1996 and 2004. The death rate from CHD varies with age, gender, socioeconomic status, ethnicity and UK geographic

location. Death rates in men under 75 are 3 times higher than in women, and death rates in affluent areas in the UK are half of those in deprived areas. People of South Asian origin have almost a 50% higher death rate than the general UK population.

In England and Wales in 2013/14, more than 80,000 hospital admissions were because of MI, according to the [Myocardial Ischaemia National Audit Project \(MINAP\)](#). Twice as many men had MIs as women. The data also showed that 30-day mortality decreased between 2003/04 and 2013/14 through improved treatment.

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

- life expectancy
- mortality
- incidence of cardiovascular disease (CVD) events
- health-related quality of life for people with long-term conditions
- readmissions
- functional ability after MI
- return to employment
- patient experience
- psychological wellbeing.

## 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](#)

- [Adult Social Care Outcomes Framework 2015 to 2016](#)
- [Public Health Outcomes Framework 2013 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 secondary prevention after an MI.

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 secondary prevention after an MI specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole secondary prevention pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people after an MI.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing high-quality interventions for MI are listed in [related NICE quality standards](#).

## 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 people with MI 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 source(s) 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 people with MI. 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 admitted to hospital with a myocardial infarction (MI) have an assessment of left ventricular function before discharge.

Statement 2 Adults admitted to hospital with an MI are referred for cardiac rehabilitation before discharge.

Statement 3 Adults admitted to hospital with an MI have the results of investigations and a plan for future treatment and monitoring shared with their GP.

Statement 4 Adults referred to a cardiac rehabilitation programme after an MI have an assessment appointment within 10 days of discharge from hospital.

Statement 5 (developmental) Adults referred to a cardiac rehabilitation programme after an MI 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.

# Quality statement 1: Assessment of left ventricular function

## Quality statement

Adults admitted to hospital with a myocardial infarction (MI) have an assessment of left ventricular function before discharge.

## Rationale

After an MI, some people have heart failure because of damage to heart muscle and impaired contraction of the left ventricle. This is known as left ventricular systolic dysfunction (LVSD). The effectiveness of drug treatment with angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers, aldosterone antagonists and beta-blockers depends on left ventricular function. The assessment of left ventricular function after an MI informs the type, titration and duration of drug treatment and the type of cardiac rehabilitation that is appropriate. To improve the clinical effectiveness of treatment and to ensure patient safety, this assessment should be done before discharge from hospital.

## Quality measures

### Structure

Evidence of local arrangements to ensure that adults admitted to hospital with an MI have an assessment of left ventricular function before discharge.

Data source: Local data collection.

### Process

Proportion of discharges from hospital after an MI where the patient had an assessment of left ventricular function while in hospital.

Numerator – the number in the denominator where the patient had an assessment of left ventricular function while in hospital.

Denominator – the number of discharges from hospital after an MI.

Data source: Local data collection.

## What the quality statement means for different audiences

**Service providers** (secondary and tertiary care services) ensure that adults admitted to hospital with an MI have an assessment of left ventricular function before discharge.

**Healthcare professionals** assess the left ventricular function of adults admitted to hospital with an MI before discharge.

**Commissioners** (clinical commissioning groups) commission services that have the capacity and expertise to assess left ventricular function before discharge in adults admitted to hospital with an MI.

**Adults who are admitted to hospital with a heart attack** have a scan to see how well the blood is being pumped through their heart. This helps with decisions about the type and dose of drug treatment and the recovery programme that is appropriate for them. The scan should be done before a person leaves hospital.

## Source guidance

Acute coronary syndromes. NICE guideline NG185 (2020), recommendations 1.1.27 and 1.2.26

## Definitions of terms used in this quality statement

### Assessment of left ventricular function

Left ventricular function can be assessed using a variety of methods, including echocardiography, cardiac magnetic resonance imaging (MRI), angiography and nuclear imaging. [Expert opinion]

# Quality statement 2: Referral for cardiac rehabilitation

## Quality statement

Adults admitted to hospital with a myocardial infarction (MI) are referred for cardiac rehabilitation before discharge.

## Rationale

Cardiac rehabilitation aims to address the underlying causes of cardiovascular disease and improve physical and mental health after a heart attack. Cardiac rehabilitation encourages a healthy lifestyle which slows the progression of heart disease. It also reduces the risk of dying prematurely, especially as a result of a heart attack or stroke. People who are referred to rehabilitation programmes before they are discharged from hospital have better rates of uptake and adherence and improved clinical outcomes.

## Quality measures

### Structure

Evidence of local arrangements to ensure that adults admitted to hospital with an MI are referred for cardiac rehabilitation before discharge.

**Data source:** Local data collection.

### Process

Proportion of discharges from hospital after an MI where the patient was referred for cardiac rehabilitation while in hospital.

**Numerator** – the number in the denominator where the patient was referred for cardiac rehabilitation while in hospital.

**Denominator** – the number of discharges from hospital after an MI.

Data source: Local data collection.

## Outcome

Uptake rates of cardiac rehabilitation programmes.

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 \(NACR\)](#).

## What the quality statement means for different audiences

**Service providers** (secondary and tertiary care services) ensure that adults admitted to hospital with an MI are referred for cardiac rehabilitation while they are in hospital.

**Healthcare professionals** refer adults admitted to hospital with an MI for cardiac rehabilitation while they are in hospital.

**Commissioners** (clinical commissioning groups) commission services that have the capacity and expertise to refer adults admitted to hospital with an MI for cardiac rehabilitation while they are in hospital.

**Adults who are admitted to hospital with a heart attack** are referred to a cardiac rehabilitation programme while they are in hospital. A cardiac rehabilitation programme includes exercise sessions, information about health and lifestyle changes and how to cope with stress. This helps to slow down or stop heart disease and to reduce the risk of a heart attack or stroke in the future.

## Source guidance

[Acute coronary syndromes. NICE guideline NG185 \(2020\)](#), recommendations 1.8.1 and 1.8.13

## Definitions of terms used in this quality statement

### Cardiac rehabilitation

Cardiac rehabilitation is a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease. It provides the best possible physical, mental and social conditions so that people can, by their own efforts, continue to play a full part in their

community. A healthier lifestyle and slowed or reversed progression of cardiovascular disease can also be achieved. [[NICE's full guideline on acute coronary syndromes](#)]

Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [[NICE's guideline on acute coronary syndromes](#), recommendations 1.8.1 and 1.8.19]

## Quality statement 3: Communication with primary care

### Quality statement

Adults admitted to hospital with a myocardial infarction (MI) have the results of investigations and a plan for future treatment and monitoring shared with their GP.

### Rationale

People with an MI have cardiac investigations in hospital – clear communication of these results to primary care in a discharge summary ensures that people receive the right treatment after they leave hospital. Other key information to be shared with the GP includes future treatment, including incomplete drug titrations, plans for further revascularisation procedures and plans for antiplatelet and anticoagulant treatment. A clear plan for monitoring blood pressure and renal function ensures that people are on the correct drug dose after they leave hospital. Finally, it is also important for GPs to know that people have been referred for cardiac rehabilitation to encourage them to attend.

Ensuring that this information is included in a discharge summary will improve clinical outcomes, patient experience and continuity of care between primary and secondary or tertiary care services. This is especially important for people who have had hospital treatment for an MI outside of their local area.

### Quality measures

#### Structure

Evidence of local arrangements to ensure that adults admitted to hospital with an MI have the results of investigations and a plan for future treatment and monitoring shared with their GP.

Data source: Local data collection.

#### Process

a) Proportion of discharges from hospital after an MI where the patient had the results of investigations shared with their GP.

Numerator – the number in the denominator where the patient had the results of investigations shared with their GP.

Denominator – the number of discharges from hospital after an MI.

Data source: Local data collection.

b) Proportion of discharges from hospital after an MI where the patient had plans for future treatment and monitoring shared with their GP.

Numerator – the number in the denominator where the patient had plans for future treatment and monitoring shared with their GP.

Denominator – the number of discharges from hospital after an MI.

Data source: Local data collection.

## Outcome

a) Readmission rates.

Data source: [NHS Digital national data on emergency readmissions within 30 days of discharge from hospital.](#)

b) Rates of uptake and adherence to cardiac rehabilitation.

Data source: Local data collection.

c) Patient experience of GP services.

Data source: Local data collection.

## What the quality statement means for different audiences

Service providers (secondary and tertiary care services) ensure that adults discharged from hospital after an MI have the results of investigations and a plan for future treatment and monitoring shared with their GP.



**Healthcare professionals** include the results of investigations and a plan for future treatment and monitoring in the GP discharge summary for adults discharged from hospital after an MI.

**Commissioners** (clinical commissioning groups) commission services that provide GP discharge summaries for adults discharged from hospital after an MI. The GP discharge summaries should include the results of investigations and a plan for future treatment and monitoring.

**Adults who are admitted to hospital with a heart attack** have a letter sent to their GP, which includes the results of any tests and a plan for treatment and monitoring in the future. This helps to make sure that people get the right treatment after they leave hospital and start a programme to improve their long-term health (cardiac rehabilitation) as soon as possible.

## Source guidance

Acute coronary syndromes. NICE guideline NG185 (2020), recommendations 1.4.2, 1.4.25 and 1.7.1

## Definitions of terms used in this quality statement

### Results of investigations

People admitted to hospital with an MI may have several investigations of cardiac function while in hospital. These may include coronary angiography and should include assessment of left ventricular function. [Expert opinion]

### Plan for future treatment and monitoring

A plan for future treatment and monitoring after an MI should include details of:

- any further revascularisation procedures
- any drug titrations that need to be completed by the GP
- duration of antiplatelet treatment
- duration of any anticoagulant treatment
- blood pressure and renal function monitoring
- referral for cardiac rehabilitation.

[Expert opinion]

## Quality statement 4: Cardiac rehabilitation – assessment appointment

### Quality statement

Adults referred to a cardiac rehabilitation programme after a myocardial infarction (MI) have an assessment appointment within 10 days of discharge from hospital.

### Rationale

Starting cardiac rehabilitation as soon as possible after a heart attack significantly improves ongoing attendance at cardiac rehabilitation programmes. Cardiac rehabilitation improves clinical outcomes and is cost saving through a reduction in unplanned re-admissions for cardiac problems. An assessment appointment within 10 days of discharge ensures that people have contact with a member of the cardiac rehabilitation team as soon as possible. Because some people may not be able to drive or may not be ready for physical assessment within 10 days of discharge, this appointment can be an outpatient appointment, a home visit or a telephone interview.

### Quality measures

#### Structure

Evidence of local arrangements to ensure that adults referred to a cardiac rehabilitation programme after an MI have an assessment appointment within 10 days of discharge from hospital.

Data source: Local data collection.

#### Process

a) Proportion of referrals to a cardiac rehabilitation programme from hospital where the patient attends an assessment appointment within 10 days of discharge after an MI.

Numerator – the number in the denominator where the patient attends an assessment appointment within 10 days of discharge.

Denominator – the number of referrals to a cardiac rehabilitation programme from hospital after

admission for an MI.

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

## Outcome

Uptake rates of cardiac rehabilitation programmes.

**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 \(NACR\)](#).

## What the quality statement means for different audiences

**Service providers** (secondary and tertiary care services) ensure that adults referred to a cardiac rehabilitation programme after an MI can have an assessment appointment within 10 days of discharge.

**Healthcare professionals** ensure that adults referred to a cardiac rehabilitation programme after an MI have an assessment appointment within 10 days of discharge.

**Commissioners** (clinical commissioning groups) commission services that have the capacity to give adults referred to a cardiac rehabilitation programme after an MI an assessment appointment within 10 days of discharge.

**Adults referred to a cardiac rehabilitation programme after a heart attack** have an appointment for an assessment within 10 days of leaving hospital. Starting cardiac rehabilitation as soon as possible encourages people to take part in the programme and makes it more likely that they will carry on.

## Source guidance

[Acute coronary syndromes. NICE guideline NG185 \(2020\), recommendation 1.8.13](#)

## Definitions of terms used in this quality statement

### Assessment appointment

An assessment appointment is the first session of a cardiac rehabilitation programme. The session includes advice on lifestyle and risk factors and an assessment of the person's cardiac function and suitability for different components of the programme. The assessment appointment can be an outpatient appointment, a home visit or a telephone interview.

### Cardiac rehabilitation

Cardiac rehabilitation is defined as a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical, mental and social conditions, so that people can, by their own efforts, continue to play a full part in their community. A healthier lifestyle and slowed or reversed progression of cardiovascular disease can also be achieved. [[NICE's full guideline on acute coronary syndromes](#)]

Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [[NICE's guideline on acute coronary syndromes](#), recommendations 1.8.1 and 1.8.19]

# Quality statement 5 (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 referred to a cardiac rehabilitation programme after a myocardial infarction (MI) 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.

## Rationale

Cardiac rehabilitation programmes improve clinical outcomes for people who have had an MI. Offering cardiac rehabilitation programmes at different times of day and at different venues is likely to increase both uptake and adherence and to improve patient experience. It is important that programmes are provided outside normal working hours, so that they are accessible to people who work and to those with other commitments during the day.

## Quality measures

### Structure

Evidence of local arrangements to provide cardiac rehabilitation programmes 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 cardiac rehabilitation programme 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 people referred to a cardiac rehabilitation programme after an MI.

## Outcome

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

b) Patient experience of cardiac rehabilitation programmes.

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

## What the quality statement means for different audiences

**Service providers** (secondary and tertiary care services) offer cardiac rehabilitation programmes during and outside working hours and the choice of undertaking the programme at home, in the community or in a hospital setting.

**Healthcare professionals** offer adults referred to cardiac rehabilitation programmes a choice of programmes during and outside working hours, and a choice of undertaking the programme at home, in the community or in a hospital setting.

**Commissioners** (clinical commissioning groups) commission cardiac rehabilitation services that have the capacity and expertise to provide programmes during and outside working hours and the choice of undertaking the programme at home, in the community or in a hospital setting.

**Adults referred to a cardiac rehabilitation programme** can choose a programme in the daytime or outside working hours, at a hospital, in the local area or at home. Having a choice of time and place means that they are more likely to be able to take part in a programme.

## Source guidance

[Acute coronary syndromes. NICE guideline NG185 \(2020\)](#), recommendations 1.8.1 and 1.8.9

## Definitions of terms used in this quality statement

### Cardiac rehabilitation

Cardiac rehabilitation is defined as a coordinated and structured programme designed to remove or reduce the underlying causes of cardiovascular disease, as well as to provide the best possible physical, mental and social conditions, so that people can, by their own efforts, continue to play a full part in their community. A healthier lifestyle and slowed or reversed progression of cardiovascular disease can also be achieved. [[NICE's full guideline on acute coronary syndromes](#)]

Cardiac rehabilitation programmes should include a range of interventions with health education, lifestyle advice, stress management and physical exercise components. [[NICE's guideline on acute coronary syndromes](#), recommendations 1.8.1 and 1.8.19]



## 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.

## 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 healthcare professionals and people with myocardial infarction (MI) 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. People with MI 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.

[Acute coronary syndromes. NICE guideline NG185 \(2020\)](#)

## Policy context

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

- [NHS England. Strategic and operational planning 2014 to 2019: Reduce premature mortality 3. Cardiovascular disease \(CVD\) \(2014\)](#)
- [British Heart Foundation. The national audit of cardiac rehabilitation 2013 \(2013\)](#)
- [Department of Health. Cardiovascular disease outcomes strategy: improving outcomes for people with or at risk of cardiovascular disease \(2013\)](#)
- [Department of Health. Designing and planning cardiac facilities \(Health Building Note 01-01\) \(2013\)](#)
- [National Institute for Cardiovascular Outcomes Research. Myocardial ischaemia national audit project: annual public report April 2012–March 2013 \(2013\)](#)
- [Department of Health. A review of emerging cardiac technologies: their potential impact on cardiac services over the next 10 years \(2011\)](#)
- [Chartered Society of Physiotherapy. Physiotherapy works: cardiac rehab \(2011\)](#)

## Definitions and data sources for the quality measures

[British Heart Foundation. National Audit of Cardiac Rehabilitation \(2013\)](#)

## Related NICE quality standards

- [Physical activity: encouraging activity in the community. NICE quality standard 183 \(2019\)](#)
- [Obesity: clinical assessment and management. NICE quality standard 127 \(2016\)](#)
- [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 \(2015\)](#)
- [Atrial fibrillation: treatment and management. NICE quality standard 93 \(2015, updated 2018\)](#)
- [Personality disorders: borderline and antisocial. NICE quality standard 88 \(2015\)](#)
- [Physical activity: for NHS staff, patients and carers. NICE quality standard 84 \(2015\)](#)
- [Smoking: reducing and preventing tobacco use. NICE quality standard 82 \(2015\)](#)
- [Psychosis and schizophrenia in adults. NICE quality standard 80 \(2015\)](#)
- [Acute coronary syndromes in adults. NICE quality standard 68 \(2014\)](#)
- [Anxiety disorders. NICE quality standard 53 \(2014\)](#)
- [Peripheral arterial disease. NICE quality standard 52 \(2014\)](#)
- [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 \(2012, updated 2017\)](#)
- [Alcohol-use disorders: diagnosis and management. NICE quality standard 11 \(2011\)](#)
- [Chronic heart failure in adults. NICE quality standard 9 \(2011, updated 2018\)](#)
- [Depression in adults. NICE quality standard 8 \(2011\)](#)

- [Diabetes in adults. NICE quality standard 6 \(2011, updated 2016\)](#)
- [Chronic kidney disease in adults. NICE quality standard 5 \(2011, updated 2017\)](#)
- [Stroke in adults. NICE quality standard 2 \(2010, updated 2016\)](#)

The full list of quality standard topics referred to NICE is available from the [quality standards topic library](#) on the NICE website.

# 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, East Midlands

**Mr Barry Attwood**

Lay member

**Professor Gillian Baird**

Consultant Developmental Paediatrician, Guy's and St Thomas' NHS Foundation Trust, London

**Mrs Belinda Black**

Chief Executive Officer, Sheffcare, Sheffield

**Dr Ashok Bohra**

Consultant Surgeon, Dudley Group of Hospitals NHS Foundation Trust

**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 Derek Cruickshank**

Consultant Gynaecological Oncologist/Chief of Service, South Tees NHS Foundation Trust

**Miss Parul Desai**

Consultant in Public Health and Ophthalmology, Moorfields Eye Hospital NHS Foundation Trust, London

**Mrs Jean Gaffin**

Lay member

**Dr Anjan Ghosh**

Consultant in Public Health, Public Health Merton, London

**Mr Jim Greer**

Principal Lecturer, Teesside University

**Dr Ulrike Harrower**

Consultant in Public Health Medicine, NHS Somerset

**Professor Richard Langford**

Consultant in Anaesthesia and Pain Medicine, Barts Health NHS Trust, London

**Mr Gavin Lavery**

Clinical Director, Public Health Agency

**Dr Tessa Lewis**

GP and Medical Adviser in Therapeutics, Carreg Wen Surgery

**Ms Robyn Noonan**

Lead Commissioner Adults, Oxfordshire County Council

**Dr Michael Rudolf (Chair)**

Consultant Physician, Ealing Hospital NHS Trust

**Mr David Minto**

Adult Social Care Operations Manager, Northumbria Healthcare Foundation Trust

**Dr Lindsay Smith**

GP, West Coker, Somerset

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

**Dr Rajai Ahmad**

Consultant Cardiologist, Sandwell and West Birmingham Hospitals NHS Trust

**Ms Louise Batey**

CHD Nurse Clinical Lead/Cardiac Rehabilitation Coordinator, University Hospital South Manchester

**Dr Ivan Benett**

GP and Clinical Director, NHS Central Manchester Clinical Commissioning Group

**Mr Sanjay Ramdany**

Community Matron with Special Interest in CVD, Isle of Wight NHS Trust

**Dr Alan Rees**

Consultant Physician in Diabetes, Endocrinology and Clinical Lipidology, University Hospital of Wales Cardiff

**Mr John Walsh**

Lay member

**Professor Anthony Wierzbicki**

Consultant in Metabolic Medicine/Chemical Pathology, Guy's and St Thomas' NHS Foundation Trust, London

**Dr Robert Wright**

Consultant Cardiologist, James Cook University Hospital, Middlesbrough

## **NICE project team**

**Nick Baillie**

Associate Director

**Karen Slade**

Consultant Clinical Adviser

**Rachel Neary-Jones and Esther Clifford**

Programme Managers

**Craig Grime**

Technical Adviser



**Justine Karpusheff and Abigail Stevenson**

Technical Analysts

**Natalie Boileau and Jenny Mills**

Project Managers

**Nicola Cunliffe**

Coordinator

## Update information

### Minor changes since publication

**November 2020:** The source guidance references for the quality statements were changed to align this quality standard with the new [NICE guideline on acute coronary syndromes](#).

## 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.

This quality standard has been included in the [NICE Pathways on acute coronary syndromes: early management](#) and [acute coronary syndromes: secondary prevention and rehabilitation](#), which bring 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.

- [Association of Chartered Physiotherapists in Cardiac Rehabilitation \(ACPICR\)](#)
- [HEART UK](#)