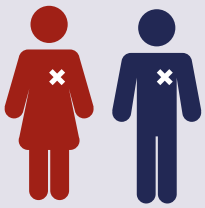
Alliance for
Heart Failure



Primary Care
A call to action

Transforming heart failure services
in the community

www.allianceforheartfailure.org

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About the Alliance for Heart Failure

The Alliance for Heart Failure is a coalition of charities, patient groups, professional bodies and healthcare companies working together to improve outcomes for people living with heart failure. This report draws on a broad range of clinical and patient testimony from our network, as well as existing data sources, journal articles and reports.

The Alliance for Heart Failure is supported and funded by AstraZeneca UK, Boehringer Ingelheim Limited, Medtronic UK Ltd, Novartis Pharmaceuticals UK Ltd, and Roche Diagnostics Ltd.

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Preface

The growing burden of heart failure is a national health emergency demanding urgent action. Affecting predominantly older adults but increasingly reaching across all age groups, it exerts profound clinical, social, and economic pressure across the country on a daily basis.

Heart failure care has long been reactive — focused largely on treating patients in hospitals rather than earlier diagnosis and optimisation of care in the community.

This approach is no longer sustainable. The Government's Ten Year Health Plan, built around delivering the "three shifts" from hospital to community, treatment to prevention, and analogue to digital, offers a once in a lifetime opportunity to transform heart failure care.

At the heart of this opportunity is primary care. Over the past decade, advances in diagnostics through NT-proBNP testing and a better understanding of multidisciplinary working have expanded the potential of everyone from practice nurses to community pharmacists to deliver life-changing care.

From the work of the Alliance over the past two years, we know there is a real desire amongst those working in primary care to help address the needs of people living with heart failure. Yet we are aware that NICE guidance is frequently not being followed to facilitate an early and timely diagnosis of this condition.

While the pandemic has understandably slowed progress, a deeper cultural shift and stronger leadership is now still required to ensure that heart failure is prioritised across the NHS on a par with other major conditions.

This report presents the foundations of the best of the NHS when it comes to diagnosing and treating those with heart failure in primary care.

Together with strong leadership and system-wide collaboration, it presents a compelling vision, and the means of achieving this, to ensure that heart failure will finally receive the priority it demands.

This will mirror the progress seen with other major conditions, saving lives and improving the quality of life for hundreds of thousands of patients across the country.

Dr Jim Moore,
GP with Specialist Interest in Cardiovascular Medicine & Immediate
Past President Primary Care Cardiovascular Society

Introduction

A major condition underserved by primary care

Dealing with the growing burden of heart failure is one of the major health challenges of this century. Around one million people are living with the condition across the UK, with a further 200,000 new diagnoses each year.

By the middle of the century cases are set to double, making heart failure one of the fastest growing major conditions in the country.[1] The timely diagnosis and treatment of heart failure is now a major priority, yet already there are an estimated 385,000 individuals who remain undiagnosed, leaving them at heightened risk of being hospitalised with severe and costly long-term illness and premature mortality.[2]

Historically heart failure has not received the same emphasis on prevention, diagnosis, and treatment as other major conditions, despite the disproportionate impact on patients, the NHS and the economy. It has traditionally been seen as a complex condition, often misunderstood as being solely associated as a condition of the elderly associated with end-of-life care.

A significant number of primary healthcare professionals remain unaware of diagnostic pathways, treatment and rehabilitation available.

Over the last decade, advances in medical therapy and rehabilitation, alongside the development and adoption of NT-proBNP diagnostic tests, offer a critical opportunity to relieve this growing burden. Despite progress, the full potential of this revolution in heart failure care has yet to be fully realised across the NHS. This is particularly evident in primary care.

A significant number of primary healthcare professionals remain unaware of diagnostic pathways, treatment and rehabilitation available. Despite knowledge of the condition among GPs, early detection is not currently prioritised, with updated NICE guidelines from 2010 requiring the use of NT-proBNP testing to rule out heart failure not being widely followed.[3]

This is placing an unsustainable burden on hospitals across the country. 80% of heart failure cases are diagnosed in hospital, despite half of those having had signs and symptoms that should have triggered an earlier assessment and access to life saving therapies. This should not be happening in a modern, prevention-first healthcare system.[4]

Poor optimisation of guideline-based therapy during admission and following discharge from secondary care means readmission rates are also high.[5] 20-30% of patients return to hospital within 30 days of being discharged, with readmission rates the highest for any condition in the over 65s.[6]

Local and national leadership must now urgently support and prioritise a change in culture across primary care to dramatically improve the early diagnosis and management of heart failure.

1. Consensus statement on cardiovascular disease, British Heart Foundation (accessed 25.09.25)
2. British Heart Foundation. Heart failure: a blueprint for change. London: BHF, 2020
3. Kwok CS, Burke H, McDermott S, Welsh V, Barker D, Patwala A, Duckett S, Satchithananda D, Mallen CD. Missed Opportunities in the Diagnosis of Heart Failure: Evaluation of Pathways to Determine Sources of Delay to Specialist Evaluation. Heart Fail Rev. 2022 Jun;27(3):1003-1014. doi: 10.1007/s10741-022-10218-w. Epub 2022 Apr 25. PMID: 35666345; PMCID: PMC9169019
4. Bottle A, Kim D, Aylin P, et al. (2018) Routes to diagnosis of heart failure: observational study using linked data in England Heart.104:600-605.
5. Fylan B, Marques I, Ismail H, et al, Gaps, traps, bridges and props: a mixed-methods study of resilience in the medicines management system for patients with heart failure at hospital discharge, BMJ Open 2019;9:e023440. doi: 10.1136/bmjopen-2018-023440
6. Sankaranarayanan, Rajiv, Validation of Risk Calculator to Predict 30-day Heart Failure Outcomes, NHS Health Research Authority, 2020

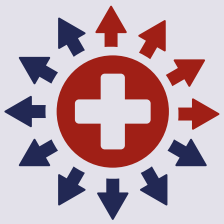
This report draws on over five years of learning and working with primary care heart specialists. It lays out pragmatic, evidence-based solutions to achieve this: from improving the uptake of NT-proBNP testing, expanding screening via pharmacies and Community Diagnostic Centres, to supporting primary care to better optimise medication in the community.

The report is structured around two core transformation areas: shortening time to diagnosis and time to treatment and optimising management in primary care. Based on clinical and patient testimony, consensus from the heart failure community, and proven interventions, it presents ready-made solutions and recommendations for transforming heart failure care.

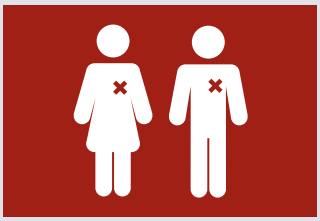
Over the next decade, the planned focus on expanding the role of primary care through workforce expansion, digital tools, new contractual models and integrated community services such as the Neighbourhood Health Service offers unprecedented opportunities for improving outcomes for heart failure patients.[7]

However, heart failure risks being overlooked as part of these reforms unless stakeholders across the system champion a focus on heart failure as part of these reforms.

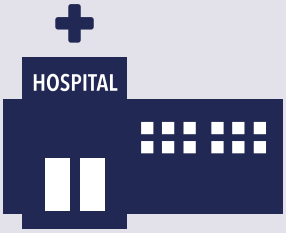
For the Government's ambitions to move from treatment to prevention, hospital to community, and analogue to digital to be realised, it must heed the recommendations set out by our consensus of patients, clinicians, and heart failure experts.



BNP TESTING IN PRIMARY CARE and the community could reduce demand on specialist diagnostic services **BY 30%**[8]



PEOPLE WITH HEART FAILURE have **worse survival rates** than many cancers.[9]



60-70% OF THE £2.4 BILLION

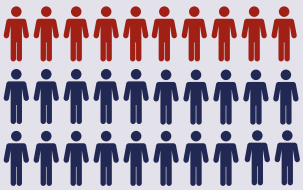
NHS spend on heart failure goes on hospital-based care.[10]

7. Johnston, George et al, The future of primary care, NHS Confederation, 2025
8. Irish Cardiac Society. 2016. Irish Cardiac Society calls for rapid Community Heart Failure diagnosis [online]. Available from: http://www.irishcardiacsociety.com/pages/news_box.asp
9. Taylor CJ et al., "Survival following a diagnosis of heart failure in primary care: a retrospective cohort study of the UK population", Heart, 2017 https://heart.bmj.com/content/103/12/882
10. Hickey, D.A. et al., Hospital admissions for heart failure in England; an increasing burden on NHS resources and the focus of effective cost containment, Value in Health, Volume 21, S113 (2018)

The underutilised role of primary care in diagnosing heart failure is placing an unnecessary burden on the NHS and patients.

Katie's story

A THIRD OF
heart failure patients in the last decade were initially misdiagnosed in primary care.[11]



"The next person might not survive what I went through."

My life changed one day in March when I arrived at A&E and was diagnosed with severe heart failure. My heart was functioning at just 17% of its normal rate. They told my family it was touch and go as to whether I'd make it through the night. I ended up spending 12 weeks in the hospital. I was only 25 years old.

Months before I had presented at my GP with symptoms: breathlessness, rapid weight gain, and a racing heart at rest. But they were treated as minor issues — possibly a chest infection. I was given antibiotics, then inhalers, even anti-anxiety medication. While I was still in hospital, the same GP called me. They apologised. They'd added my case to their training programme as an example of how heart failure can be missed if you don't look past assumptions.

It took a move to a different hospital to get me stable. I hadn't been started on any of the core heart failure drugs — the "big four" — before. Once I was, my ejection fraction began to improve. I was also put on sacubitril with valsartan, which my previous hospital wouldn't consider. My heart function rose from 17% to 54%. It gave me my life back.

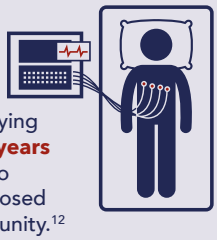
But then, once I was stable, I was discharged back to primary care. And this is where the cracks reappeared.

My GP won't adjust my medication, even if my symptoms change. I don't get ECGs or echos, just six-monthly medication reviews. If something goes wrong, I'd need to wait for a re-referral. That's the scary part. Without access to basic diagnostics like ECGs, how would I know if something's changing? What if I get worse before anyone acts?

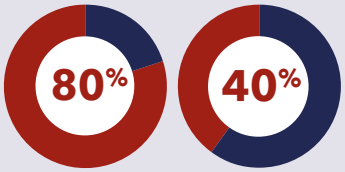
I've since become passionate about patient education, because the next person might not survive what I went through. Primary care is where heart failure begins and where it ends. But GPs need support. They need in-depth training in heart failure, the confidence to prescribe the right medications, and access to diagnostics.

PATIENTS DIAGNOSED IN HOSPITAL HAD A

28%



HIGHER
chance of dying within **two years** compared to those diagnosed inthe community.[12]



OF THE 80% OF HEART FAILURE CASES DIAGNOSED IN HOSPITAL,
40% of these could have triggered an earlier assessment in primary care.[13]

11. Censuswide, Data from survey of 625 heart failure patients analysed for this report (via Roche https://hfreport.roche.com/image/6721401/Roche%20HF%20report%20portrait%20final.pdf)
12. Bachtiger P, Kelshiker MA, Petri CF, Gandhi M, Shah M, Kamalati T, Khan SA, Hooper G, Stephens J, Alrumayh A, Barton C, Kramer DB, Plymen CM, Peters NS. Survival and health economic outcomes in heart failure diagnosed at hospital admission versus community settings:a propensity-matched analysis. BMJ Health Care Inform. 2023 March
13. Bottle A, Kim D, Aylin P, et al. (2018) Routes to diagnosis of heart failure: observational study using linked data in England Heart.104:600-605

There is significant potential to relieve the burden of heart failure via primary care through better integrated care and optimisation of medication.

Emily's story

Early diagnosis and optimal management can **reduce hospitalisations by up to 30%**.[14]

"Nobody told me the first time I was diagnosed with heart failure – I found out from a letter over a year later."

In August 2020, I had a transient ischaemic attack (TIA) and was rushed by ambulance to hospital. After being discharged, I was told it was unlikely I would have another stroke, and that they had no idea what had caused it.

I returned to my job as a teacher, but I knew something wasn't right with my body: dizziness, fatigue, and breathlessness. I had no idea that during that visit I'd also been diagnosed with heart failure.

It took a year of struggling at work until I ended up in hospital again. I told the Accident and Emergency team my history: the TIA, the palpitations, the breathlessness and fatigue. Although they didn't mention heart failure at the time, they must have suspected it as they checked my ankles for swelling and asked me about my socks feeling tight.

I had another echo and a 24-hour ECG. Then I saw a cardiologist. I walked out of that appointment without any clear explanation of what was going on. About a week later, a letter arrived by post telling me I had severe left ventricular dysfunction. **That letter was the first time anyone officially told me I had heart failure despite a diagnosis having been made following my TIA back in August well over a year ago.**

Cardiology assumed the GP had explained it. The GP assumed it was cardiology. Surely, at some point, someone should have checked that I knew. Looking back, I can't help but think that if that initial diagnosis had been communicated to my GP, or if primary care had recognised my symptoms earlier, I might have avoided months of unnecessary suffering and uncertainty.

My care has dramatically improved since changing hospitals, but there's still a disconnect between secondary care and primary care. My GP can't see the results of my echos. If my heart failure nurse or cardiologist changes my prescription, it doesn't go through to my GP automatically. I have to make calls, chase things up — it's frustrating, and frankly, it's not safe. The system is clunky, doesn't seem to prioritise heart failure and the patient ends up being the go-between.

14. Heart Failure Policy Network, The handbook of multidisciplinary and integrated heart failure care, 2018

Improvement area 1: Detection and diagnosis in primary care

Addressing the growing burden of heart failure will require local and national leadership to empower primary care to take a more proactive role in detection and diagnosis.

A modern primary care heart failure service should see all primary care health professionals:

- **Use the BEAT symptom tool** to proactively assess for risk factors, a family history, comorbidities, and signs and symptoms particularly in frail patients, whilst understanding the complexity of the condition that is frequently misdiagnosed as COPD, asthma and/or anxiety.
- **Deploy point-of-care NT-proBNP testing** to rapidly confirm or exclude heart failure.
- **Understand how to use the results** of this test to accurately triage patients to specialist diagnostic services.

A systematic review to determine the rates of heart failure misdiagnosis found rates of heart failure misdiagnosis of 68.5% when general practitioners referred patients to a specialist setting, with it commonly being misdiagnosed as COPD.[15]

A 2019 study found that just 7% of patients follow the NICE recommended route to heart failure diagnosis, with significant variation between GP practices.[16]

Between 2011 and 2021 only 18.3% of patients with heart failure had received an NT-proBNP before being diagnosed.[17]

Less than 2 in 10 practice nurses would offer an NT-proBNP test after identifying the common symptoms of heart failure.[18]

The easiest way to overcome these challenges is the appropriate use of NT-proBNP testing. Despite widespread availability, there is still variation in uptake.

Based on best practice and a consensus amongst our members, the Alliance believes that mandating NT-proBNP testing as compulsory for accessing specialist services is an effective way to:

- **incentivise uptake and ensure patients receive timely treatment**
- **improve heart failure knowledge and awareness amongst the primary care workforce**
- **avoid unnecessary referrals and reduce the incidence of open access to echocardiography that is placing an unsustainable strain on the service**

There is also a strong need to expand screening beyond general practice into areas of the community where the burden is most acutely felt.

Research by the Alliance for Heart Failure has found that despite NHS England guidance, the majority of Community Diagnostic Centres do not provide access to NT-proBNP testing.[19]

There is also potential to build on existing hypertension services in pharmacies, to offer a heart failure case finding service.

Without a proactive effort in primary care to drive the awareness of heart failure symptoms and the uptake of NT-proBNP testing, late diagnosis of the condition will continue, placing an unsustainable burden on hospitals across the country.

15. Wong CW, Tafuro J, Azam Z, Satchithananda D, Duckett S, Barker D, Patwala A, Ahmed FZ, Mallen C, Kwok CS. Misdiagnosis of Heart Failure: A Systematic Review of the Literature. J Card Fail. 2021 Sep;27(9):925-933. doi: 10.1016/j.cardfail.2021.05.014. Epub 2021 May 25. PMID: 34048921

16. Kim D, Hayhoe B, Aylin P, Majeed A, Cowie MR, Bottle A. Route to heart failure diagnosis in English primary care: a retrospective cohort study of variation. Br J Gen Pract. 2019 Sep 26;69(687):e697-e705. doi: 10.3399/bjgp19X705485. PMID: 31455645; PMCID: PMC6713513.

17. IQVIA Medical Research Data, IQVIA Ltd, incorporating data from THIN, a Cegedim database, 2011 - 2021

18. Censuswide survey of 100 General Practice Nurses in England, (2025)

19. Alliance for Heart Failure FOI request to ICBs and Trusts in England, March and September 2024

"All primary care health professionals need to be thinking about heart failure in every patient contact."

Louise Clayton,
Advanced Nurse Practitioner

Case study

Heart failure is a clinical syndrome characterised by a constellation of symptoms but also crucial anecdotal signs like shortness of breath in everyday life, waking up gasping for air, or difficulty breathing when lying flat.

Patients rarely present with all these symptoms neatly aligned, so it's essential that we remain vigilant for any signs, however subtle. Face to face history taking and clinical examination are absolutely key in uncovering the diagnosis early.

Simple questions like, "Have you struggled to walk your dog lately?" or "Have your shoes or socks felt tighter?" can reveal subtle changes that patients might not otherwise report. Directly asking, "Are you breathless?" may not always yield the full picture because patients often normalise their symptoms.

At the first point of contact, it's crucial to recognise that many patients with heart failure have multiple comorbidities — around 25% have diabetes, 40% have atrial fibrillation, and 70% have hypertension. **These patients are often seen in clinics for these long-term conditions, providing us with multiple chances to screen for heart failure using simple, targeted questions.**

Solution: BEAT HF

The Pumping Marvellous Foundation's BEAT HF initiative (beathf.org.uk) is a patient-led campaign aimed at improving the early detection of heart failure in primary care and incentivising the use of NT-proBNP testing.

The acronym BEAT stands for Breathlessness, Exhaustion, Ankle swelling, and Time for a simple blood test (BNP). This mnemonic is designed to help both patients and healthcare professionals recognise the key symptoms of heart failure promptly, facilitating timely diagnosis and treatment.

Its inclusion in the recent Heart Failure Plan for Health Innovation Networks is a positive step. There is now a need to ensure it is scaled up to every general practice, community pharmacy and Community Diagnostic Centre to ensure the timely use of NT-proBNP testing.

Solution: Embedding NT-proBNP triage in primary care

NHS England's 2023 guidance recommends NT-proBNP testing as the first-line triage tool when heart failure is suspected, with clear pathways for onward referral: patients with very high levels (> 2,000 ng/L) should be referred for echocardiography within two weeks, and those with high levels within six weeks. This structured approach not only ensures prompt diagnosis for those at greatest risk but also helps use echocardiography capacity more effectively.

However, uptake of this guidance across the NHS has been inconsistent and often poorly implemented. Many patients are referred directly for echocardiography without prior NT-proBNP testing. **An audit highlighted that as many as 30% of primary care referrals for echocardiography did not deliver clinical benefit.**

Widespread adoption of the BSE's triage guidance has the potential not only to identify urgent cases earlier but also to manage demand by reducing unwarranted echocardiograms, freeing capacity and shortening waiting times for patients who genuinely need investigation.

There is also clinical consensus that NT-ProBNP testing should be a prerequisite to a referral. A recent national consensus paper on echocardiography found that 98% of respondents agreed that "referrals for specialist assessment for patients with suspected heart failure must include NT-proBNP as a minimum data."[20]

20. Paton MF, Barton C, Baruah R, et al. Echocardiography reporting in heart failure with preserved ejection fraction: Delphi consensus study. Open Heart 2025

Screening is straightforward but nuanced. Fatigue, for example, can be difficult for patients to articulate; it's not just tiredness, but profound exhaustion. When we talk about the diagnostic pathway, blood tests such as a full blood count, liver function, and thyroid tests are vital to rule out reversible causes of heart failure, like anaemia or thyroid disease.

A chest x-ray can be helpful but should not delay further treatment. It's also important to interpret biomarkers properly — patients with atrial fibrillation typically have NT-proBNP levels up to three times higher than those without.

An NT-proBNP below 400 pg/mL makes heart failure very unlikely. Levels between 400 and 2000 pg/mL require urgent assessment and echocardiography within six weeks. However, if NT-proBNP exceeds 2000 pg/mL, this is prognostically significant and warrants an urgent referral — akin to the priority we give to suspected cancer cases.

NT-proBNP is released in response to cardiac muscle stretch, making it a quick and accessible rule-out test. It's cost-effective at around £24 per test and helps us avoid unnecessary echocardiograms while speeding up diagnosis. Early, accurate diagnosis not only reduces healthcare costs but is immensely reassuring to patients, allowing them to receive timely specialist care.

Improving early diagnosis isn't just about learning the symptom by rote, but a vigilant awareness backed up by detailed history taking, an understanding of how to use and interpret NT-proBNP testing, and onward timely referral. It transforms the diagnostic pathway — something that's long been reactive — into something proactive. All primary care health professionals need to be thinking about heart failure in every patient contact.

There is also potential to expand screening for heart failure in pharmacies and Community Diagnostic Centres, so we can remain as vigilant for heart failure as we are for other major conditions.

Case study

Solution: Expanded point of care NT-proBNP testing in Community Diagnostic Centres

Despite its inclusion in national guidance, recent analysis by the Alliance for Heart Failure found that as of October 2024, very few trusts or ICBs reported offering NT-proBNP testing in their CDCs. The Royal College of Pathologists, and the British Society for Echocardiography, have strongly advocated for its wider rollout, noting that timely NT-proBNP testing can help identify patients unlikely to have heart failure and avoid unnecessary referrals for echocardiography.

Expanding access to rapid NT-proBNP testing in all CDCs would support more efficient triaging, significantly reducing inappropriate demand on echocardiography services, which continue to face substantial backlogs. By enabling quicker rule-out of heart failure, the test not only reduces delays for patients who need urgent imaging, but also prevents others from undergoing avoidable and stressful waits.

Solution: Case finding service in community pharmacies

The NHS Ten Year Plan wants to give community pharmacies a bigger role in prevention, by expanding their role in screening for risk of cardiovascular disease. An easy win is building on the existing hypertension case finding service that exists in community pharmacies to expand screening for heart failure. Hypertension has a high population-attributable risk for heart failure, accounting for 39% of cases in men and 59% in women.[21] Additional questions to aid in the detection of heart failure, with the option to refer for an NT-proBNP test at either a GP or a CDC would significantly expand diagnostic screening of undetected heart failure cases, particularly in high-risk areas.

21. Levy D, Larson MG, Vasan RS, Kannel WB, Ho KK. The progression from hypertension to congestive heart failure. JAMA. 1996 May 22-29;275(20):1557-62. PMID: 8622246.

Recommendations

1. **Create a culture across primary care for a proactive and accurate heart failure case finding using NT-proBNP testing:**

   - **Local commissioners should mandate NT-proBNP testing as the gateway to specialist care.** Access to echocardiography and heart failure services should be dependent on NT-proBNP testing, creating a consistent, evidence-based pathway for diagnosis and referral that incentivises heart failure education, awareness and uptake of effective triage guidance.
   - **Integrated Care Boards (ICBs) should drive a culture of early detection** by embedding heart failure symptom checks into routine reviews for patients with COPD, diabetes, and atrial fibrillation. This will ensure at-risk patients are systematically assessed and identified earlier.
   - **Primary Care Networks (PCNs) and Health Innovation Networks should integrate decision-support and triage tools** using the British Society for Echocardiography's guidance. Electronic prompts for NT-proBNP testing and referral guidance should be embedded in practice systems. Staff must be trained to interpret NT-proBNP results and fast-track patients with high readings directly to the dedicated specialist heart failure pathway rather than untriaged direct access to echo.
   - **ICBs and PCNs should work in collaboration with organisations such as Pumping Marvellous** to raise public awareness of heart failure symptoms, empower patients to request timely assessment and care and ensure all primary care health professionals utilise the BEAT acronym.

2. **Expand timely diagnostic capacity through pharmacies, Community Diagnostic Centres and practice nurses in GPs**

   - **ICBs should ensure point-of-care NT-proBNP testing is available across primary care including CDCs.** Every GP practice and CDC should have access to point-of-care NT-proBNP testing, ensuring rapid triage and reducing avoidable delays in referral to echocardiography or specialist services.
   - **ICBs and community pharmacy providers should integrate heart failure screening into the NHS Blood Pressure Check Service.** Standardised heart failure symptom questions should be included in blood pressure checks, creating an additional opportunity to identify patients at risk during routine community encounters.
   - **The Department for Health and Social Care should implement the British Society for Echocardiography workforce recommendations** to ensure sustainable echocardiography capacity, including investment in training, recruitment, and workforce retention.
   - **NHS England should require annual reporting of diagnostic performance at practice level.** Primary care providers should submit data on time-to-diagnosis and NT-proBNP utilisation rates, enabling ICBs to benchmark performance, identify gaps, and drive continuous improvement in early diagnosis.

3. **Integrate specialist heart failure care into primary care services to support faster diagnosis and treatment**

   - **Every Primary Care Network (PCN) should have a named heart failure specialist linked to their services.** Direct access to specialist expertise will support GPs and community teams in managing complex cases, ensuring timely escalation and reducing variation in care.
   - **Each PCN should appoint a designated Heart Failure Champion.** The Heart Failure Champion will act as the local lead for driving improvements in diagnosis, care pathways, and patient education, ensuring that heart failure remains a priority within integrated care planning.

Improvement area 2: Managing heart failure in the community

Improving the management of heart failure in primary care is essential to addressing the increasing burden of the condition on the NHS by reducing readmissions and enabling patients to live well with the condition.

The growing prevalence of heart failure and resource constraints mean that patients now spend less time under specialist oversight. As our patient stories highlight, referral back to primary care can be disjointed and the long-term management of the condition uncertain.

A modern heart failure service should see primary care:

- Adept at working with specialists when it comes to co-ordinating care plans and initiating investigations for cases that escalate
- Optimising medication amongst newly-diagnosed and legacy patients for both heart failure with reduced ejection fraction (HFrEF), heart failure with mildly reduced ejection fraction (HFmrEF) and preserved ejection fraction (HFpEF)
- Empowering patients through education and supported self-management while ensuring access and uptake of cardiac rehabilitation
- Fully utilise the role of pharmacy as part of the MDT

Only a minority of patients on heart failure registers receive optimal GDMT in the UK.[22]

Only 15% of people who are hospitalised for heart failure are referred for cardiac rehabilitation.[23]

An audit of heart failure patients in primary care found **5 in 10 required medicine optimisation**.[24]

£ £ £ **70%** OF THE TOTAL ANNUAL COST OF MANAGING HEART FAILURE is when the disease is **in its late stages**.[25]

22. Markus Schichtel et al, Schichtel M, Barclay S, Papworth H, et al. Pharmacist-led guideline-directed medical therapy in heart failure: impact analysis in primary care. BMJ Open Quality 2025;14:e003401. doi:10.1136/bmjoq-2025-003401
23. NICOR National Heart Failure Audit 2023
24. Matthew Kahn, Antony D Grayson, Parminder S Chaggar, Marie J Ng Kam Chuen, Alison Scott, Carol Hughes, Niall G Campbell, Primary care heart failure service identifies a missed cohort of heart failure patients with reduced ejection fraction, European Heart Journal, Volume 43, Issue 5, 1 February 2022, Pages 405–412, https://doi.org/10.1093/eurheartj/ehab629
25. Duffy, David, The NHS must break the cycle on heart failure, Integrated Care Journal, 2023

"We've reduced one year mortality rates from heart failure by 20%."

Dr Jim Moore,
Gloucestershire Community Heart Failure Service

Our service was established over 20 years ago by a small group of dedicated clinicians, built on the principle of delivering the right care, by the right team, in the right place. Serving a population of around 640,000, we now have around 12 full-time equivalent heart failure specialist nurses, three GPs with Specialist Interest (GPSi), a patient educator and dedicated administration team.

A key feature of our service is access to NT-proBNP testing in primary care. We perform thousands of tests a year, allowing GPs to quickly and easily screen patients for heart failure. Using this basic test is still a challenge in primary care. On a recent webinar run by the Alliance for Heart Failure, a poll of 100 attendees found that a quarter of primary care health professionals hadn't requested the test.

What we've tried to embed is a fully integrated approach. We work closely with our hospital colleagues, not only heart failure specialists but across multiple disciplines. We hold weekly MDT meetings involving heart failure consultants, specialist nurses, and palliative care teams. This ensures complex cases both in hospital and in the community are discussed collaboratively, enabling early discharge with seamless care transitions.

From primary care, a patient is referred to us using a specific heart failure referral proforma. We ask primary care to provide a recent NT-proBNP result and an ECG to help triage referrals efficiently and appropriately. Nearly all heart failure cases in our county, except for the most acutely unwell, come through our service. Our pathway aims to deliver assessment including echocardiography within agreed national time frames based on clinical detail and natriuretic peptide level with urgent patients prioritised for review within two weeks. Once their heart failure is optimally managed, patients are safely handed back to their GPs for ongoing care.

Our initial appointment is thorough — typically lasting 40 minutes — allowing us to take a detailed history and develop a personalised management plan. We support primary care clinicians to take ownership of stable patients, with regular reviews recommended every six months (NICE guideline), or at least annually in keeping with the Quality and Outcomes Framework (QoF) Heart Failure review indicator.

Case study

Solution: Rapid Titration Service for newly diagnosed cases

A new Heart Failure Rapid Titration Service at Barts Health NHS Trust is demonstrating the clinical benefits of accelerated treatment optimisation. The trial showed that patients who received rapid initiation and up-titration of all four foundational heart failure therapies within six weeks had significantly better outcomes — including a 33% reduction in risk of death or hospitalisation — compared to standard care.

Among 96 patients treated across Barts Health and UCLH, 92% were discharged on all four recommended heart failure therapies — ARNis, beta-blockers, MRAs, and SGLT2 inhibitors — with an average time to target dose of just 36 days and no reported adverse effects. Notably, none were readmitted for heart failure.

This innovative approach demonstrates the huge potential to not only rapidly titrate newly-diagnosed cases of heart failure, but also the importance of correctly titrating historic cases of heart failure in the community through GP coding and community pharmacy services.

We annually audit all aspects of our service.

The results are encouraging — while the National Heart Failure Audit shows a 30% mortality rate at one year for patients admitted acutely to hospital to hospital, our community service results consistently shows that around 10% of audited patients don't survive beyond a year. This is a testament to the effectiveness of early diagnosis, specialist input, and ongoing management.

Education remains a cornerstone of our work. We provide extensive opportunities for both patients, their families and clinicians to deepen their understanding. Our helpline supports queries from clinicians, patients or their families and we have a dedicated IT platform for clinician support. We proactively engage practices with low NT-proBNP usage to improve testing rates and raise heart failure awareness.

We also strongly advocate for cardiac rehabilitation, in line with NICE guidelines. The evidence shows it can significantly improve outcomes and reduce costs.

Building the service around NT-proBNP testing and specialist triage supported by integrated, multidisciplinary working that includes pharmacists and a patient-centred approach including education, we deliver timely, effective care that improves survival and quality of life. This is a model which can be reproduced in other areas.

Case study

Solution: Finding "missed cohorts" of patients through primary care auditing

A 2022 study demonstrated the critical role of systematic auditing in identifying and optimising heart failure patient care within primary care settings. The study used a retrospective clinical audit approach to scrutinise GP records across 78 practices covering a population of over 860,000 patients.[26]

Key findings included a 47% increase in detection of patients with heart failure with left ventricular systolic dysfunction (LVSD) following audit-driven case finding. This demonstrated a significant under-diagnosis in routine primary care. Furthermore, the audit identified that 45% of patients required medication optimisation, and 27% were eligible for advanced device therapy but had not yet received it.

Patients flagged through the audit were offered consultant cardiologist reviews at their local GP practices, improving access to specialist care without hospital visits. The audit process also improved coding accuracy by adding missing diagnosis codes for 47% of patients, enabling better tracking and management.

But auditing is complex, and as Crundall et al. argue in their study on heart failure coding in primary care published in the British Journal of Cardiology, there is a need for a national framework supported by consistent educational training to improve accuracy and confidence among primary care staff.[27]

Solution: Community pharmacy heart failure specialists

Pharmacists are increasingly recognised as vital members of the heart failure care pathway. Pharmacists fully integrated into patient care as part of the MDT can lower hospitalisations by one-third, with even greater effectiveness in outpatient settings where extended interventions are provided.[28] Despite this, at present only 15% of UK heart failure clinics have a specialist pharmacist seeing referrals.[29]

As a Primary Care Network (PCN) lead pharmacist, Jaya Authunuri works closely with GPs and specialists to identify patients, interpret echocardiograms, and optimise treatment in line with NICE guidelines. This includes initiating and titrating the "four pillars" of heart failure therapy — where timely adjustments are crucial. Within six months, his work increased the proportion of patients on all four therapies from 6% to 24%, a dramatic improvement noticed by local cardiologists.

26. Kahn M, Grayson AD, Chaggar PS, Ng Kam Chuen MJ, Scott A, Hughes C, Campbell NG. Primary care heart failure service identifies a missed cohort of heart failure patients with reduced ejection fraction. Eur Heart J. 2022 Feb 3;43(5):405-412. doi: 10.1093/eurheartj/ehab629. PMID: 34508630; PMCID: PMC8825238.

27. Crundall, A., Crawshaw-Ralli, M., Fuat, A., Authunuri, J., Oberoi, K., Crossan, J., & Jones, S. (2024, September). Lessons learnt from HF coding in primary care. What might best practice look like? British Journal of Cardiology, 31, 106–110

28. Van der Linden L, et al. "Effects of pharmacist care on hospitalizations in heart failure across outpatient and inpatient settings: A systematic review and meta-analysis." Br J Clin Pharmacol. 2025 Aug 21.

29. Chun Shing Kwok et al. Heart failure services from the hospital perspective in the UK: a cross-sectional survey, January 2025Br J Cardiol 2025;32:14–8

Recommendations

1. **Design and commission services that optimise heart failure medication management in primary care**

   - **ICBs should commission services for rapid up-titration of heart failure medications.** Integrated Care Boards and Primary Care Networks should collaborate to establish virtual wards based on the model successfully piloted at Barts Health, that enable the rapid up-titration of heart failure medications.
   - **ICBs and training providers should deliver structured training and decision-support tools in primary care to support the initiation and up-titration of evidence-based therapies** for both heart failure with reduced ejection fraction (HFrEF) and preserved ejection fraction (HFpEF). Decision-support tools should be embedded in practice systems to guide safe prescribing and barriers to prescribing recommended therapies in primary care should be removed. ICBs must also ensure that funding mechanisms cover associated blood monitoring, preventing financial disincentives to optimal prescribing.
   - **PCNs and GP practices should implement protocols for regular medication reviews.** Heart failure patients should receive a structured medication review at least every six months, with clear escalation routes to specialist teams for complex cases or those not achieving optimal therapy.
   - **NHS England and ICBs should expand and establish pharmacist-led heart failure medicines optimisation clinics within pharmacy settings.** These clinics should provide timely medication titration, patient education, and monitoring, integrated closely with primary care and specialist teams to enhance patient outcomes, reduce hospital admissions, and optimise the use of guideline-directed treatments.

2. **Embed integrated, multidisciplinary models of care focused on preventing readmissions**

   - **ICBs should replicate best practice integrated care models.** Successful services, such as the Gloucestershire Primary Care Heart Failure Service, demonstrate the value of collaboration between primary and secondary care through shared MDT meetings. ICBs should adopt and scale similar models across their systems.
   - **NHS England and ICBs should establish consistent pathways for hospital-to-community transitions.** Clear, standardised pathways must be developed to ensure patients discharged from hospital move seamlessly into community heart failure services, reducing the risk of avoidable readmissions and ensuring continuity of care.
   - **NHS England and ICBs should make cardiac rehabilitation referral opt-out.** All newly-diagnosed and existing heart failure patients should be automatically referred to cardiac rehabilitation in line with NICE guidance. Commissioners should support flexible delivery models — such as digital, home-based, or community options — to improve uptake in underserved populations.

3. **Create a culture of continuous education, audit, and improvement for managing heart failure in the community**

   - **ICBs and primary care networks should work together to establish routine local outcome audits for primary care to drive earlier diagnosis and optimise treatment and rehabilitation for those living with heart failure.** Mortality, readmissions, NT-proBNP uptake, medication optimisation rates and cardiac rehabilitation uptake should be regularly audited at practice and ICB level. Similar to NICOR data collection in acute trusts, this will allow variation to be identified and addressed systematically. A national guideline for heart failure coding, accompanied by standardised educational training for primary care teams should also be implemented.
   - **NHS England and DHSC should enhance and expand heart failure indicators within QoF.** Expand QoF indicators to prioritise early diagnosis and triage through NT-proBNP testing, optimise medication across all four key heart failure therapy pillars to target doses, increase referrals to cardiac rehabilitation, and implement regular audits of heart failure patients, while increasing point values to reflect the condition's clinical seriousness relative to other major conditions like cancer.

A heart failure service in primary care built on the three shifts

At present, primary care is underserved and underutilised when it comes to managing the growing burden of heart failure. This neglect has left too many patients undiagnosed until hospital admission, with avoidable consequences for survival, quality of life, and NHS resources.

Yet as this paper demonstrates, the building blocks for a modern heart failure service already exist across the NHS. It now demands clinical and national leadership to bring them together to create a modern heart failure service that benefits every patient no matter where they live.

Realising this vision demands that heart failure is elevated to a national and local policy priority on a par with other major conditions. If we act with urgency, we can relieve pressure on hospitals, improve lives for hundreds of thousands of people, and turn heart failure from a growing crisis into a model of how integrated, modern primary care built on the three reforming shifts can deliver lasting impact.

The Alliance for Heart Failure is a coalition of charities, patient groups, professional bodies, and corporate members for the purpose of raising the profile of heart failure in Government, the NHS, and the media.

The Alliance for Heart Failure is supported and funded by Abbott, AstraZeneca UK, Boehringer Ingelheim Limited, Medtronic Limited, Novartis Pharmaceuticals UK Ltd, and Roche Diagnostics Ltd.

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- AstraZeneca UK
- Boehringer Ingelheim Limited
- British Association for Cardiovascular Prevention and Rehabilitation
- British Association for Nursing in Cardiovascular Care
- British Society for Echocardiography
- British Society for Heart Failure
- Cardiomyopathy UK
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