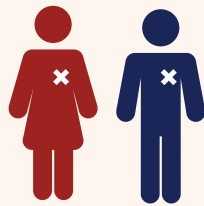


Alliance for Heart Failure



Heart Failure

an unsustainable national health emergency

An analysis of heart failure's growing
burden across England's regions.

www.allianceforheartfailure.org

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About this report

This report draws on patient-level heart failure data for the four years from 2021–22 to 2024–25. Volume indicators are expressed per 100,000 population using ONS mid-year estimates, so that larger ICBs are not ranked as higher burden simply because they serve more people.

The maps and index use ICB boundaries as constituted from April 2023, the basis on which all source data was collected. A fuller account of the methodology accompanies the Heart Failure Burden Index later in this report.

The maps, analysis and commentary presented in this report are the work of the Alliance for Heart Failure, drawing on data from a dashboard created in partnership between Compufile Systems Ltd (CSL) and AstraZeneca UK that uses Hospital Episode Statistics (HES). AstraZeneca UK and CSL were not involved in their design, production or interpretation, and the findings and conclusions are the Alliance's own.

Hospital Episode Statistics (HES) data for England is provided under licence by NHS England and subject to copyright. The HES data analysis was designed by AstraZeneca UK. Hosting of the data and its presentation in the dashboard are provided by Compufile Systems Ltd (CSL).

This dashboard was initiated and funded by AstraZeneca and co-developed with CSL and healthcare professionals and is now independently supported and updated by CSL. It is provided to the NHS personnel involved in the care of heart failure patients. Clinicians should exercise professional judgement when using this dashboard.

Access to the Heart Failure dashboard is provided free of charge to NHS professionals for the purpose of comparing and benchmarking contrasting data between Trusts and ICBs and can be requested via info@csl-uk.com.

The Alliance for Heart Failure is supported and funded by AstraZeneca, Medtronic Limited, and Roche Diagnostics Ltd.

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Introduction

Heart failure is set to be one of the fastest-growing major conditions in England.¹ It is a progressive, life-limiting syndrome with debilitating symptoms and its prevalence is rising as the population ages and as the risk factors that drive it, particularly hypertension, obesity and diabetes, become more common.

Across the UK, around one million people are living with a heart failure diagnosis and an estimated further 400,000 are living with the condition undiagnosed. Over the coming decades, across much of the western world, this is set to place an unsustainable burden on secondary care.²

This report uses data from Hospital Episode Statistics, the Office for National Statistics and the NICOR National Heart Failure Audit to establish what this growing burden looks like across the NHS in England, broken down to the level of all 42 Integrated Care Boards (ICBs) between 2021 and 2025.

It maps where patients with a hospital visit are most concentrated, where people are dying in emergency care and where they are being readmitted. It then draws these strands together into a single Heart Failure Burden Index that ranks every ICB in England by highest burden.

The central finding is stark regional variation across a number of indicators. Areas with high readmissions and emergency admissions are also often areas with low referral rates to heart failure specialist nurses who play a pivotal role in the long term management of patients. As our analysis shows, in the most affected parts of the country, the population dies from a heart failure emergency admission at twice the rate where the burden is less acute.

Hospital activity and cost for heart failure increased during the period, with the need to ease the burden of heart failure on secondary care presenting itself as a whole system priority. Emergency heart failure admission and one year readmissions alone cost the NHS in England close to £2 billion between 2021 and 2025. These are incidences which can be reduced through improved access to specialist nurses, timely treatment and diagnosis demonstrated by a number of successful initiatives already trialled in the NHS.³

But behind these numbers are also individual patients, many in urgent need of improved diagnosis and access to treatment and specialist care. This report argues that the burden is now a health emergency given the unsustainable burden it is placing on secondary care, and one that deserves urgent priority from both local health leaders and government.

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1. Watt, T., Raymond, A., Rachet-Jacquet, L., Head, A., Kyridemos, C., Kelly, E. and Charlesworth, A. (2023) Health in 2040: projected patterns of illness in England. London: [The Health Foundation](#).
 2. Driscoll A, Meagher S, Kennedy R, Hay M, Banerji J, Campbell D, Cox N, Gascard D, Hare D, Page K, Nadurata V, Sanders R, Patsamanis H. What is the impact of systems of care for heart failure on patients diagnosed with heart failure: a systematic review. [BMC Cardiovasc Disord](#). 2016 Oct
 3. Guleria R, Singh A, Majmudar HP, Ang ZY, Awasthi P. Evidence-Based Management of Heart Failure: Clinical Impact and National Health Service Implications. Cureus. 2025 Sep

Heart failure and the reform and restructuring of the NHS

Of all the major conditions, heart failure may have the most to gain from the direction of travel set out in the Government's Ten Year Health Plan for England, published in July 2025. The Plan is built on three shifts: from sickness to prevention, from hospital to community, and from analogue to digital.

Heart failure is, in many respects, the textbook case for all three. The NHS will achieve better health outcomes if we improve earlier detection and risk-factor management; it is far better managed in the community than in an emergency department; and it is well suited to the remote monitoring and digital pathways the plan champions. The Plan itself acknowledges that, in chronic heart failure, thousands of lives could be saved by treating people earlier in the pathway.⁴

The Plan committed to a new modern service framework for cardiovascular disease, and that framework was published on 7 July 2026. There is much in the framework to welcome. Accountability is a priority, with Integrated Care Boards becoming the primary point at which performance is measured, held to account for narrowing the gap between the best and worst performing parts of the system, and each required to name a clinical lead for cardiovascular delivery.

The framework also acknowledges that the NHS Health Check misses opportunities to detect heart failure where symptoms present, and that new models are needed to expand case finding in the community and ensure the 400,000 people living with undiagnosed heart failure receive timely care.

Yet there is concern across the Alliance for Heart Failure's network about whether the framework will translate into change on the ground fast enough to keep up with the growing burden described in this report. Its accountability measures may improve the optimisation of treatment in patients already diagnosed, while the task of finding undiagnosed heart failure is left without a metric or a target.

As a secondary consideration within a broad framework focused on the prevention of first events, heart failure risks being overlooked. The Alliance for Heart Failure's view is that the framework must contain explicit, measurable commitments on heart failure diagnosis, specialist workforce and community management — not fold it into a wider cardiovascular ambition, nor leave delivery to cardiac networks which are already struggling to prioritise heart failure improvement.

That concern is sharpened by structural change. ICBs are being reduced in number and consolidated, with running-cost reductions and a first phase of boundary changes from April 2026 that abolishes 12 ICBs and creates six new organisations, and a further phase expected in 2027.

The Alliance for Heart Failure's network reports a clear lack of strategic oversight for the planning of heart failure services through this transition. As the maps that follow show, the areas carrying the heaviest burden are placing real stress on secondary care across whole regions and are therefore a priority for any system seeking to free up beds and ease pressure on its hospitals.

The uncertainty that comes with this reorganisation risks heart failure falling between the cracks of newly-merged systems at precisely the moment it most needs coordinated attention. The Alliance for Heart Failure brings together national leaders who understand the challenges, know where the solutions lie, and are ready to support the NHS in delivering better outcomes through the modern service framework.

4. Department of Health and Social Care (2025) Fit for the future: 10 Year Health Plan for England. London: HM Government. Available at: [GOV.UK 10 Year Health Plan](https://www.gov.uk/10-year-health-plan) (p. 124 Accessed: 27 August 2026).

Katie's story



"I am extremely lucky to be alive, but with the right support and management, heart failure patients can rebuild their lives."

"My life looks very different now. I've learnt to adapt and listen to my body, take breaks where needed and say no to activities I can no longer carry out."

At 25, working as a support worker with vulnerable children, Katie developed breathlessness, a racing heart and rapid weight gain.

Over months, these symptoms were repeatedly misread — treated as a chest infection, then dismissed as mental health, with antibiotics, inhalers and eventually antidepressants prescribed instead.

When Katie arrived in emergency care, her heart was functioning at just 17% of normal. She spent 12 weeks in hospital and her family were told it was touch and go whether she'd survive the night.

Once discharged, Katie's recovery struggled to gain ground. It was only after she moved her care to Leeds that things began to shift. There, clinicians reviewed her medication properly and started her on the full range of core heart failure drugs — the "four pillars" — for the first time, including sacubitril and valsartan, which her previous hospital had declined to consider.

Her ejection fraction, the percentage of blood your heart beats in a pump, rose from 17% to 54%.

Despite this recovery, Katie was never offered cardiac rehabilitation and learned to manage her condition largely through her own research and peer support via the Pumping Marvellous patient community.

"I am extremely lucky to be alive, but with the right support, medication and self-management, heart failure patients can rebuild their lives."

"I do the things that matter to me, just with a bit more care. Working with Pumping Marvellous has made me realise the importance of education and spreading awareness among both patients and healthcare professionals."

"I now have an incredible support system around me and it's only right that every heart failure patient gets this opportunity to rebuild their life on their terms."

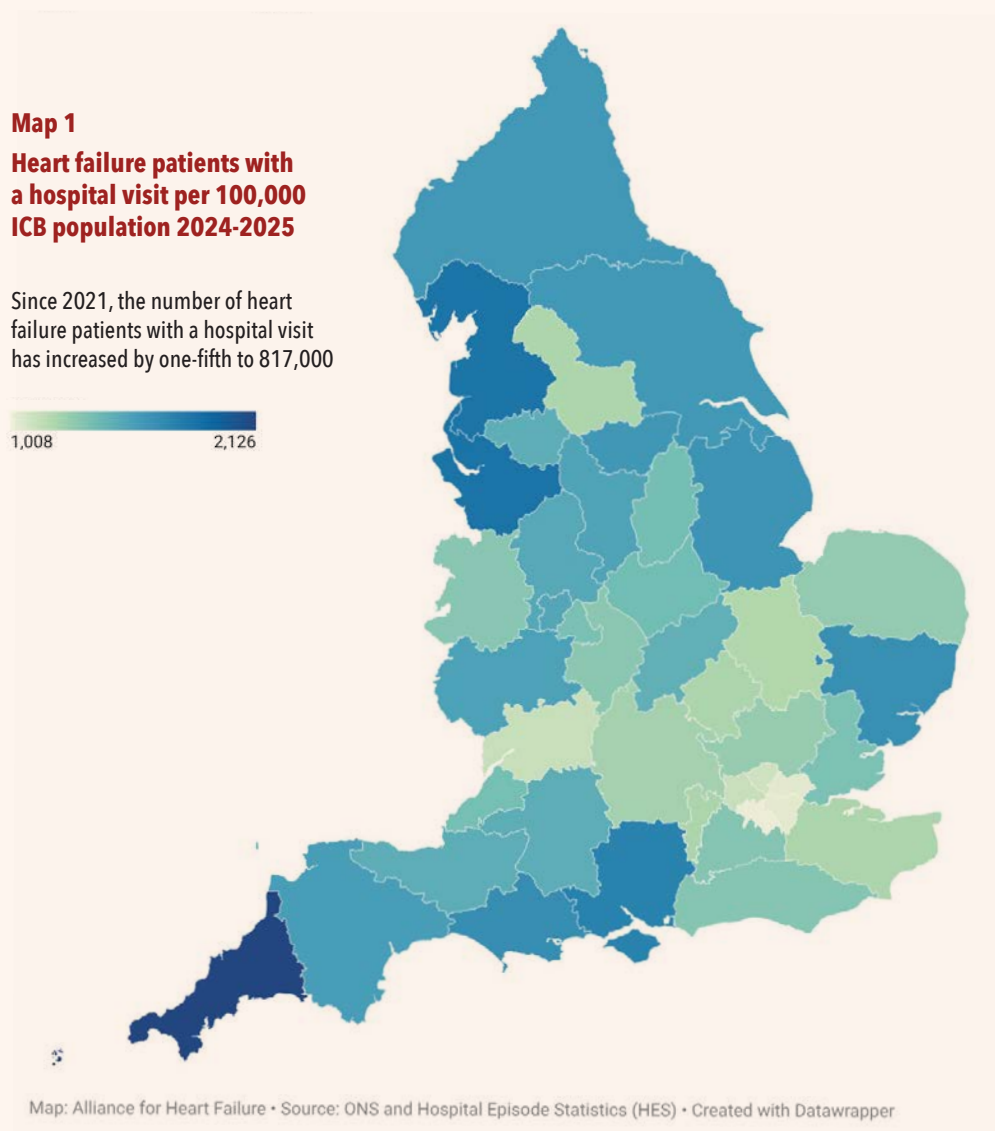
Section one: Prevalence and mortality

This section sets out the burden heart failure is placing on secondary care across England – showing the areas where patients with heart failure are presenting in hospital at the highest numbers, how quickly these instances are growing, and the areas with the highest emergency care mortality.

Map 1

Heart failure patients with a hospital visit per 100,000 ICB population 2024-2025

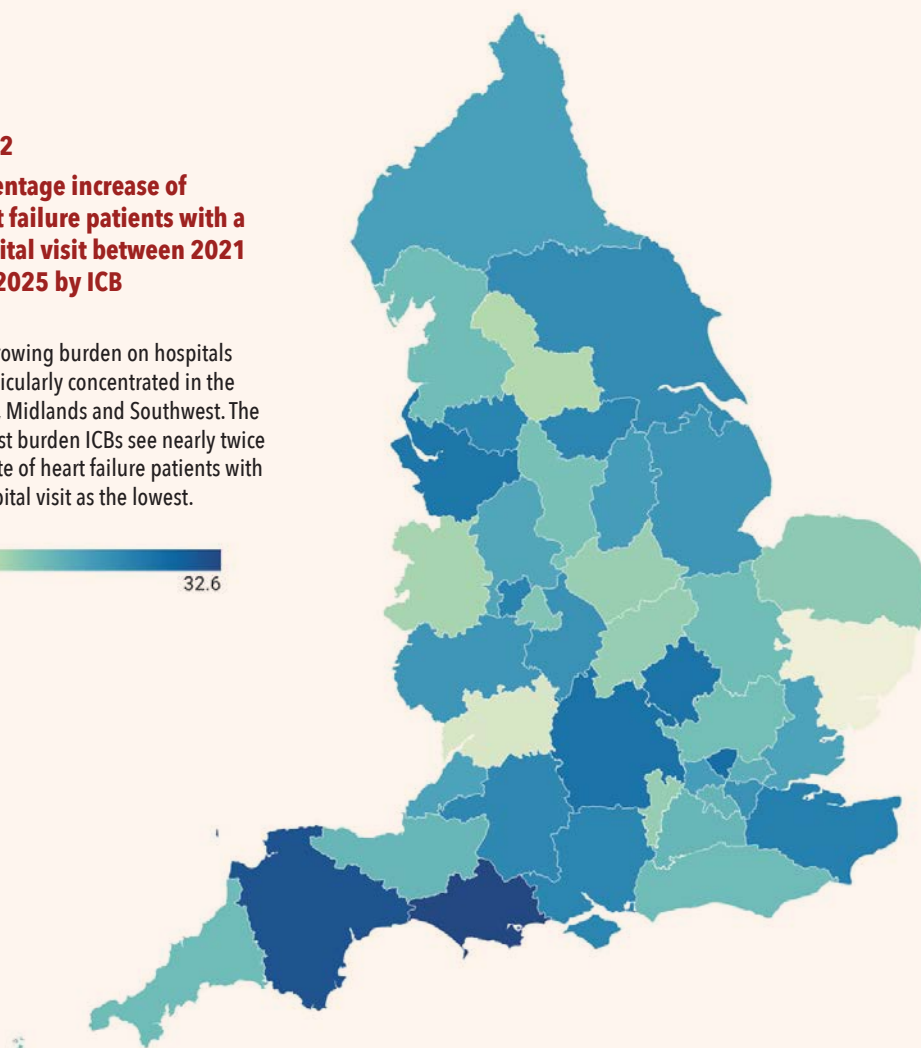
Since 2021, the number of heart failure patients with a hospital visit has increased by one-fifth to 817,000



Map 2

Percentage increase of heart failure patients with a hospital visit between 2021 and 2025 by ICB

The growing burden on hospitals is particularly concentrated in the North, Midlands and Southwest. The highest burden ICBs see nearly twice the rate of heart failure patients with a hospital visit as the lowest.



Map: The Alliance for Heart Failure • Source: Hospital Episode Statistics (HES) • Created with Datawrapper

Alliance for Heart Failure ANALYSIS

The burden of heart failure on hospitals

The maps above show where England's heart failure patients are presenting in secondary care. Around 817,000 heart failure patients presented with a hospital visit in 2024–25, up from roughly 671,000 in 2021–22 — an increase of a fifth in four years.

The burden is far from evenly spread: some ICBs in the North and Southwest now manage twice the rate of heart failure patients with a hospital visit compared to the lowest.

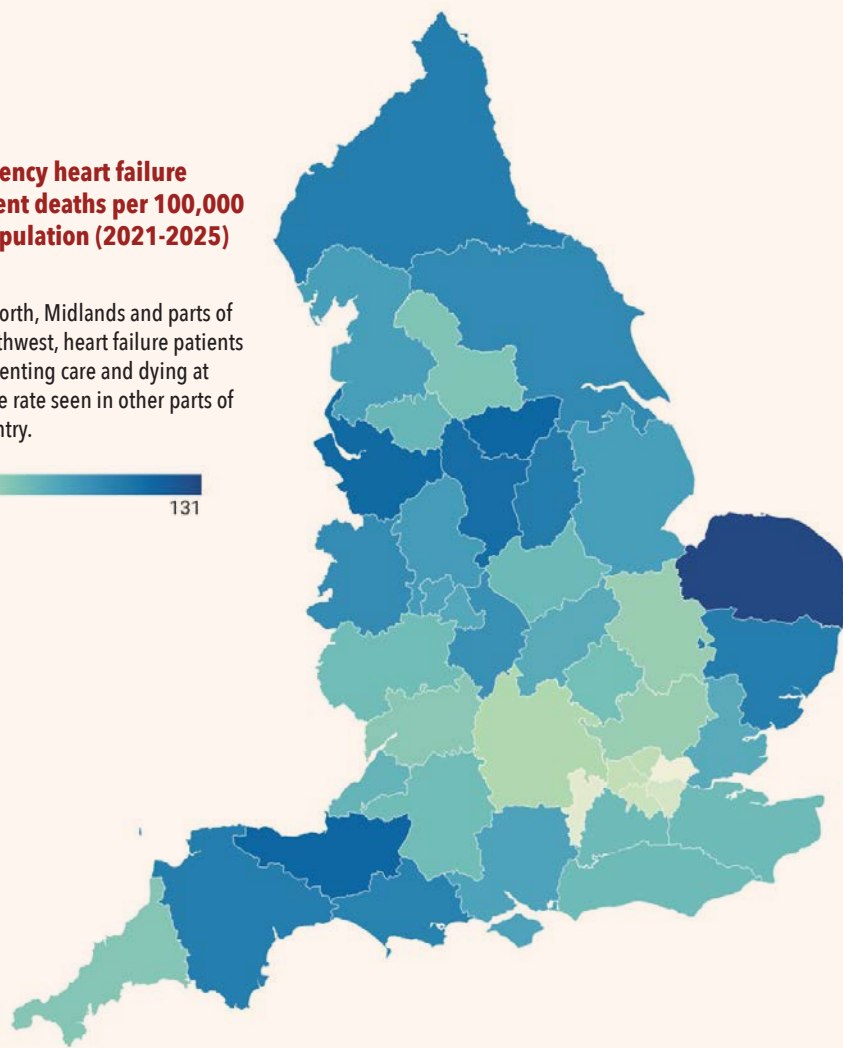
It is important to point out this data does not pick up those patients diagnosed in the community without a hospital visit. Additionally, there are an estimated 400,000 people across the UK who have heart failure and remain undiagnosed, and ensuring these patients receive timely care is vital.

As we shall see later in this report, in many areas of England the resourcing and services required to keep patients stable, healthy and out of hospital are not keeping up with this level of case-finding.

Map 3

**Emergency heart failure
inpatient deaths per 100,000
ICB population (2021-2025)**

In the North, Midlands and parts of the Southwest, heart failure patients are presenting care and dying at twice the rate seen in other parts of the country.



Map: The Alliance for Heart Failure • Source: ONS and Hospital Episode Statistics (HES) • Created with Datawrapper

**Alliance for
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Emergency inpatient mortality

Across England, around 50,000 patients died as inpatients following an emergency heart failure admission over the four years to 2024–25 — some 12,000 in the most recent year alone. Death during an emergency admission indicates that the system may be catching and managing the disease too late. These are patients who have reached crisis point before receiving timely and appropriate care.

The geography is deeply unequal. In the North, the Midlands and parts of the Southwest, patients are presenting in emergency care and dying at twice the rate seen in other parts of the country.

Emergency heart failure admissions are long admissions, occupying in the order of 12 bed days each, and they are often falling hardest on the systems least equipped to absorb them.

Section two: Late diagnosis and readmissions

Where heart failure is diagnosed early and managed well in the community, there is a greater opportunity for the burden and cost in secondary care to be avoided. This section looks at two indicators where this may not be happening consistently: the volume of emergency admissions, and the rising number of patients returning to hospital within a year of discharge.

Map 4
Emergency admissions for heart failure per 100,000 ICB population (2021-2025)

The burden on emergency services remains significant across England, with a particular strain in the Northwest.



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Map: Alliance for Heart Failure • Source: ONS and Hospital Episode Statistics (HES) • Created with Datawrapper

Emergency admissions

Properly diagnosed and managed, many heart failure patients can avoid emergency admission altogether. Over the four years to 2024–25 there were around 426,000 emergency heart failure admissions across England. The absolute burden on emergency services remains significant nationwide, but the map reveals a particular problem in the Northwest and the Midlands.

A high rate of emergency admission may indicate upstream failures: late diagnosis, where heart failure is identified only once a patient is acutely unwell, and weak community management, where known patients are not being supported well enough to keep them stable at home and out of hospital.

Sources: Alliance for Heart Failure analysis of emergency heart failure admissions data and ONS population estimates; diagnosis-route figure from the British Society for Heart Failure.

Map 5
**One year readmissions for
heart failure per 100,000 ICB
population (2021-2025)**

The number of heart failure patients being readmitted to hospital within one year remains a problem across England.



Map: Alliance for Heart Failure • Source: ONS and Hospital Episode Statistics (HES) • Created with Datawrapper

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One-year readmissions

The number of heart failure patients readmitted to hospital within a year of discharge is rising across England, up 15% since 2021/22.

Readmission within twelve months can be used as a proxy indicator for the quality of the transition out of hospital and of community follow-up: it reflects whether patients leave on the right medication, at the right dose, with the right support and cardiac rehabilitation to follow up.

Parts of the system are already demonstrating that this is largely preventable. A heart failure rapid-titration service developed at Barts Health NHS Trust — which ensures patients are prescribed the four recommended heart failure therapies far faster than usual care, with remote monitoring — reported that, across an initial group of patients, none were readmitted because of their heart failure, with 92% discharged on all four key treatments.

Structured specialist follow-up after discharge has been shown to cut heart failure readmissions substantially, with investment in optimised treatment and specialist follow-up at the point of discharge being cost-effective.

Driscoll A, Gao L, Watts JJ. Clinical effectiveness and cost-effectiveness of ambulatory heart failure nurse-led services: an integrated review. BMC Cardiovasc Disord. 2022 Feb 22;22(1):64.

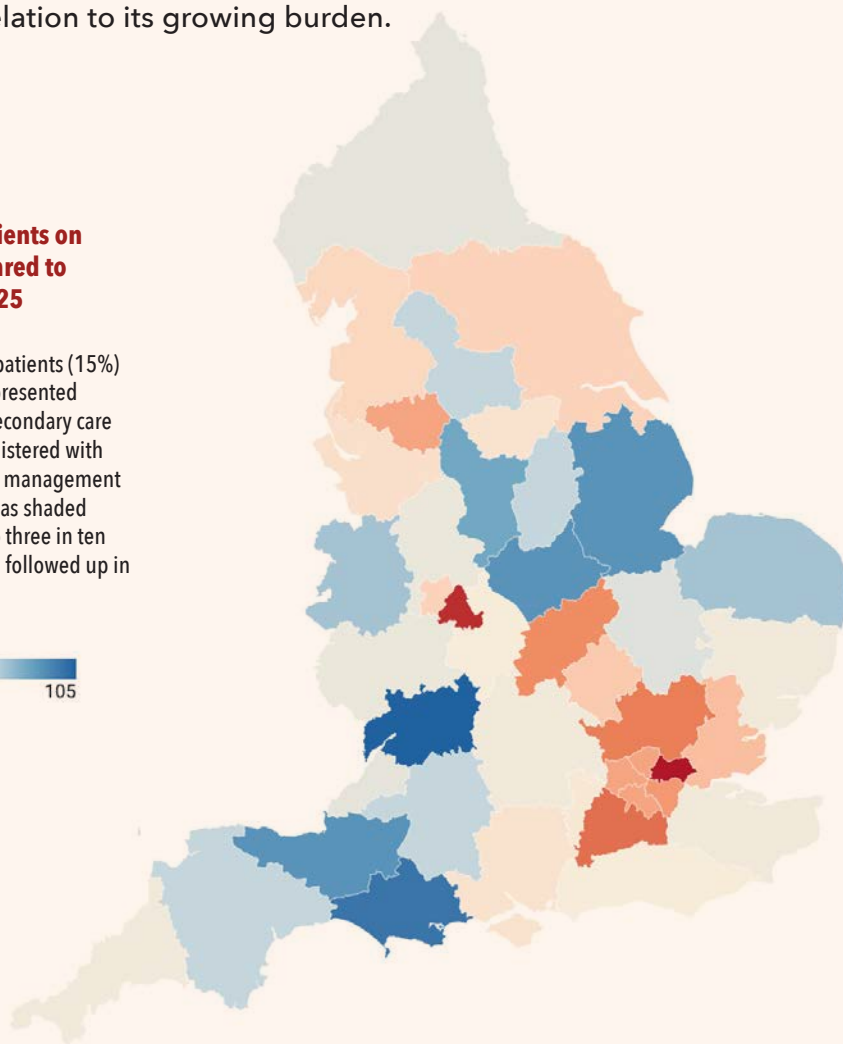
Section three: Primary care and workforce

If the community is to carry more heart failure care, two things have to be in place: patients must be followed up in primary care, and there must be enough specialist heart failure nurses to support them. The next two maps provide indicators that show in many areas of the country this is not being achieved in relation to its growing burden.

Map 6

Percentage of patients on GP register compared to presenting 2024-25

Around one in seven patients (15%) across England have presented with heart failure in secondary care but have not been registered with their GP for long-term management in the community. Areas shaded red indicate that up to three in ten patients are not being followed up in primary care.



Map: Alliance for Heart Failure • Source: ONS and Hospital Episode Statistics (HES) • Created with Datawrapper

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Continuity into primary care

The number of heart failure patients readmitted to hospital within a year of discharge is rising across England, up 15%. Around one in seven heart failure patients across England — or some 116,000 people — has presented with heart failure in a hospital setting but not been recorded on a GP register for long-term management in the community.

GPs also have a separate heart failure register, and though the two are not identical, a patient missing from the GP register is highly likely to be also missing from its HF register. In some systems, including Birmingham and parts of North London, up to three in ten patients are not being followed up in primary care.

Patients who fall off the register are patients who can get lost in the system: they are less likely to have their medication optimised, less likely to be monitored and referred to rehabilitation services, and more likely to return to hospital as an emergency.

Part of the problem is coding — the British Society for Heart Failure has highlighted how inconsistent recording of heart failure leaves patients invisible to the primary care teams for long-term management. Closing this gap is one of the lowest-cost, highest-value interventions available.

Map 7

Average referral to heart failure specialist nurse (%) (2024-2025)

Across England, an average of 61% of patients admitted to hospital with heart failure are referred to a specialist heart failure nurse on discharge. Areas shaded in red have the lowest average referral rates, suggesting workforce gaps, pressure on services and lack of strategic oversight for community care.



Map: Alliance for Heart Failure • Source: ONS and NICOR National Heart Failure Audit • Created with Datawrapper

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The specialist nurse workforce

Across England, an average of around 61% of patients admitted to secondary care with heart failure are referred to a specialist heart failure nurse on discharge — but the range is enormous, from under 34% in the lowest ICB to over 97% in the highest. NICE guideline NG106 expects every heart failure patient to have a named coordinator of their care, usually a specialist nurse.

A low referral rate is an area of concern. Patients who do not have access to a heart failure specialist nurse have significantly worse outcomes. Specialist nurses keep patients stable, and optimise their medication and prevent the costly, distressing emergency admissions mapped earlier in this report.

A British Heart Foundation programme of community heart failure specialist nurses delivered a 35% reduction in all-cause admissions and estimated savings of around £169,000 per 1,000 patients; a single whole-time-equivalent specialist nurse has been estimated to save on the order of £42,000 a year.⁵

It may also be a marker of a workforce shortage. There is no reliable estimate of the heart failure specialist workforce in the community, making it harder to plan and address areas that have a higher burden of the disease.

Sources: Alliance for Heart Failure analysis of NICOR NHFA 2024–25 referral data. Effectiveness and cost-saving figures from the British Heart Foundation and Stewart et al. (European Heart Journal, 2002). NICE NG106.

5. Masters, J., Barton, C., Blue, L. and Welstand, J. (2019) 'Increasing the heart failure nursing workforce: recommendations by the British Society for Heart Failure Nurse Forum', British Journal of Cardiac Nursing, 14(11), pp. 1–12.

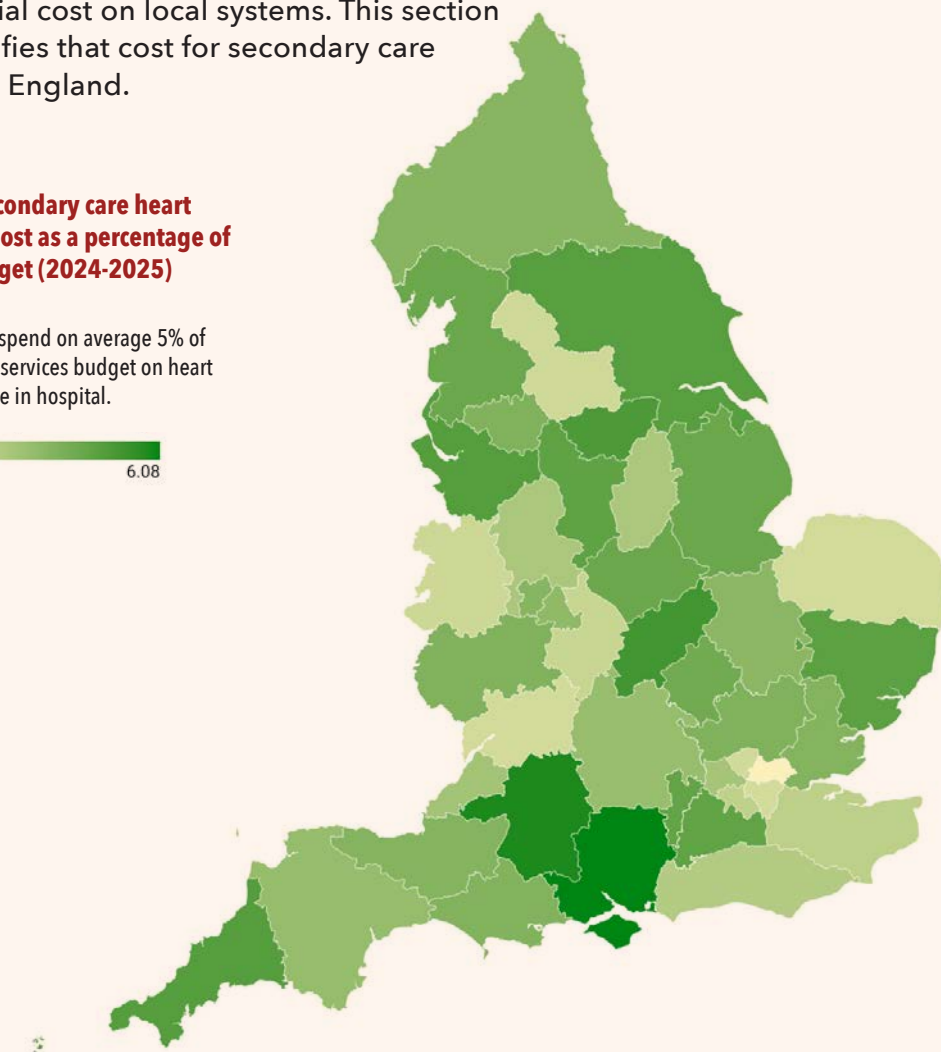
Section four: The growing burden on secondary care

Late diagnosis and weak community management not only harm patients, they impose a large and growing financial cost on local systems. This section quantifies that cost for secondary care across England.

Map 8

Total secondary care heart failure cost as a percentage of ICB budget (2024-2025)

ICBs now spend on average 5% of their core services budget on heart failure care in hospital.



Map: Alliance for Heart Failure • Source: NHS England and Hospital Episode Statistics (HES) • Created with Datawrapper

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Cost

At an ICB level, the secondary care cost of treating heart failure in hospitals has reached around on average 5% of core services spend — and ranges from roughly 3.7% to over 6% across England.

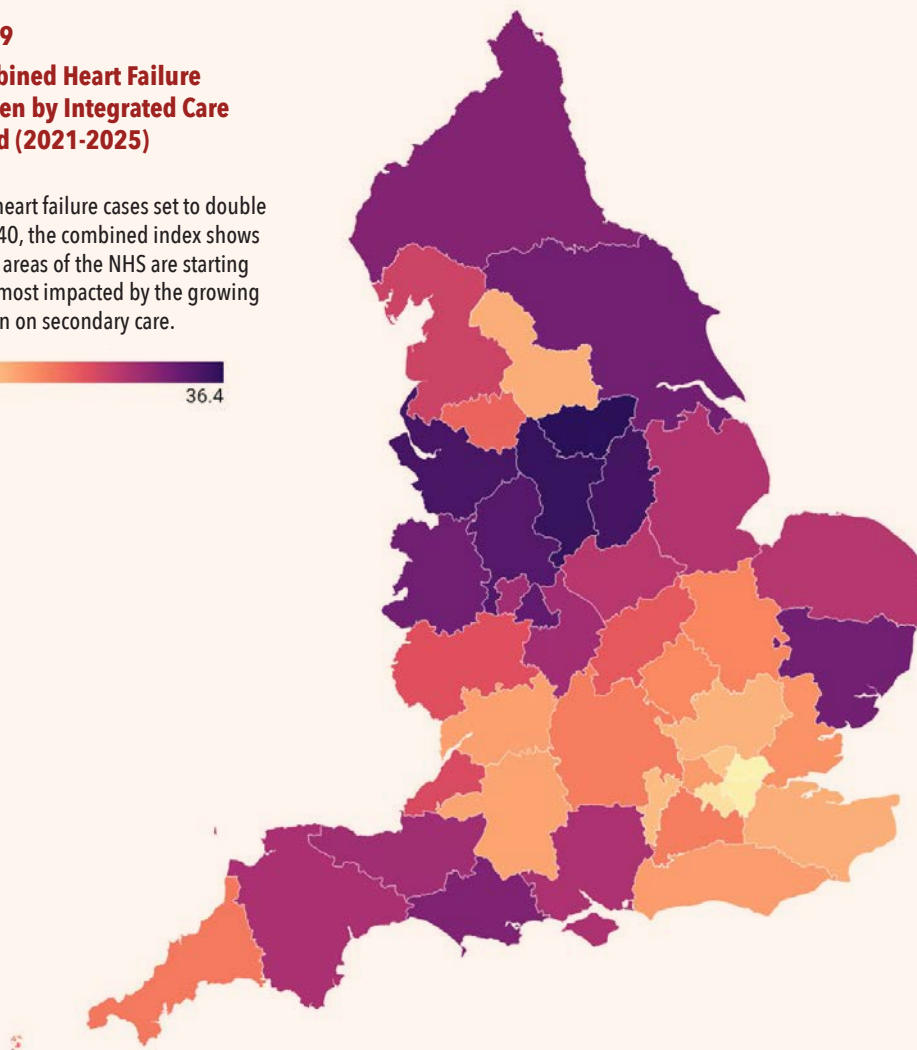
Over the four years to 2024–25, emergency heart failure admissions alone cost close to £2 billion, with the average emergency patient costing around £4,668 per admission and occupying 10 bed days. Late diagnosis and poor community management are, in effect, a transfer of cost into the most expensive part of the system.

The Heart Failure Burden Index

Map 9

Combined Heart Failure Burden by Integrated Care Board (2021-2025)

With heart failure cases set to double by 2040, the combined index shows which areas of the NHS are starting to be most impacted by the growing burden on secondary care.



Map: Alliance for Heart Failure • Source: ONS, NICOR, NHS England and Hospital Episode Statistics (HES) • Created with Datawrapper

The ten critical priority regions

Rank	Integrated Care Board	NHS region/ New ICB	Index score
1	NHS South Yorkshire	Northeast & Yorkshire	36.4
2	NHS Derby and Derbyshire	Midlands	35.4
3	Nottingham and Nottinghamshire	Midlands	34.4
4	NHS Cheshire and Merseyside	Northwest	34
5	NHS Staffordshire and Stoke-on-Trent	Midlands	33
6	NHS Birmingham and Solihull	Midlands	32
7	NHS Shropshire, Telford and Wrekin	Midlands	30.8
8	NHS Humber and North Yorkshire	Northeast and Yorkshire	30.6
9	NHS Suffolk and North East Essex	East	30.6
10	NHS Dorset	Southwest	29.6

Critical priority ICBs (ranks 1–10 of 42). Index score is the mean rank across five population-adjusted indicators; a higher score denotes a higher combined burden. Full ranking of all 42 ICBs is held in the accompanying spreadsheet.

[Access the full burden Index](#)

Alliance for Heart Failure ANALYSIS

Reading the index

The Heart Failure Burden Index combines five population-adjusted indicators into a single measure of where the burden of heart failure on secondary care is most severe: the volume of heart failure patients with a hospital visit, emergency admissions, one-year readmissions, emergency inpatient mortality and the availability of the specialist nurse workforce.

Each ICB is ranked from 1 to 42 on each indicator, and the five ranks are averaged with equal weight to give a composite score, on which the ICBs are then ranked. Expressing the activity indicators per 100,000 population ensures the index captures the intensity of burden rather than simply the size of an ICB.

The ten critical priority areas listed above cluster heavily in the Midlands and the North — the same regions that recur throughout this report on mortality, readmissions and emergency admissions.

These are the systems where high and rising demand meets weaker community infrastructure, most visibly a thin specialist nurse workforce. They are the areas that require the most urgent improvement in resourcing and pathways, and they are where the recommendations that follow should be focused first.

Source: Alliance for Heart Failure, Heart Failure Burden Index (six-indicator composite, population-adjusted). Full methodology accompanies this report.

Conclusion and recommendations

Heart failure is growing faster than almost any other major condition – but the burden it creates is not spread evenly across England.

As this report has shown, the condition is severely under-resourced and under-prioritised relative to its scale, and in many parts of the country the pressure it places on secondary care is becoming unsustainable.

It clearly demonstrates a fragmented approach to a condition that needs a resolute plan that is consistent for every patient across the country.

The recurring theme is avoidability. Much of the burden mapped here — the emergency admissions, the readmissions within a year, the deaths during emergency stays, and the cost that follows them — could be reduced through earlier diagnosis, faster access to optimised treatment, reliable continuity into primary care, and an adequately trained and staffed specialist community workforce.

This model of care is burgeoning in pockets of the NHS, but it now requires decisive local and national leadership to ensure it is scaled to the areas that need it the most.

The Alliance for Heart Failure welcomes the cardiovascular disease modern service framework and supports its cardiovascular-kidney-metabolic approach. But a framework alone cannot close the gaps this report has mapped, and there is a risk that heart failure is subsumed within the plan's broader ambitions.

The recommendations below set out the accountability, resourcing and leadership now to deal with the under-recognised and growing burden of heart failure. It is a plan that will save lives, save money and prevent the risk of the health service becoming overwhelmed as cases of heart failure are set to increase 92% by 2040.⁶

6. Watt, T., Raymond, A., Rachet-Jacquet, L., Head, A., Kypridemos, C., Kelly, E. and Charlesworth, A. (2023) Health in 2040: projected patterns of illness in England. London: [The Health Foundation](#).

Conclusion and recommendations

We recommend:

1. Commission heart failure services against data, and hold ICBs accountable for it

- **ICBs** are accountable for outcomes and for reducing inequalities in them, yet nothing requires heart failure to be assessed or commissioned against its own data — so it falls between a generic needs assessment and an aggregate cardiovascular plan.
- **Every ICB** should produce a heart failure needs assessment, using burden indicators of the kind set out in this report, and set out its commissioning response, owned by the named CVKM clinical lead created by the cardiovascular MSF.
- **Through the NHS mandate** and planning guidance, the Department for Health & Social Care should require high-burden ICBs to show, in their improvement, how they will match capacity to projected demand over three years — assessed through the Oversight Framework, with escalation where the gap fails to close.
- **The delivery plan** should make heart failure variation visible within that accountability architecture, drawing on existing National Heart Failure Audit data at ICB level and adding the community diagnostic measures the acute audit cannot capture.

2. Build community heart failure capacity — through skills as well as numbers — starting where burden is highest

- **Absence of specialist community services**, notably the heart failure nurse, is a consistent driver of regional inequality. In the highest-burden ICBs, referral to specialist nurse follow-up on discharge is markedly lower than in the best-performing systems — and because that referral is strongly associated with lower readmission, closing the gap is an invest-to-save priority as much as a workforce one.
- **But heart failure is not managed** by specialist nurses alone. Community pharmacists, primary care staff and the wider multidisciplinary team can increasingly deliver the titration, monitoring and follow-up on which good outcomes depend.

– **The Department for Health & Social Care** should first commission a baseline census of community heart failure capacity by ICB — specialist nurses and the wider workforce delivering heart failure care — since no reliable national count exists, and capacity that has not been measured cannot be planned.

– **That baseline** should set an expected minimum level of specialist provision per head of diagnosed population, met through funded recruitment and structured upskilling and accreditation of community pharmacists and the wider primary and community workforce, so titration and follow-up can be delivered closer to home — consistent with the framework's own shift toward neighbourhood-based care.

– **Critical Priority ICBs** identified in this report should set out, in their improvement plans, how they will close the capacity gap over the framework's three-year period.

3. A national heart failure plan focused on a unified pathway, with dedicated local capacity where it is needed most

– **The framework** sets the metrics for closing the gap between best and worst without the local capacity to close it, relying on cardiac networks within which — Alliance for Heart Failure members report — heart failure is too often deprioritised. The 2015 Independent Cancer Taskforce offers the precedent: its lasting achievement was the Cancer Alliances, dedicated sub-regional partnerships with their own leadership, delivery plans and funding, widely credited with driving earlier diagnosis and better-coordinated care.

– **The Department should establish** dedicated national leadership for heart failure delivery — as a time-limited taskforce reporting to the Secretary of State, or a dedicated remit within the framework's national delivery board — clinically led and with patient representation.

– **It should set a nationally consistent** heart failure pathway: an NT-proBNP result as a condition of any referral being accepted, specialist triage of those referrals alongside heart failure specialist input for long term community management. It should close the routes, such as direct-access echocardiography, that currently let patients through without specialist oversight.

– **Its first task** should be a cost delivery plan for the highest-burden ICBs, establishing Cancer Alliance style partnerships to carry out the improvement of services funded on an invest-to-save basis against the admissions it would prevent.

– **It should report annually** against published heart failure variation metrics, so Parliament and the public can see where variation and outcomes are improving.

Methodology and data sources

This analysis is intended as a tool for policy prioritisation and advocacy. It is not a performance-management instrument, and it is expressly not intended to name, rank or hold to account individual organisations; its purpose is to provide a defensible estimate of the regional distribution of heart failure burden across the NHS, so that attention and investment can be directed to where need is greatest.

Population adjustment

Every population-based rate in this report is expressed per 100,000 population, so that larger Integrated Care Boards (ICBs) are not counted as higher-burden simply because they serve more people. Population denominators are drawn from ONS mid-year population estimates (November 2025 edition). Because the activity figures are cumulative across four years (2021–22 to 2024–25), each ICB's rate uses a four-year average population rather than a single year, so that the denominator matches the period over which activity was counted. Where the 2021 mid-year estimate was unavailable in the ONS edition used, the 2022 estimate was taken as a proxy.

Preventable cost

The cost analysis estimates the hospital cost, across the same four years, that each ICB could have avoided had its rates of emergency heart failure admission and 365-day readmission matched the best-performing quartile of ICBs. For each year, emergency admissions and readmissions were expressed as a rate per 1,000 heart failure patients; the best-quartile (25th-percentile) rate across all 42 ICBs was taken as the benchmark; and the excess above that benchmark was costed at a uniform £3,500 per admission and summed across the four years. On this basis, the four-year preventable cost is approximately £176 million, of which around £123 million arises from emergency admissions and £53 million from readmissions.

The Heart Failure Burden Index

The index identifies which ICBs face the greatest combined burden of heart failure. Rather than ranking on a single measure, it combines six complementary indicators, each capturing a distinct dimension of burden: heart failure patients per 100,000 population; four-year emergency admissions per 100,000; four-year readmissions per 100,000; emergency inpatient deaths per 100,000; total preventable cost; and the average rate of referral to a heart failure specialist nurse on discharge, drawn from the National Heart Failure Audit (2024–25) and used as a proxy for specialist nursing capacity.

Each ICB is ranked from 1 to 42 on each indicator, with the highest-burden ICB scoring 42; for specialist nurse referral the ranking is inverted, since a low referral rate is the adverse result. The composite score is the simple average of the six ranks, giving each indicator equal weight, and ICBs are then grouped into four tiers, from Critical Priority to Lower Priority.

Several limitations should be borne in mind. The index applies equal weighting across its six indicators; a reader who judges some dimensions more important than others may reasonably weight them differently. The specialist nurse referral rate is a proxy for workforce capacity and does not directly measure staffing levels. Rates are not adjusted for the age or deprivation profile of local populations.

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.

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Member organisations:

- AstraZeneca
- 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
- Cardiovascular Care Partnership
- Education for Health
- Health Innovation Network
- Medtronic UK
- National Heart & Lung Institute
- Primary Care Pharmacy Association
- Pumping Marvellous Foundation
- Roche Diagnostics Ltd
- Southeast Clinical Networks
- Yorkshire and Humber Heart Failure Academy
- UK Heart Failure Pharmacy Forum

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