Heart failure: A national health priority

Friday 6th November, 15:05-15:50, Nottingham
Welcome

Dr Sarah Jarvis
GP, Richford Gate Medical Practice, London

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Disclosures

Dr Sarah Jarvis has received honoraria for lecturing, chairing meetings and attending advisory boards for Astra Zeneca, Janssen, MSD, Novartis, Sanofi and Takeda
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<tr>
<th>Task</th>
<th>Instructions</th>
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<tr>
<td>Turn off mobile phones</td>
<td>Please turn off mobile phones</td>
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<tr>
<td>Ask a question to the faculty</td>
<td>To ask a question to the faculty, complete the question card on your seat and hand to hostess</td>
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<td>Provide details for accreditation certificate</td>
<td>Please provide your details to receive your accreditation certificate at the close of meeting</td>
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<td>Complete evaluation form</td>
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Voting pads

• You will find your voting pad under your seat
• A question will appear on the screen with numbered options
• When you are asked to vote, press the corresponding number on your keypad
• If you wish to change your choice simply press your new selection
Test question

What is the name of the famous outlaw who lived in Sherwood Forest and ‘stole from the rich and gave to the poor’?

A. Hansel

B. Robin Hood

C. Blackbeard

D. Pinocchio

E. Rumpelstiltskin
Your faculty

Professor Ahmet Fuat
GPSI Cardiology, Darlington Memorial Hospital

Dr Sarah Jarvis
GP, Richford Gate Medical Practice, London

Dr Yassir Javaid
Cardiovascular and Diabetes Clinical Lead, Nene Clinical Commissioning Group
Our programme for today

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<td>15:05—15:10</td>
<td>Welcome and objectives</td>
<td>Dr Sarah Jarvis</td>
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<td>15:10—15:20</td>
<td>HF should be a national health priority: a clinical perspective</td>
<td>Professor Ahmet Fuat</td>
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<td>15:20—15:30</td>
<td>HF should be a national health priority: a policy perspective</td>
<td>Dr Yassir Javaid</td>
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<td>15:30—15:50</td>
<td>Facilitated panel discussion</td>
<td>Professor Ahmet Fuat, Dr Sarah Jarvis, Dr Yassir Javaid</td>
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Meeting objectives

- To raise awareness of heart failure as a national health priority in the UK and expose current gaps in heart failure services
- To discuss heart failure service options in the community and specialists centres
- To highlight the unmet needs in chronic heart failure management and the challenges faced by primary care physicians and patients with chronic heart failure
- To recognise that there is no place for suboptimal chronic heart failure care in primary care
- To raise the profile of heart failure on the national health agenda
Please vote: yes or no

Is heart failure a priority within your local area?
Please vote: yes or no

Do you agree that heart failure should be more of a national health priority?
Please vote

In the last 2 years have your local heart failure services:

A. Improved
B. Stayed the same
C. Worsened
Heart failure should be a national priority:

A clinical perspective

Professor Ahmet Fuat
GP and GPSI Cardiology, Darlington
Professor of Primary Care Cardiology, Durham University

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Prof Fuat has received research grants from Servier, Roche diagnostics, MSD, Heart Research UK, BHF, Research for Patient Benefit.
Heart failure presents a significant burden to the NHS

- >550,000 people in the UK have heart failure (HF) with potentially the same number again undiagnosed\(^1,2\)
  - >60,000 new diagnoses every year\(^3\)
- HF accounts for 2% of all NHS inpatient bed-days and 5% of all emergency admissions to hospital\(^4\)
  - Outcomes for patients are poor and have often been compared with those of the worst cancers\(^3\)

Many patients with HF have a history of CV events

- Coronary artery disease (CAD) is the most common cause of HF\(^1,2\)
  - Accounts for ~70% of cases
- HF is the most common cause of hospitalisation in people >65 years\(^2\)
  - Average age at first admission is 77.5 years\(^3\)

How can the healthcare community help patients with HF?

- NICE recommend an integrated approach to HF across the healthcare community for a positive effect on the patients life expectancy and QoL\(^1,2\)
  - Information, education and support is essential along with increasing patient self-management\(^1,2\)
    - Should include supervised cardiac rehabilitation (CR) based on group exercises\(^1\)
  - Effective and appropriate pharmacological treatment is vital\(^1\)

Patient pathway recommended by NICE

- There is variation in HF diagnosis and care across the UK\(^1\)
- NICE recommend the following steps:\(^2\)
  - Detailed past medical history and a thorough clinical examination as well as additional diagnostic tests if required
  - Treatment to include lifestyle advice, suitable drug therapy, monitoring and possible longer term treatment options
  - Offer a supervised group exercise-based rehabilitation programme designed for HF
  - Only discharge when condition is stable and optimised management and care plans are in place
  - Discuss prognosis with patients and carers in a sensitive and honest manner and consider that depression might occur

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Treatment options for patients with chronic HFrEF (NYHA class II-IV)

What do NICE say about the role of the primary care team?

- Effective primary care services can help to reduce recurrent hospital stays by 30–50%\(^1\)

- Practices should establish a register of patients who have been diagnosed with HF or a risk factor\(^2\)
  - Patients should be referred for special assessment and additional diagnostic tests e.g., echocardiography or natriuretic peptide measurement\(^2\)

- Provide a suitable treatment regimen for patients based upon diagnosis and severity of symptoms\(^2\)

- Establish an exercise based rehabilitation program if possible\(^2\)

- Maintain standard of care by using audit data to monitor performance\(^2\)

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The new HF challenges facing primary care

- Patients on GP HF registers have on average a 5-year survival rate of 58% compared with 93% in the general population\(^1\)

- HF is generally poorly identified in the primary care setting and is mistaken for conditions, such as COPD\(^2\)

- Management in primary care is not optimal and many patients do not have access to specialist multidisciplinary HF teams\(^1\)
  - Many services are now using Practitioners with a Specialist Interest (PWSI), who have additional specialist training to triage referrals or provide cardiology services\(^2\)

Inclusion of HF in the Quality and Outcomes Framework

- The Quality and Outcomes Framework (QOF) is an annual GP incentive program
  - Introduced as part of the contract in 2004
- HF was included in QOF because it represents the only major CVD with increasing prevalence
  - Responsible for dramatic impairment of QoL
  - Costly for the NHS to treat (second only to stroke)

How do practices earn financial reward?

- Practices score points against the indicators according to their level of achievement\(^1,2\)
  - Points are awarded for delivery of high quality care across a range of areas
- The higher the score, the higher the financial reward for the practice\(^1,2\)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement threshold</th>
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<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
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<tr>
<td>HF001. The contractor establishes and maintains a register of patients with heart failure</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Initial diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register</td>
<td>6</td>
<td>50–90%</td>
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<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
<td></td>
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<tr>
<td>HF003. In those patients with current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB</td>
<td>10</td>
<td>60–100%</td>
</tr>
<tr>
<td>HF004. In those patients with currently diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure</td>
<td>9</td>
<td>40–65%</td>
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Barriers to accurate diagnosis and effective management of CHF

- Uncertainty in clinical practice
  - Diagnosis difficult, particularly in obese and elderly
  - Concerns about drug side effects
  - Co-morbidities and polypharmacy

- Local organisational factors
  - Availability of diagnostic services
  - Interactions with secondary care
  - Different levels of training

- Awareness of relevant evidence
  - Perceived complex therapeutic area
  - Doubts about applicability in primary care
  - Fear of information overload

1. Fuat A, Hungin APS, Murphy JJ. BMJ 2003;326:196-200
Barriers to accurate diagnosis and effective management of heart failure have not changed in the past 10 years: a qualitative study and national survey

• The same barriers to the way heart failure is diagnosed and managed are apparent at the present time; variable access to diagnostic tests, modes of care delivery and a non-uniform management approach persist and extend from primary to secondary care.

• Lack of clarity about responsibility for end-of-life care for heart failure has emerged as an additional concern.

• The NHS context within which heart failure is diagnosed and managed falls short of optimal requirements, which require more co-ordinated care, responsibility and effective training.

The National Heart Failure Audit

- 85% of all Acute HF admissions England & Wales
- Lengths of stay remain long, with considerable spread
  - Length of stay: 13 days on first admission
  - Length of stay: 12 days on re-admission
- 7.0% mortality on Cardiology wards
- 11.0% mortality on General Medical wards
- 14.0% mortality on Other Wards

Heart failure should be a national priority:

A policy perspective

Dr Yassir Javaid
Primary Care CVD lead Nene CCG and East Midlands SCN
Disclosures

Dr Javaid is receiving an honorarium from Novartis for presenting at this meeting.

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HF: More impact on survival than cancer?

- Five year survival of patients admitted to hospital in Scotland 1991\(^1\)
- Five year heart failure relative survival rates were around 62% in 2010\(^2\)

Overwhelming efficacy of HF medical therapy

The predicted effects on survival of sequentially adding medications and an ICD for a HF patient with an annual mortality of 20% and a mean survival of 4.1 years at baseline\(^1\)

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ICD- implantable cardioverter defibrillator
Heart Failure Treatments: The overwhelming evidence for benefit

<table>
<thead>
<tr>
<th>Therapy</th>
<th>RRR in Mortality</th>
<th>NNT for Mortality</th>
<th>NNT standardised to 36 months</th>
<th>RRR in HF hospitalisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE-I</td>
<td>17%</td>
<td>22 over 42m</td>
<td>26</td>
<td>31%</td>
</tr>
<tr>
<td>Beta-Blocker</td>
<td>34%</td>
<td>28 over 12m</td>
<td>9</td>
<td>41%</td>
</tr>
<tr>
<td>Aldosterone Antagonist</td>
<td>30%</td>
<td>9 over 24m</td>
<td>6</td>
<td>35%</td>
</tr>
<tr>
<td>CRT</td>
<td>36%</td>
<td>12 over 24m</td>
<td>8</td>
<td>52%</td>
</tr>
<tr>
<td>ICD</td>
<td>23%</td>
<td>14 over 60m</td>
<td>23</td>
<td>N/A</td>
</tr>
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RRR-relative risk reductions, NNT-number needed to treat, CRT- cardiac resynchronization therapy, ICD-implantable cardioverter defibrillator
Heart failure

CCG: NHS Nene CCG

The unwarranted variation in care

Produced by East Midlands Knowledge and Intelligence team as part of the local contribution programme

Speaker's own data

September 2014
Detected HF prevalence by Practice

- Dr Ker D A J & Partners C82010
- Husbands Bosworth Surgery C82109
- Dr Druquer M H & Ptnrs C82079
- Dr Tobin T A & Partners C82013
- Dr Ss Chohan & Partners C82048
- Dr Lawrence N W & Ptnrs C82068
- Dr Jones J P & Ptnrs C82077
- Dr Kirkup B & Ptns C82038
- Dr Davies M J & Partners C82021
- Dr Shanks M P & Ptnrs C82112
- Dr Dayah A R & Partner C82108
- Woolford Ranpura Ahyow & Milton C82066
- Dr Cooper J G & Partners C82056
- Dr Shaffu M T C82641
- Dr Bishop F M & Partners C82009
- Dr Watson H J & Partners C82098
- Dr Gs Johnson & Partners C82025
- Dr Masharani V C82611
- Dr Hollington A & Ptns C82039
- Dr Ker D A J & Ptns (Market Overton) C82649
- Dr Hurwood R S & Ptns C82042
- Dr Aram G E & Ptnrs C82002
- Dr Selmes S E & Ptnrs C82044
- Dr Bhutani H C & Partner C82631
- Dr Jk Inman & Partners C82078
- Dr Kapur R C82119
- Dr Austin M W E & Ptnrs C82022
- Dr Prowse G D W & Ptnrs C82055
- Dr Griffin B J & Partners C82071
- Dr N Choudhury & Partners C82001
- Dadge Dalby McCole & Partners C82067
- Dr Kilpatrick & Ptnrs C82036
- Dr S Wooding & Partners C82016
- Oadby And Wigston Walk In Medical Centre Y02725

Heart failure prevalence
GP practice
CCG
Expected Prevalence
% LVSD patients on ACE-I/ARB and BB therapy

Treated with ACE-I / ARB
No treatment
Exceptions reported
CCG

Speaker's own data
LVSD Heart Failure
Nene CCG

Diagnosed LVSD pts

On ACE-I/ARB

On ACE-I/ARB and BB

35% of coded LVSD patients are not on an ACE-I (or ARB) and BB

5206 pts not diagnosed or coded as having LVSD HF

Optimum Management of Heart Failure: The Huge opportunity in Nene CCG

1. Massive underdiagnosis and undercoding of LVSD: **5206 pts** not diagnosed or coded
2. **35%** of patients are not on ACE-I (or ARB) and BB combination
3. Many patients exception reported inappropriately for BB therapy eg COPD
4. Patients on ACE-I and/or BB are often on suboptimal doses

Speaker’s own data
HF Emergency Admissions – Primary Diagnosis

2012-13
- Admissions: 585
- Cost: £1,789,000

2013-14
- Admissions: 628
- Cost: £1,924,000

30 Day Re-admissions in 2013-14 = 56
Readmission Rate:  
- CCG – 8.9%
- East Midlands – 6.9%

90 Day Re-admissions in 2013-14 = 96
Readmission Rate:  
- CCG – 15.2%
- East Midlands – 11.3%

- 1 admission: 76%
- 2 admissions: 16%
- 3 admissions: 3%
- 4 admissions or more: 5%

Speaker's own data
HF Admissions - Primary & Secondary Diagnosis

Primary Diagnosis Only

2013-14
Admissions: 628
Cost: £1,924,000

Primary and Secondary Diagnosis

2013-14
Admissions: 2,838
Cost: £7,621,000

Speaker’s own data
The financial burden of heart failure

- 1 million inpatient bed days\(^1\)
- 2% of all inpatient bed days\(^2\)
- 5% of all medical emergency admissions\(^2\)
- 1-2% of total health budget\(^1\)

Key Points

• HF is an enormous financial burden for the NHS
• Survival rates for HF are worse than many cancers
• There is compelling evidence for the benefits of HF medication
• Considerable variation is evident in detection and treatment of HF across the UK
• Multiple hospital admissions for HF are costly and unsustainable
Panel discussion
Please vote: yes or no

Do you agree that heart failure should be more of a national health priority?
Please vote

What is the biggest barrier to improving the management in heart failure?

A. HF is not a local priority
B. Integration between primary and secondary care
C. Local funding and resources
D. Complexity of the patient/condition
E. Limited treatment options
Please vote

Heart failure would be a national health priority if:

A. Public awareness of the condition was improved

B. Policy-makers and the media were aware of the cost to the NHS

C. It was not seen as an older person’s condition

D. All of the above
Please vote: yes or no

I am committed to making heart failure a local priority and improving patient outcomes.
Thank you for listening