Chronic Heart Failure: scope workshop discussions – summarised Date: 07/12/2015		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.1 Who is the focus: **<u>Groups that will be covered:</u>** • Adults (18 and older) with symptoms or a diagnosis of chronic heart failure **<u>Groups that will not be covered:</u>** • Patients with right heart failure as a consequence of respiratory or congenital disease. • Pregnant women • Screening or diagnosis of people who are asymptomatic • People undergoing treatment for HIV • Patients receiving chemotherapy	• Is the population appropriate? • Are the exclusions appropriate for the guideline? • Are there any specific subgroups that have not been mentioned (in either list)?	<u>Acute heart failure</u> It was suggested that 'acute heart failure' could be listed in the groups that will not be covered for clarity. <u>Population</u> One group suggested that the population include those above 16, rather than 18, as paediatric guidelines end at the age of 16. <u>Afro-Caribbean</u> One group were unsure as to why inequalities relating to patients of Afro-Caribbean origin had been singled out. They noted that there is some evidence around different treatment needs for African–Americans. Another group questioned why other groups were not included, such as those who are educationally or economically disadvantaged. <u>Oncology patients</u> One group thought oncology patients should be included as there is increasing evidence about the oncology population of chronic heart failure patients. Similarly, the group thought that the structure of treatment for oncology patients should be addressed. <u>Pregnant women</u> One group expressed concerns over who is covering women who are pregnant and then develop heart failure, if they are not covered by this guideline. Similarly, another group suggested that women who develop heart failure during pregnancy should be a sub-group. One group suggested that peripartum cardiomyopathy patients should be covered. Another group noted that pre-conceptual counselling is important in women with heart failure. <u>Right-sided heart failure</u> One group noted that there is a lack of guidance on patients with right-

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		sided heart failure and these patients make up a notable proportion of patients admitted to hospital. Another group thought that right heart failure should be re-worded to 'isolated right heart failure'. <u>People who are asymptomatic</u> One group thought people who are asymptomatic through good care and treatment, but have had symptoms in the past, should be covered. They also noted that genetic screening of family members of people who have symptoms is important. <u>Patients who are elderly/frail/housebound</u> One group noted that these patients are often not fit enough to get an Echo or BNP assessment, as this requires travelling to a laboratory. Similarly, couriers cannot be used due to the stability of the sample (< 1 hour), therefore testing patients at home is not yet feasible. This group of patients should be acknowledged in the recommendations as implementation may be difficult. <u>Co-morbidities</u> One group expressed concerns about the applicability of the guideline as co-morbidities are not mentioned. They thought patients with co-morbidities should be covered with a particular reference to polypharmacy and access to treatment.
1.2. Settings • Primary and secondary NHS-commissioned care including referral to tertiary care	• Are the listed settings appropriate? • Are there other settings that should be considered?	One group thought the management of transition of care for people with heart failure should be addressed throughout the guideline. Another group thought tertiary care should be included as standards need to be set for all stages of care. It was noted that some people may also have social care needs.
1.3 Activities, services or aspects of care: **<u>Key areas that will be covered:</u>** **Diagnosis** • Role of circulating biomarkers (including	These are the key clinical areas that have been prioritised for inclusion in the guideline. • Do you think that these	<u>General</u> One group thought it was important to establish whether the palliative care guideline is covering chronic heart failure specifically, as it may not be sufficient. The disease trajectory for chronic heart failure is not fully established and access to hospices/palliative care can be a problem.

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natriuretic peptide) concentration • Echocardiography and cardiac MRI **Treatments** • Aldosterone antagonists • inotropes • Statins - cessation of therapy- - n-3 polyunsaturated fatty acids - Angiotensin receptor neprilysin inhibitor (Sacubitril (LCZ696) • Non-invasive ventilatory support (including CPAP, APAP, BiPAP, ASV) • How to manage different patient subgroups: - Iron deficiency - Anaemia treatment - Chronic kidney disease • Monitoring of N-terminal pro-B-type natriuretic peptide **Rehab** • Rehabilitation in chronic heart failure including: Tele-monitoring, Domiciliary oxygen, exercise training (including FES) , discharge planning **<u>Areas that will not be updated:</u>** • Pharmacological treatments o Isosorbide/hydralazine o Angiotensin-converting enzyme (ACE) inhibitors o Angiotensin-II receptor antagonists	prioritised areas are appropriate for the topic? • Are there other topics not listed that should be included? Why? What is the evidence base? • Should we consider the role of circulating biomarkers and in particular the cut off values of BNP? • Does MRI provide added benefit over echo? • Include nutrition advice in rehab section or is this covered adequately in other NICE guidelines? • Should we consider whether statins provide any benefit for people with HF? • Is there a role for n-3 polyunsaturated fatty acids? • Should selective phosphodiesterase-5 inhibitor be included? • Are there any particular information/support needs of patients or	It was suggested that there needs to be better integration between the guideline and technology appraisals. For example, the use of cardiac resynchronization therapy (CRT) and implantable cardioverter-defibrillators (ICDs) together needs to be clearer. If this is not highlighted in the guideline, GPs may not know to look for the technology appraisal. One group noted that the question on advice it was not useful as advice is different for different patients. <u>Role of circulating biomarkers (including natriuretic peptide) concentration</u> Overall, the stakeholders agreed that the role of circulating biomarkers is important to include. It was suggested that the question looking at the integrated use of biomarkers and imaging as biomarkers should be used to look into ruling out heart failure and the need for imaging. It was also noted that, for referral, GPs want to know a cut-off value for biomarkers. <u>Echocardiography and cardiac MRI</u> One groupgreed that cardiac MRI is becoming very important and the question should focus on in whom cardiac MRI should be indicated (although it was noted there is very little evidence). One group noted that there is a lack of access to echocardiograms and a lack of healthcare professionals trained to deliver them. Another group also noted echocardiography could potentially miss a lot of symptoms. Similarly, one group noted that the ejection fraction from echocardiograms is currently reported numerically which is often difficult to interpret and, therefore, it would be useful for the guideline to include guidance on this. <u>Treatments</u> The stakeholders agreed that inotropes should not be included in this guideline, citing the following reasons: • Inotropes are not relevant to heart failure.

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(ARBS) ○ Diuretics ○ Beta-blockers ○ Aspirin ○ Calcium channel blockers • Referral and approach to care: ○ referral back to specialist care ○ multidisciplinary team ○ support groups	carers that warrant including in the scope? • Are there other areas of rehab we should consider? • Are the excluded areas appropriate? • Should the role of therapies for mild chronic heart failure (NYHA grades 1 & 2) be included in the scope?	• Inotropes are already included in the Acute Heart Failure guideline. • There is no new evidence for inotropes such as digoxin. The following points were also raised, regarding treatment: • The term 'aldosterone antagonists' is out of date. It was suggested 'mineralocorticoids' be used as an alternative. • There are emerging drugs on lowering potassium levels. • Statins and n-3 polyunsaturated fatty acids do not warrant inclusion. <u>Sub-groups</u> The stakeholders suggested that those with diabetes and atrial fibrillation be included as patient sub-groups. <u>Rehabilitation</u> Overall, the stakeholders agreed that rehabilitation should be a significant part of the guideline and should include psychological support as well as addressing problems with access and service delivery. One group suggested that the focus of rehabilitation should be on remote monitoring (replacing tele-monitoring) whilst another group suggested the focus should be maintaining the link between primary and secondary care. Similarly, it was noted that a smooth transition into palliative care is important. It was questioned whether there is evidence for patients who have heart failure and respiratory conditions. From a commissioning perspective, it would be cost-effective to have a joint rehabilitation rather than separate cardiac and respiratory rehabilitation. One group suggested that 'rehabilitation' could be re-named 'non-medical therapy'. <u>Exercise training/functional electrical stimulation (FES)</u> One group thought exercise and FES should be expanded, with FES as a separate bullet point. However, another group thought FES should be

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		removed as there is currently not enough evidence. It was noted that some population groups will struggle with exercise, including the frail and the elderly. <u>Nutrition</u> A group suggested that nutrition should be separate from rehabilitation whilst another suggested that 'salt and fluid balance' would be more appropriate for inclusion than nutrition. It was noted that people who cannot get to rehabilitation centres will still need nutrition advice. <u>Discharge planning</u> More than one group suggested that discharge planning is more relevant to acute heart failure (and already covered in the AHF guideline) so may not need to be included. However, they also noted that transfer of care from secondary care to the GP/community programmes would be important to include. One group suggested that discharge planning should include an on-going surveillance management plan, which should include a transition into an advanced care plan. It was noted that, once discharged, patients often don't know who to contact. <u>Multidisciplinary team (MDT)</u> One group suggested that a primary care team should be part of the MDT. Another group thought that the guideline should include a suggested core group of people essential to the MDT. <u>Monitoring of N-terminal pro-B-type natriuretic peptide</u> One group suggest that monitoring of N-terminal pro-B-type natriuretic peptide should be broadened to include more biomarkers. <u>Home-based care</u> The stakeholders agreed that information and support is very important in home-based care. They also agreed that there is variation around the

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		country between home-based care and clinic-based care; and it is important to consider the cost effectiveness and outcomes of home-based care. Overall home based therapies was thought to be an important area of focus <u>Self-monitoring</u> One group suggested that self-monitoring programmes should focus on home-based interventions. <u>Self-management</u> One group suggested that 'self-management' needs to be clearly defined, as it is not the same as self-monitoring. Another group suggested that the use of the wording 'failure' deters people from adopting self-management. It was noted that self-management should include tools for symptom management and adherence to medication as well as advice/informed consent with cardiac devices. <u>Tele-monitoring</u> More than one group noted that there needs to be a clear definition of tele-monitoring. One group noted that tele-monitoring has huge workload implications and questioned who in primary care would be responsible for this. The stakeholders suggested that the following could be included in the guideline: • Home based therapies • Diagnosing the cause of heart failure • Subcutaneous/intravenous diuretics • Referral to and from specialist care • Prevention of chronic heart failure • Early diagnosis • Identifying why people with CHF suddenly deteriorate • Sleep apnoea in 'how to manage different patient subgroups' • Referral back to specialist care is an area that should be updated.

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		The stakeholders suggested that the following should not be included in the guideline: • Statin cessation • Non-invasive ventilatory support • Phosphodiesterase inhibitors. • Statins and n-3 polyunsaturated fatty acids • Iron deficiency subgroup.
1.4 Economic Aspects An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked/**biggest cost** implications for the NHS? • Are there any **new practices** that might **save the NHS money** compared to existing practice? • Do you have any further comments on economics?	The stakeholders suggested the following new practises that could potentially save the NHS money: • Prevention of admission programmes; • Heart failure MDTs case management. • IV services in the community, which stop admission to hospital - particularly with diuretics. • Early discharge teams – currently used in Tunbridge Wells Hospital Trust. • Ambulatory services; SHINE model. • Tele-medicine. • In-reach/outreach • Models of care impact assessment.
1.5 Key issues and questions This section expands upon the areas mentioned in section 1.3. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.	• Would you like to add any additional questions to this list? • Are there any questions that can be removed?	The following issues/questions were raised amongst the stakeholder groups: <u>Questions</u> • Is there any evidence to recommend a reduction in salt intake and fluid restriction in heart failure patients? • What is the best/most effective model of the MDT? • Which medications are safe to use in patients with heart failure and anxiety/depression? <u>Issues</u>

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		• The aetiology of chronic heart failure should be defined in order to define the appropriate treatment. This does not necessarily have to be a review question but should be mentioned in the chapter. • Relevant questions should be asked on inherited cardiac conditions. • One group thought that questions 1.1, 1.3, 1.4, 2.2, 2.3, 2.4, 2.5 and 3.2 should be removed from the scope. • It was noted that BNP is already the gold standard in diagnosis; therefore, the guideline should be looking at ECG versus the gold standard.
1.6 Main Outcomes 1. Mortality 2. Hospitalisation 3. Readmission to hospital 4. Quality of Life 5. Total adverse events	• Is the list of outcomes appropriate? Are any key outcomes missing? • Please identify the top 5 outcomes.	One group thought that palliative care/end of life services and models of care should be included as outcomes. One group questioned whether time to event data and dichotomous data should be specified in the scope within readmission to hospital. Another group suggested that length of stay should be included as this is crucial for costing exercise and the health economic modelling. One group suggested that 'total adverse events' should be re-worded to 'adverse events', and that cardiac-specific events should be made more explicit.
GDG Membership. 2 x GP with specialist interest 2 x Specialist Nurse/practice nurse 1 x Rehab nurse 2 x Cardiologist 1 x Physician in elderly care/Geriatrician 1 x Commissioner 1 x Pharmacist 2 x Patient/carer	• Do you have any comments on the proposed membership of the committee?	The stakeholders made the following comments regarding the guideline committee membership: • There could be two rehabilitation professionals rather than two specialist nurses and a rehabilitation nurse. This will allow other professionals involved in delivering the total rehabilitation package to be represented. • It is important to have a nephrologist when looking at the order of titration for ACE inhibitors, beta-blockers and mineralocorticoid receptor antagonists. • There will be a variety of patients, including those who are stable and those with more severe CHF. They will have different needs and, therefore, would bring a different view point to the committee. • There should be co-opted dietician.