



NEWSLETTER

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We report highlights from the 7th BSH Annual Autumn Meeting, which was run jointly with the Coronary Heart Disease (CHD) Collaborative. The meeting, entitled, "Heart failure: translating evidence into practice", was held in London on 25–26 November 2004, and included plenary sessions by leading practitioners on:

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The meeting also included breakout sessions on several challenging areas including diagnosis, chronic disease management, palliative care and cardiac networks.

BSH AGM

Professor Henry Dargie (Edinburgh) chairman of the BSH, gave an encouraging overview at the BSH AGM, held prior to the start of the 7th BSH Annual Autumn Meeting in London on 25 November 2004. The Society now has over 600 members and although these include a good cross-section of healthcare professionals, geriatricians are still under-represented and should be encouraged to get involved.

Heart failure: translating evidence into practice – the 7th Annual Autumn meeting of the BSH

This meeting was the first event hosted jointly by the CHD Collaborative and the BSH. Professor Henry Dargie (Edinburgh) summarised the overall message from the meeting that all patients with heart failure (HF) should have ready access to the diagnostic tests, treatment options and support appropriate to their needs. He commented on the importance of the National Service Framework (NSF) for Coronary Heart Disease in changing the HF landscape and said that it is time to push HF up the government agenda. He commended Dr Roger Boyle (National Director for Heart Disease) as a powerful advocate for improved HF management and encouraged healthcare professionals to support him as he seeks to influence the government in this important area.

The election of the new BSH Board for June 2005–May 2007 will be held during the spring of 2005. The results will be announced at an EGM to be held at 12.30 pm on 23 May 2005 during the British Cardiac Society (BCS) Annual Scientific Conference in Manchester. Members will be sent nomination papers in February (to be returned to the BSH Secretariat no later than Monday 21 March 2005); ballot papers will follow in April.

In addition to its highly successful scientific meetings' programme in 2004, the BSH has been involved in a number of other initiatives, including the development of heart failure datasets, a nurse education programme in collaboration with the British Heart Foundation, Caledonian University and the University of Leicester, involvement with National Institute of Clinical Excellence (NICE) guidelines on atrial fibrillation and post-myocardial infarction (MI), and the first BSH Charity Ball.

There are a number of exciting meetings planned for 2005, including seven plenary sessions focusing on heart failure at the BCS Annual Scientific Conference 23–26 May (details and programmes can be found on the BSH website in the Future Meetings section [<http://www.bcs.com/restricted/registered/affiliates/bsh.html>]). The date and location of the 8th BSH Annual Autumn Meeting will be announced soon. Professor Dargie noted that collaborations between the BSH and other professional groups are developing rapidly.

Dr Theresa McDonagh, treasurer of the Society, described a healthy financial position with a 30% income increase over the past year.

We are particularly grateful to the Friends of the BSH (see back page for details) for their continued enthusiastic support.

National, secondary care and primary care overviews of heart failure

Dr Mark Dancy (London), the national clinical chair of the CHD Collaborative, presented a national overview of HF in England and Wales. He noted that, unlike many other specialities, high-quality care has been shown to be the most cost-effective approach in HF, and he highlighted the role of the NSF and the Planning and Policy Framework for HF, which help set targets to provide this care.

He commented that it was a good time to focus on HF, with the current emphasis on chronic disease management, financial benefits for primary care trusts (PCTs), and a growing understanding of the role of GPs with special interest (GPwSI) and practitioners with special interest (PwSI). However, continuing challenges in HF include linking individual patients to appropriate care, building and maintaining HF

registers, coping with the demand for echocardiography services, establishing patients on evidence-based therapies, developing palliative care and strengthening information technology to improve communication.

Dr Dancy highlighted a number of resources to support healthcare professionals, notably the HF Service Improvement Guide,¹ and the Rapport website (<http://www.chdcollaborative.nhs.uk>), which is a valuable source of improvement stories. He encouraged a greater focus on improving quality of life rather than solely prolonging life in HF, and suggested that protocols, for all their benefits, can sometimes be rather blunt instruments in managing some aspects of HF. However, there is now a significant opportunity to break down the NHS organisational barriers in HF, in particular between primary and secondary care, and demonstrate these successes to other specialities.

Although the past 10 years have seen dramatic advances in drug therapy for HF, Professor Dargie reminded delegates of the shift in focus away from these drugs toward delivery of care with a multi-disciplinary approach. Newer, more expensive techniques, including cardiac resynchronisation therapy (CRT) and left ventricular assist devices (LVADs), also need to be considered in more detail. He described the goal of an integrated local HF service receiving patients from multiple sources and delivery of a management plan through primary care, with a specialist service for patients with advanced HF (Figure 1).

He suggested that the major contribution of secondary care was in diagnosis and assessing prognosis, as this has proved particularly difficult in primary care. Sophisticated tests using cardiac magnetic resonance imaging (MRI) may be necessary to provide an

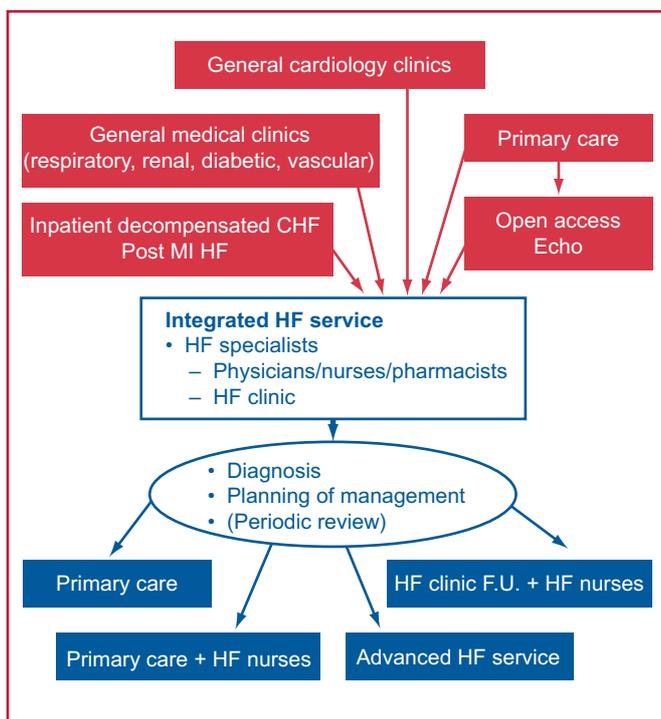
accurate diagnosis and build a foundation for effective management. In addition, the correct assessment of HF is important as a recent study shows that it may be reversible (reversible ischaemia and hibernating myocardium).²

There is now good evidence for the benefit of most types of multi-disciplinary strategies of care in HF³ and it was noted that crucial elements include trained HF nurses, education about HF (including dietary advice, and the need for adherence) and access to clinicians trained in HF. Professor Dargie encouraged the establishment of a national database to further improve standards and to learn more about the disease. He concluded that multi-disciplinary integrated care is the future for HF, and the identification of all HF patients in the community will allow selected patients to benefit from more sophisticated techniques.

Dr Ahmet Fuat (Darlington) presented experience of HF in primary care from the Darlington area which, following a qualitative survey in 2003,⁴ has developed a HF service that includes a one-stop diagnostic clinic funded jointly by the PCT and South Durham NHS Trust. He described data from the Durham Dales PCT showing good uptake of beta-blockers and angiotensin converting enzyme inhibitors within primary care following specialist HF nurse involvement in all 12 practices.

Dr Fuat commented that expedient HF diagnostic services based on local needs and resources are central to any service, but was concerned about the current lack of uniform availability of these services. In a study of different B-type natriuretic peptide (BNP) diagnostic techniques he suggested that a laboratory based assay is more practical for primary care.⁵ He suggested that the new General Medical Services (GMS) contract and the growing numbers of GPwSI are also encouraging factors in improving services in primary care, and highlighted the importance of GPs in prevention, early detection and treatment. He confirmed Professor Dargie's view of the integrated HF model and urged the development of close communication and seamless integration across primary, secondary and tertiary care.

Figure 1. Suggested design for an integrated local heart failure service.



Hot topics

The SENIORS trial

Professor Philip Poole-Wilson (London) presented the results of the SENIORS* trial. Although earlier beta-blocker trials (MERIT-HF*, CIBIS II*, BEST*, COPERNICUS*) showed significant mortality benefits they did not provide sufficient data on women, outpatients and the elderly. The SENIORS trial studied all-cause mortality and hospital admissions in patients with a mean age of 76 years and a clinical diagnosis of HF (left ventricular ejection fraction [LVEF] <35% or hospital admission for HF). The study compared patients treated with nebivolol (n=1067) with those receiving placebo (n=1061). Nebivolol therapy significantly reduced death or hospitalisation in these

*Trial acronyms are defined on page 8.

older patients; there was a 4% absolute reduction in primary end-point event rate in the nebivolol-treated group (35.3% versus 31.1%) with a hazard ratio of 0.86 (0.73; 0.99; $p=0.039$). These effects were seen regardless of ejection fraction, age or gender, and the study shows that beta-blockade is effective in HF for all these patient groups, notably in patients of advanced age. The study is due to be published shortly and a copy of Professor Poole-Wilson's presentation is now available on <http://www.cteu.org>.

Cardiac resynchronisation therapy

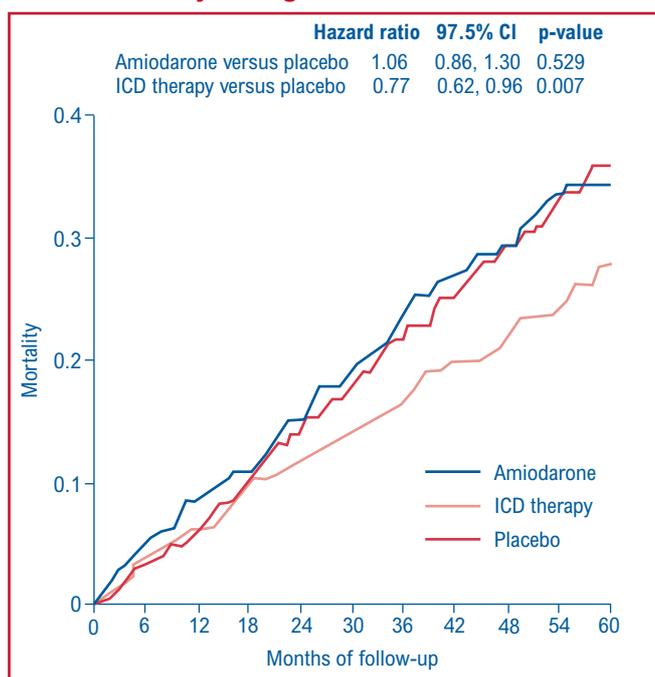
Dr Peter Cowburn (Southampton) described CRT as a promising therapeutic option for selected patients with advanced chronic HF and left ventricular (LV) dyssynchrony, and summarised some of the major trials that have established this therapy in HF.⁶⁻⁸ CRT re-times the failing heart and increases cardiac output and systolic blood pressure, reduces mitral regurgitation and improves LV function without increasing myocardial oxygen demand. He commented that CRT should be considered an adjunctive therapy for chronic HF, allowing further up-titration of medical treatment, and that close collaboration is required between HF physicians, electrophysiologists, nurses and primary care to maximise patient benefit.

Dr Derek Connelly (Glasgow) presented results from three implantable cardioverter defibrillator (ICD) studies conducted over the past 12 months (DINAMIT*,⁹ DEFINITE*¹⁰ and SCD-HeFT*¹¹). DINAMIT studied the role of ICDs versus standard therapy in acute myocardial infarction (MI). Although the trial showed no decrease in all-cause mortality, there was a decrease in arrhythmic mortality from use of ICDs.⁹

The DEFINITE study showed a risk reduction of 35% from use of ICDs when compared with standard therapy, but with the relatively small numbers in the trial ($n=458$) this did not reach statistical significance ($p=0.08$).¹⁰ However, there was a trend toward decreased mortality in patients treated with ICDs (2-year mortality 7.9% with ICDs versus 14.1% with standard therapy).

The SCD-HeFT trial studied 2521 patients (mean age 60 years) with symptomatic HF (New York Heart Association [NYHA] functional class II-III) and LVEF <35%, and is the largest HF trial to use ICDs to date.¹¹ These patients were randomised to one of three groups, no anti-arrhythmic therapy, amiodarone or ICD therapy, with a 5-year follow-up. The study showed that ICD therapy decreased mortality by 23% ($p=0.007$) when compared with placebo, and that amiodarone has no effect on mortality rates in these patients (Figure 2). The data suggest that ICDs may be more beneficial in younger patients and those in NYHA class II, although this is not consistent with other ICD trials such as CIDS*.¹² There is similar benefit in ischaemic and non-ischaemic patients, and greater benefit in patients already receiving beta-blockers and those with diabetes. A recent economic analysis showed the affordability of ICD therapy in these patients,

Figure 2. Mortality by intention-to-treat in the SCD-HeFT study. Reproduced with permission from reference 11. Copyright 2005 Massachusetts Medical Society. All right reserved.

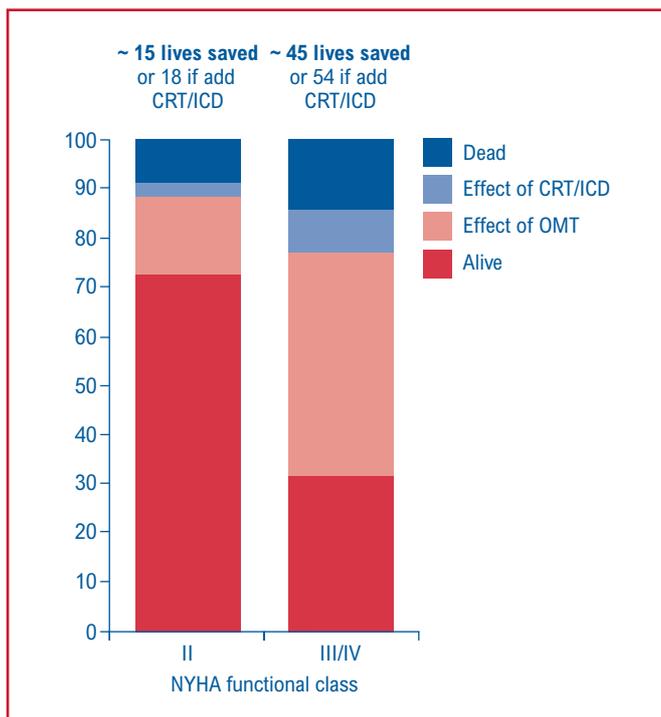


with cost per life-year saved being approximately £16,000, which compares well with costs of routine implantation in patients with ventricular tachycardia and fibrillation.¹³ Dr Connelly suggested that the question to ask is no longer whether ICDs should be implanted in patients with HF, but what type of ICD should be implanted.

Professor John Cleland (Kingston-upon-Hull) discussed whether it is beneficial to combine CRT and ICDs, or whether to use them alone. The results from four studies (CONTAK-CD,¹⁴ MIRACLE-ICD*,¹⁵ RHYTHM ICD*,¹⁶ MIRACLE-ICD-II*⁸), in which CRT was added to ICD in over 1000 patients, show a general improvement in NYHA class and quality-of-life scores but no change in hospitalisation, mortality or ventricular tachycardia. Although these well-designed studies showed symptom and quality-of-life benefit in patients receiving CRT in addition to an ICD, there was a suggestion that CRT may simply be removing the iatrogenic consequences of using an inappropriate pacing mode, as observed in the DAVID* trial in which more advanced pacing technology produced ventricular dyssynchrony.¹⁷ However, Professor Cleland suggested that there was a case for using CRT in addition to ICD in selected cases, ensuring the use of optimal pacing technology.

The COMPANION* study¹⁸ showed that adding ICD to CRT does not improve symptoms or prognosis further, and Professor Cleland commented that there was no reason to add ICD to CRT unless there is an existing indication for an ICD. He reminded delegates that although ICDs have demonstrated a statistically significant survival benefit, this is small compared with optimal medical therapy, and other issues of morbidity and cost must be taken into account as this therapy becomes more widely available (Figure 3).¹⁹

Figure 3. Lives saved over two-years per 100 patients treated for heart failure using three or more drugs with or without devices. OMT = optimal medical therapy. Adapted from reference 19.



Draft acute heart failure guidelines

Professor Dargie presented draft acute HF guidelines from the European Society of Cardiology (ESC). The ESC defined a number of presentations of acute HF including acute decompensated HF, hypertensive HF, pulmonary oedema, cardiogenic shock, high output failure and right HF. Professor Dargie discussed another recent classification of advanced HF that has gained some support in the USA, although he commented that the approach may be unfamiliar to healthcare professionals in the UK.²⁰ He presented a draft treatment algorithm that included a number of treatment options currently not well-used in the UK, including continuous positive airway pressure (CPAP) and a greater use of vasodilators in treating patients with mean blood pressure >60–70 mmHg. Professor Dargie noted that CPAP in patients with cardiogenic pulmonary oedema improves oxygenation, decreases symptoms and signs of AHF.^{21,22} In addition, the draft guidelines state that the use of CPAP and non-invasive positive pressure ventilation (NIPPV) in acute cardiogenic pulmonary oedema is associated with a significant reduction in the need for tracheal intubation and mechanical ventilation, and that it is likely we will see more use of this therapy in the UK in this condition. There are also data showing the benefits of using vasodilators²³ and continuous infusion rather than bolus diuretics.²⁴

The draft guidelines make other recommendations on the organisation of care, further understanding of pathophysiology by using haemodynamic monitoring, treatment of ischaemia, surgery and indications for circulatory support. Professor Dargie also commented on draft notes for guidance on the development of medicinal products for the treatment of acute HF.

Influencing the heart failure agenda

This session highlighted the role of government, public health specialists, patients and local Health Authorities in improving HF services.

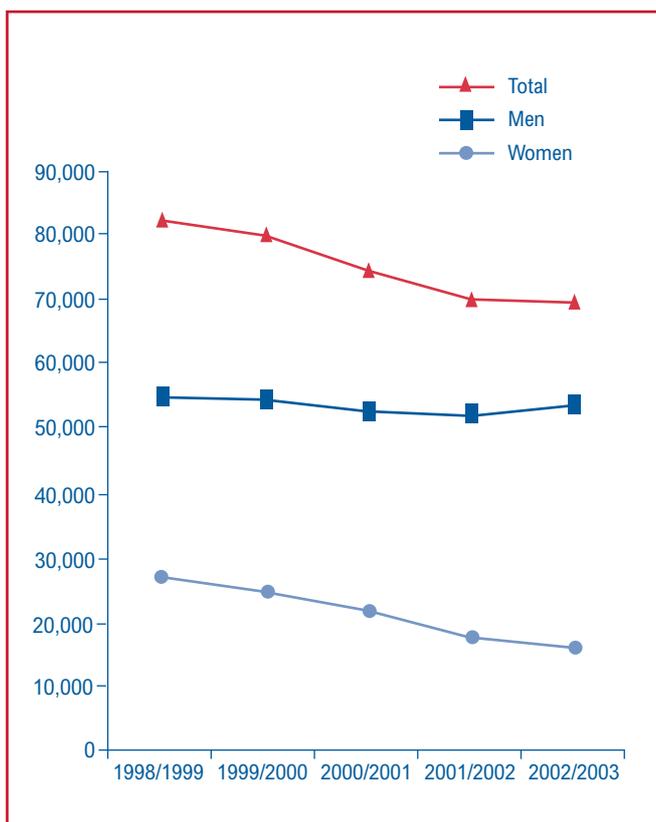
Role of government

Dr Roger Boyle, National Director for Heart Disease, outlined some of the national developments that have taken place since publication of the NSF, including the publication of the NICE guideline, the progress of the HF Workstream of the CHD Collaborative, the development of HF nurses and increased funding of HF research projects. He noted that additional echocardiography equipment is now available, although the greatest challenge in diagnostic services remains the availability of a trained workforce.

Although the emerging trends of improved treatment of MI and an ageing population suggest a large increase in chronic HF admissions in the future, this is not currently reflected in HES (hospital episode statistics) data (Figure 4), perhaps due to better treatment of HF, which is also reflected in the upward prescribing trends of cardiovascular drugs.

Despite the successes and clear evidence of improvement, Dr Boyle commented that much remains to be done in terms of diagnosis, treatment and supervision, as well as the introduction of new technology. Although we are in an era of reduced emphasis on national targets, one that is being enthusiastically pursued is the 18-week target from GP referral to treatment, which will require a greater emphasis on diagnostic pathways. Dr Boyle said that, “Provision of HF services is patchy across the country,

Figure 4. Admissions to hospital of patients with heart failure in England (HES data 1998–2003).



and it is clear that progress in HF has not been as marked as in other areas". He described the urgent need to develop the workforce, whether nurses, cardiac physiologists or cardiologists. However, he was encouraged by significant developments in HF, including the move toward chronic disease management, and a growing network approach to ensure consistency of care and collaboration across primary and secondary care.

Role of public health specialists

Dr Ellis Friedman (Director of Public Health, Burnley, Pendle and Rossendale PCT) presented an overview of HF from the perspective of a public health physician. He encouraged an improved focus on the psychological and mental health consequences of HF as there is significant morbidity associated with the disease. He also called for further improvements in palliative care and end-stage management. He re-emphasised the point that HF is best managed in a multi-disciplinary team and identified HF registers as a key factor in identifying at-risk groups in order to offer the best care to the population.

Dr Friedman commented on the excellent progress made in chronic disease management, which he hoped would encourage some healthcare professionals currently in secondary care into the community to share their expertise and knowledge. This approach will also encourage patient empowerment and the development of negotiated care plans. He also highlighted the new GMS contract as a significant step in offering further management improvements in HF. He concluded by noting that although we have an excellent evidence base in HF there are significant public health challenges in terms of improving diagnosis, treatment, monitoring and patient satisfaction.

Role of patient groups

Patient representative David Geldard (Manchester) highlighted the roles of Professor Henry Dargie, Dr Mark Dancy and Dr Roger Boyle in championing the cause of patient involvement and participation in HF management, in particular in developing the NSF. He described the HF patients' watchword as "Nothing about us, without us" and encouraged delegates to involve patients at every stage of their treatment in order to encourage effective self-management.

He noted that patients can help healthcare professionals in a number of ways, including making constructive criticism, providing encouraging feedback and assisting in the recruitment of other patients into clinical studies. He also highlighted the positive role of discovery interviews and focus groups in this process. Mr Geldard praised the moves toward a more patient-focused approach in HF, with services being redesigned with patients as the central focus. He also highlighted the role of the British Heart Foundation "Hearty Voices" campaign (<http://www.bhf.org.uk>), which provides support and training for people who

want to become involved in organisations and committees that represent the issues important to cardiac patients and their carers.

Role of local Health Authorities

Dr Iain Squire (Leicester) described the development of HF services in Leicestershire from 1998. A strategy document drafted in 2001 and updated in 2003 was based on data (such as first admissions, time to recurrent admission and mortality) that quantified the extent of the HF problems in the region. These data allowed good estimates of the costs of addressing these problems to be made.

Dr Squire described the CLINIC* trial, which is assessing the cost-effectiveness and acceptability of a nurse-led community clinic in managing patients with HF and the ability of specialist nurses (and GPs) to identify patients for whom echocardiography is appropriate. The ongoing trial has already shown the effectiveness of nurses in referring patients for echocardiography – between June 2002 and May 2003, two nurses referred 174 patients, 55% of whom were diagnosed with LV systolic dysfunction (LVSD). This compared very favourably to the 92 patients referred by GPs, of whom only 22% were diagnosed with LVSD.

The Leicestershire experience shows that nurse-led clinics can improve both the application of appropriate therapies and the assessment of patients with a diagnosis of HF. There is now a dedicated HF service across the region led by primary-care HF nurses, which includes an open-access secondary care HF clinic.

Dr Squire identified some key factors in establishing a HF service:

- availability of contemporary local epidemiological data
- identification of local requirements and justification for them
- partnership between health authority, primary and secondary care
- involvement of local/regional champions
- phased development of the strategy.

Getting the patient into the driving seat

Professor Stanton Newman (London) posed the question, "Can people care for their own health?" He demonstrated that providing the correct information to people does not necessarily lead to lifestyle changes. He pointed out that significant percentages of healthcare professionals do not follow their own guidelines in terms of self-prescribing and smoking, so how can patients be expected to follow their advice?

He suggested that the move away from the use of the term 'compliance' toward 'concordance' or 'adherence' is certainly a step in the right direction. However, answers do not lie in the provision of increased information – there is a need to change the relationship

between healthcare professionals and patients so as to address underlying beliefs about the condition and its treatment. This will include the development of models to encourage patients to take greater responsibility for their own self-management. This approach should build a greater confidence in patients' abilities to make life-improving changes (self-efficacy) and yield improved clinical outcomes. Improving self-management will demand significant changes from both patients and healthcare professionals in terms of changing the model of healthcare, learning new skills, reducing the dependency of patients and further use of group interventions for health education.

Wendy Gray (National Manager, CHD Collaborative – Discovery Interviews) presented the technique of discovery interviews, which is proving a powerful catalyst for change in service provision. The discovery interview is a useful tool that can be used alongside other resources and allows healthcare professionals to 'step into the shoes' of patients and carers to understand their experiences.

The technique involves use of a framework known as a 'spine' that allows the interviewee to be taken through a journey where they explore their (and their carers) experience of illness and not just its outcome. Interviews are transcribed with minimal edits and then shared with healthcare teams for the purpose of making changes in service provision to improve patients' experiences. The interviews often show that many of the most important issues for service users are those not always seen as priorities by managers and staff.

The interviews have identified some key issues that confirm other findings. Patients want to be seen as partners, they want a personalised service with integrated provision of care. They want easy access to high-quality, consistent information and need a focus on quality-of-life issues. Ms Gray commented that, "The power of the individual stories have proved a powerful motivation for change, puts the patient in the driving seat and provides the foundation for patient inspired improvements." A booklet on discovery interviews is now available.²⁵

Andrew MacKinnon (Birmingham) described the Expert Patients Programme managed by PCTs that provides practical skills and tools for patients with chronic illness to improve self-management. The Programme looks at the consequences of chronic illness and encourages the understanding that many day-to-day issues are common to all patients. A focus on problem solving, decision making and confidence building encourages behaviour-specific changes.

The Programme consists of a six-week course (2.5 hours a week) that is conducted in a relaxed atmosphere. Mr MacKinnon said that a wide range of patients with HF would benefit from the Programme and encourage the development of a partnership with healthcare professionals. A post-course questionnaire from the 10,000 patients

who have completed the course reveals some encouraging developments, including a 30% fall in feelings of depression, a 15% reduction in days off work, a 10% improved adherence to medication, and a 9% reduction in visits to GPs and outpatient departments.

A five-year vision for heart failure services

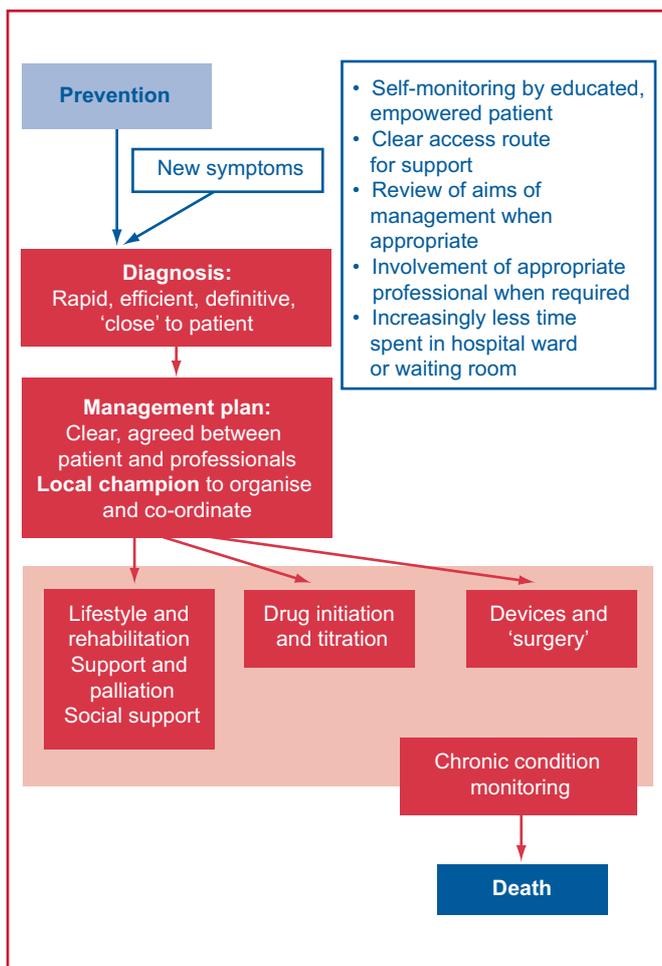
Professor Martin Cowie (London) set out his five-year vision for HF services. He presented his thoughts in the modern healthcare context, which recognises that a few patients with multiple chronic conditions consume most resources. Department of Health figures show that 5% of in-patients use 42% of total in-patient bed days. However, it was emphasised by a number of speakers during the conference that hospital treatment should not always be viewed as a poor use of resources.

Professor Cowie attempted to bring some balance to the role of evidence-based medicine. He reminded delegates of the challenges of interpreting trial data and of applying these data in practice, and suggested that the value of a trial is much reduced if its results cannot be communicated simply, as these results have to be applied by non-specialists. He also noted that bureaucracy in developing evidence-based guidelines, such as the grading of evidence, can distort the emphasis of care: many aspects of care are not amenable to randomised controlled trials, but are nonetheless important.

He emphasised the vital role played by the numerous guidelines (NICE, Scottish Intercollegiate Guidelines Network [SIGN], ESC and American College of Cardiology) in HF, and that the NSF has been a huge force for good in developing appropriate management. He also highlighted the development of new technology, including BNP in diagnosis, pacing devices, LVADs and bypass surgery, which have provided significant benefits to patients. However, he urged caution against the improper adoption of expensive technology before benefits have been established.

Professor Cowie suggested that the future of HF must be patient centred with supportive expertise being drawn in from a variety of professional groups as and when required in order to improve patient care and clinical outcomes. His vision of HF services (Figure 5) included the adoption of appropriate prevention strategies, but if HF develops, rapid and efficient diagnosis of HF is required with definitive results for patients, similar to that available for patients with chest pain. He recommended that significant resources should be allocated for identification of the type of HF, together with characterisation of co-morbidities and agreement of a management plan based on a multi-disciplinary approach. The case management philosophy is important, with a local champion, ideally a HF nurse specialist, ensuring tailored management of care and implementation of the components of the plan within the first few weeks of HF diagnosis.

Figure 5. A vision for heart failure services.



Management of this chronic condition should include a significant focus on rehabilitation and lifestyle support. Professor Cowie commented, "It is a scandal that we don't offer rehabilitation and exercise to HF patients". Greater emphasis on palliative care in HF is emerging, with the CHD Collaborative recently launching a comprehensive strategy entitled, "Supportive and palliative care for advanced heart failure".²⁶

Professor Cowie concluded that significant developments have been made in this area, in particular as HF is now recognised as a subspeciality in cardiology, and with the ongoing development of specialist HF nurses. He encouraged delegates to identify the positive changes they could make in their sphere of influence, whether small or large, and to continue to make a difference in the management of HF.

Breakout sessions

Breakout sessions were designed to give delegates an opportunity for detailed discussion on particular topics including chronic disease management, the use of information technology, medical guidelines to optimise care and supplementary prescribing, GPwSI and cardiac networks.

Supportive and palliative care in HF is being recognised as an increasingly important facet of the management of this long-term condition. A number of speakers welcomed the moves to broaden the perspective of palliative care to include more than just

patients with cancer. The sessions acknowledged the difficulties in predicting the prognosis of patients with HF and the importance of dealing with symptoms beyond those of the pain and breathlessness expected of this patient cohort. The Liverpool Care Pathway was highlighted as a well-tried end-of-life protocol worthy of piloting in this group, and other useful guidelines were presented.^{27,28}

In the session on **diagnosis**, Dr Theresa McDonagh (London) commented on the scale of the diagnostic burden of HF, which is approximately 50,000 per million population. At present, diagnosis of HF has a poor success rate in both primary and secondary care. Dr McDonagh discussed the importance of echocardiography and the growing role for BNP diagnosis.

Dr Jackie Taylor (Glasgow) described **chronic disease management** as, "A system of co-ordinated healthcare interventions and communications for populations with long-term conditions in which patient self-care is significant". She highlighted the impact of co-morbidity in HF. A recent study shows that 40% patients with HF have >5 non-cardiac co-morbidities and this group accounts for 81% of inpatient hospital days.²⁹ In addition, chronic obstructive pulmonary disease, renal failure, diabetes and depression are associated with hospitalisations.

Ms Amanda Parsons (London) highlighted the aim of **supplementary prescribing** as maximising benefits to patients and the NHS through increased flexible use of workforce skills, and decreasing doctors workload. Although the initial aim was to have 10,000 nurses trained by the end of 2004, there are currently only 2600 nurse supplementary prescribers in England. She described the importance of a written clinical management plan in ensuring the effectiveness of supplementary prescribing.

The session on **GPwSI** highlighted the need to move the delivery of HF care into the community to optimise treatment. This process is underway and will eventually mean that patients will be treated quickly without the need to attend hospital. Jan Procter-King provided details on the new national forum for GPwSI in cardiology (for more information email gpsicardiology@bradford.nhs.uk) and the postgraduate diploma in cardiology (for more information email psi@bradford.nhs.uk).

Clinical networks are defined as "Connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience". Janet Ratcliffe (Manchester) commented that a network's prime purpose is to improve services by considering the overall picture of a patient's journey through the healthcare system. For the first time, such networks offer a comprehensive set of shared resources under the direct control of clinicians and NHS managers. Clinical networks are in place or under development in many parts of the country and will provide a significant contribution to optimising HF care.

Trial acronym	Definition
BEST	The Beta-Blocker Evaluation Survival Trial
CIBIS II	The Cardiac Insufficiency Bisoprolol Study II
CIDS	Canadian Implantable Defibrillator Study
CLINIC	Clinics for Intermediate Review and Intervention by Nurse Specialists In Cardiology
COMPANION	Comparison of Medical Therapy Pacing and Defibrillation in HF
COPERNICUS	Carvedilol Prospective Randomised Cumulative Survival
DAVID	Dual Chamber and VVI Implantable Defibrillator
DEFINITE	Defibrillators in Non-Ischemic Cardiomyopathy Treatment Evaluation
DINAMIT	Defibrillators in Acute Myocardial Infarction Trial
MERIT-HF	MEtoprolol CR Randomised Intervention Trial in Congestive Heart Failure
MIRACLE-ICD	Multicenter InSync, Randomized, Clinical Evaluation-Implantable Cardioverter Defibrillator
MIRACLE-ICD-II	Multicenter InSync ICD Randomized Class II Clinical Evaluation
RHYTHM ICD	Resynchronization Hemodynamic Treatment for Heart Failure Management
SCD-HeFT	Sudden Cardiac Death in Heart Failure Trial
SENIORS	Study of Effects of Nebivolol Intervention on Outcomes and Rehospitalisation in Seniors with Heart Failure

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Obituary

Andrew MacKinnon

It was with great sadness that the BSH learned of the death of Andrew MacKinnon, one of the speakers at the BSH 7th Autumn Annual Meeting. He passed away in January.

Acknowledgements

The BSH is grateful to Abiomed, A. Menarini Pharmaceuticals, AstraZeneca, Bayer Healthcare, CHD Collaborative, GlaxoSmithKline, Medtronic, Myogen, Pfizer, Roche Diagnostics, Takeda and Wisepress for their contributions towards this meeting and to the **'Friends of BSH': A Menarini, AstraZeneca, Bayer Healthcare, GlaxoSmithKline, Medtronic, Pfizer, Roche, Servier UK and Takeda** for their continuous support throughout the year.

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