

picture of their care.

Put simply, the approach involves comparing the current way one provides and pays for support with what things would theoretically be like under a new, more flexible system. Year two of the project also examines new ways of commissioning and contracting for services, for people with long-term conditions who are eligible for the YOC tariff. A workshop has been held to look at new types of contracting and discuss options. As this work progresses the aim is to start trialling a new way of contracting in year 3.

Some early implementer teams are using computer simulation software and other methods to safely test out 'what if' scenarios, such as making changes that could improve care pathways for patients between various organisations.

A comprehensive audit undertaken by the North Staffordshire early-implementer site under the leadership of Dr Amit Arora, identified two key issues that have been fed into the national process.

The first of these was the important confounding effect of co-morbidity – for any given admission with a long-term condition, the time to the beginning of the RRR phase increased with comorbidity. It also increased with age. The second issue was a latent phase between the point that safe discharge to RRR could be anticipated – the “R” point – and the point at which it actually became medically safe for the patient to leave hospital – the liberation or “L” point. These findings are important, as they highlight the need to acknowledge medical complexity and multimorbidity in the modeling work being undertaken through NHSIQ and the fact that discharge to RRR can be anticipated in advance of the date it can safely be realized. Geriatricianly skill may well be required to negotiate both of these issues in practice.

As YoC and RRR progress, they are likely to have significant implications for the work that geriatricians do. We'll keep you updated through the newsletter.

Amit Arora
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Making sense of acute heart failure British Society for Heart Failure Conference Report

The 16th Annual Autumn Meeting of the British Society for Heart Failure (BSH) entitled “Making sense of acute heart failure”, was held on 28-29 November 2013 at the Queen Elizabeth II Conference Centre, London.

Over 700 delegates attended the meeting, which was introduced by BSH Chair Professor Andrew Clark.

Professor John McMurray (BHF Cardiovascular Research Centre, Glasgow) presented the 2013 ACCF/AHA HF guidelines on the “the hospitalised patient”. Other than venous thromboembolism prophylaxis, no treatment for acute HF is supported by Class 1 Level A evidence. He stressed the importance of up-titration of chronic HF therapies, such as angiotensin-converting-enzyme inhibitors (ACEi) or angiotensin receptor blockers (ARB), β -blockers, and mineralocorticoid receptor antagonists (MRA). Updated NICE guidelines for acute HF are currently in preparation.

Professor John Cleland (Imperial College, London) discussed triggers for hospitalisation. An identifiable

cause for decompensation is apparent in 60 per cent of cases, including pneumonia, ischaemia and arrhythmia.

Professor Theresa McDonagh (King's College Hospital, London) discussed in detail the National Heart Failure Audit for England and Wales. There have been improvements over the last year: in-hospital mortality fell from 11.1 per cent to 9.4 per cent, and the proportion of patients undergoing echocardiography and accessing specialist HF care has increased. However, 6.1 per cent of those who survived to discharge died within 30 days, with the risk doubling in patients not on ACEi/ARB at discharge.

Professor McMurray summarised recent RCTs in acute HF. The DOSE trial showed no difference in

high-dose vs. low-dose, or continuous vs. bolus intravenous diuretics. Serelaxin reduced dyspnoea but had no effect on early prognosis (RELAX-AHF); there was a reduction in all-cause mortality at 6 months. RELAX-AHF2 will evaluate this further. CARRASS-HF demonstrated no improvement in outcomes, with ultrafiltration compared to standard therapy. Similarly, the ROSE trial showed no benefit of low-dose dopamine (or nesiritide) on renal function or diuresis. In ASTRONAUT, aliskeren did not improve outcomes following discharge after a HF hospitalisation.

What does the future hold for acute HF? TRUE-AHF will investigate the novel natriuretic peptide ularitide following the disappointing results of nesiritide in ASCEND-HF. ATOMIC-AHF and COSMIC-HF will examine intravenous and oral forms of the cardiac myosin activator olmecamtiv mecarbil, which has shown improvement in cardiac function in small studies. Finally, SOCRATES will examine the effect of a novel soluble guanylate cyclase stimulator (BAY1021189).



Professor Sian Harding (National Heart & Lung Institute, London) gave the biennial Philip Poole-Wilson lecture, entitled β -blockers in heart failure:

active agents with unexplored potential". The lecture chronicled over 20 years of research into the cellular mechanisms through which β -adrenergic receptor subtypes influence cardiomyocyte function in health and disease, via divergent cardioprotective and cardiodepressive effects.

Professor Walter Paulus (VU University Medical Center, Amsterdam,

Netherlands), examined the predisposing factors and triggering events that lead to acute decompensation in patients with HF with preserved ejection fraction (HeFPEF). Professor Martin Cowie (Imperial College, London) discussed treatment of HeFPEF. ACEi and ARB, which are beneficial in HF with reduced EF, do not improve outcome in HeFPEF; however, patients with HeFPEF frequently have co-morbidities (e.g. hypertension or diabetes) that warrant treatment with these agents. Most recently, the TOPCAT trial demonstrated no effect of spironolactone on the primary composite endpoint of cardiovascular death or HF hospitalisation.

Throughout the two day conference, sessions focused on practical advice for delegates managing hospitalised heart failure. Speakers were invited from Cardiology, Heart Failure Specialist nurses, General Practice and Geriatric Medicine.

The BSH aims to provide high quality education in the management of heart failure. It provides Geriatricians an ideal opportunity to update their knowledge on all aspects of heart failure care. The BSH would welcome geriatricians to their meetings and as members. For more information please visit www.bgs.org.uk [Select Events].

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Further information

See bsh.org.uk for full list of references.

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Future BSH meetings:

- 6th Heart Failure Day for Training and Revalidation, 20th March 2014
- 4th Heart Failure Nurse Study Day, 21st March 2014
- 17th Annual Autumn Meeting, 27-28th November 2014

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