Acute heart failure: Stakeholder scoping workshop
Monday 2 July 2012, 1000-1300
The Derwent Room, NICE, MidCity Place, 71 High Holborn, London, WC1V 6NA

Summary notes

The stakeholder scoping workshop was held prior to the formal stakeholder consultation on the draft scope which will take place from 20 July until 17 August 2012.

The objectives of the scoping workshop were to:

- obtain feedback on the specified population and key clinical issues included in the first draft of the scope
- seek views on the composition of the guideline development group (GDG)
- encourage applications for GDG membership.

The scoping group (NCGC technical team, NICE AD, NICE GCM, NICE PPIP lead and the GDG Chair) presented a summary of the guideline development process, the proposed GDG composition and recruitment process, the role and importance of patient representatives on the GDG and the draft scope. The stakeholders were then divided into three subgroups, which included a facilitator and a scribe, and each group had a structured discussion based around pre-defined questions relating to the draft scope. Comments received from each subgroup discussion have been combined and summarised below.

No	Scope section	Stakeholders' feedback
3.1	**Epidemiology** Six broad subtypes of presentations: 1. acute de-compensated chronic heart failure 2. acute heart failure with hypertension 3. acute heart failure with pulmonary oedema 4. cardiogenic shock 5. high-output heart failure 6. acute right sided heart failure. Question: classification of acute heart failure is often divided into these six subtypes based on the description of	○ There was agreement that accurately classifying subtypes of acute heart failure is a difficult issue due to the paucity of evidence. ○ Clinically, diagnosis and management is done concurrently. Being specific about the subtype classification is important academically, but for the scope it would be better to mirror how patients present in A&E, rather than being specific about the subtypes upfront. ○ There was agreement that presentations of acute heart failure could be grouped into three clinical syndromes: I. Acute heart failure with pulmonary oedema II. Cardiogenic shock III. Acute right-sided heart failure. ○ 'Acute heart failure with hypertension' is rare therefore not necessary to list it specifically.

No	Scope section	Stakeholders' feedback
	the patient's condition. Do you agree with this classification?	
3.2	**Current practice** Question: Does diagnosis and management of patients occur mainly in secondary care?	○ GPs could potentially have a key role in recognising early signs of acute heart failure which could be life-saving. Therefore, indications for referral from primary care to secondary care could be specified. ○ The team that treats the patient in the first 24 hours, using optimal diagnostic and therapeutic strategy, would have the greatest impact on patient outcome.
4.1.1	**Groups that will be covered:** • Adults (aged 18 years of above) • Specific consideration for subgroups Question: Is this population appropriate?	○ There was agreement that the scope should only cover adults 18 years old and above.
4.1.2	**Groups that will not be covered:** • Children and young people under 18 • Pregnant women • Persons with congenital heart disease Question: Are these exclusions from the draft scope appropriate?	○ There was concern that excluding pregnant women could worsen their care, as many maternal deaths are due to mismanagement of common problems. ○ It may be better to remove pregnant women from the list of excluded groups and specify the caveats for their drug treatment, and that their long-term management would need to be referred to obstetric specialists. ○ There was agreement that the long-term management of people with congenital heart disease should not be covered in this guideline. ○ However, some congenital heart conditions can present in adulthood and be previously unknown. The guideline could not exclude this group of people. ○ Therefore it may be better to remove this population group from the list of groups not covered and specify that the long-term management of people with known congenital heart disease will not be covered.
4.2	**Healthcare setting** • Management in secondary care settings. • Emergency treatment in primary care Question: Are these the appropriate settings to consider?	○ The focus should be on hospital setting. ○ It was highlighted that acute decompensated heart failure is a condition that deteriorates over a time period and therefore primary care is also indicated. ○ Emergency treatment in primary care is relevant.
4.3.1	**Key clinical issues that will be covered**	○ Monitoring of heart rate and heart rhythm should be included. ○ Doppler and pulmonary artery catheter can be removed.

No	Scope section	Stakeholders' feedback
	Question: These are the key areas of clinical management that we propose to cover. Are these the correct areas to focus on? **a) Diagnosis, assessment and monitoring**	○ The organisation of care and transition are important issues so it would be useful to include a section on who will be performing the early stage diagnosis, assessment and monitoring, eg specialist HF unit comprised of specialist management team.
4.3.1	**Initial treatment** – Oxygen and ventilatory support – Renal support	○ Renal support is an important area and ultrafiltration is an emerging area that should be included.
4.3.1	**Mechanical support**	○ Mechanical cardiac support is an important area as it can be used in initial treatment to stabilise the patient. It is an emerging field that is changing practice.
4.3.1	**Treatment after stabilisation** - Pharmacological therapy - Surgical treatment - transition of care post acute phase -information needs of patients	○ It is important to compile the list of drugs used in acute heart failure (diuretics, opiates, etc) and look at the dose and route of administration. Pharmacotherapy would be very similar to the Chronic guideline, but treatment for new onset. ○ It was noted that some surgical treatment is performed percutaneously. ○ Coronary revascularisation and valvular surgery are important areas to include. ○ Palliative care may also be an important area to include as this is more relevant in the acute setting than the chronic. ○ Transfer of care back to the community was considered important. Aspects to cover included optimal discharge planning, medication pre-discharge, transfer to community cardiac teams, ○ Information needs already covered by the Chronic heart failure guideline is also appropriate for this population.
4.3.2	**Clinical issues that will not be covered** Question: Are these exclusions from the draft scope appropriate?	○ There was agreement that the scope should not cover the long-term management of underlying diseases and comorbidities. ○ There was agreement that perioperative acute heart failure would not be covered, but that postoperative heart failure or hospital-induced heart failure would fall under the clinical issues that will be covered.
4.4	**Main outcomes** • Mortality • Major cardiovascular event • Length of hospital stay • Re-admission rates • Adverse events	○ It is important to consider length of hospital stay and re-admission rates together. ○ These are the main outcomes to include.

No	Scope section	Stakeholders' feedback
	• Quality of life Question: Are there any other outcomes that should be considered?	
4.5	**Economic aspects** Question: Which practices will have the most marked/**biggest cost** implications for the NHS?	○ The timing of diagnosis (access to blood tests and echocardiography) and transition of care are areas that, if improved, could potentially have the biggest impact on cost for the NHS as could reduce the readmission rate for acute heart failure, as well as improving patient outcome. ○ Giving patients the right drugs at the right doses will improve clinical and cost-effectiveness. ○ Provision of acute coronary units and optimal stabilisation before discharge. ○ Use of BNP and echocardiography in diagnosis.
	General comments	○ The potential strength of this guideline would be to address the issue of rapid diagnosis as the first 24 hours are critical for patient outcome. ○ The guideline has the potential to address a gap in the organisation of care for patients to ensure they are discharged with the right drugs at the right doses to reduce recurrences. ○ Consideration is needed in terms of equity of care (elderly patients, language barriers, ethnicity, cognitive impairment and disability).
	Guideline Development Group composition What health professional expertise do we need on the Guideline Development Group? Do you agree with the proposed constituency?	○ There was agreement that the GDG should consist of physicians in: ▪ emergency medicine (note that 'A&E medicine' is historic term) ▪ critical care ▪ cardiology ▪ elderly care. ○ Acute medicine is a subspecialty in its own right and it would be useful to have this expertise on the GDG. ○ It would be difficult to recruit an intensive care nurse – one hospital-based heart failure nurse specialist would be adequate. ○ There was agreement that the following expert advisors should be co-opted: ▪ Cardiothoracic surgeon ▪ Pharmacist ▪ General practitioner. ○ A clinical biochemist and nephrologist should also be co-opted. ○ A hypertension/CVD specialist is not needed as a co-optee.

The meeting was closed by a brief summary of the key points discussed in each subgroup. Attendees were informed of the scope consultation dates and that GDG recruitment would happen simultaneously. Further comments on the scope and applications for GDG membership were encouraged.