For the treatment of	**Heart Failure**
Background	NHS Scarborough and Ryedale CCG (SRCCG) commissions' healthcare on behalf of its local population across primary, secondary and tertiary care sectors. Commissioning policy including clinical referral pathways and thresholds have been developed and defined using appropriate NICE guidance and other peer reviewed evidence and are summarised here in order to guide and inform referrers. This commissioning policy is needed in order to clarify the criteria for referral for Heart Failure.
Definition	**Clinician has reasonable suspicion of heart failure when the patient has symptoms of recent onset:** • Breathlessness on exertion or at rest • Orthopnoea or Paroxysmal Nocturnal Dyspnoea (PND) • Dependent Oedema in association with other heart failure symptoms **General points** • Symptoms are often non-specific and may not discriminate between heart failure and other problems • The majority of left ventricular systolic dysfunction is caused by ischaemic heart disease • Other causes for heart failure such as valvular heart disease, or cardiomyopathy should be detected through this pathway • Full history identifies previous cardiac problems (especially MI) and red flag symptoms • People with a pacemaker or other cardiac devices are at increased risk and can be referred through this pathway however if they have new symptoms and a normal BNP please contact the Cardiorespiratory department directly for pacemaker assessment • Medications particularly recent changes e.g. rate limiting calcium channel blockers or NSAID and previous chemotherapy • Clinical examination to identify signs of heart failure and red flag signs **Clinician has reasonable suspicion of heart failure when the patient has symptoms of recent onset:** • Breathlessness on exertion or at rest

	• Orthopnoea or Paroxysmal Nocturnal Dyspnoea (PND) • Dependent Oedema in association with other heart failure symptoms **Exclude Red Flag Symptoms and Signs where the Clinician should consider urgent Hospital Advice or Admission** • Severe SOB (NYHA III-IV) • New or escalating PND • Chest Pain and breathlessness • Tachycardia > 100 bpm or bradycardia <50 bpm • New onset AF • Hypoxia <95% • Syncope or hypotension systolic BP <90 mmHg • New heart murmur with heart failure symptoms • Patients with suspected heart failure and a previous MI should be referred urgently to Cardiology (NICE Quality Standard 2) via the RSS Heart Failure Pathway attaching an ECG
Management & Investigations	**Management & Investigations: Required before referral** • ECG to identify previous infarction, abnormal rhythm, (AF, heart block), LBBB and LVH • Blood tests:- FBC , U&Es, TFTs, LFTs, lipids and glucose/ HbA1c • CXR to exclude other causes of breathlessness • If there is a reasonable suspicion of heart failure then BNP should be requested (NICE Heart Failure Quality Standard 1) except with previous MI when refer urgently • Medical treatment should be offered with diuretics at this stage to improve symptoms **Outcome AFTER the results are available** • Patients with suspected heart failure and very high levels of NTproBNP > 2000 pg/ml should be referred urgently via RSS completing the Proforma stating URGENT • These high risk patients will all be offered an urgent echo , target within 2 weeks (NICE Quality Standard 2) and a specialist assessment arranged ONLY if the echo is abnormal, within 6 weeks. • If NTproBNP is elevated, 400-2000 pg/ml refer via RSS Heart Failure Service. Patients will be offered an out patient echo. This will be performed within 6 weeks (NICE Quality standard 4 six week assessment and diagnosis) • Patients identified with significant LVSD (left ventricular systolic dysfunction) will be referred directly to the Cardiology service from echo for specialist assessment and access to the MDT (NICE Quality standard 6). The patient and practice will be notified of the result of the Echo and the plan of action • Where Echo does not show any significant abnormalities the

	patient will be returned to primary care for further tests and consideration of other causes of raised BNP such as AF, ischaemia, right ventricular overload and PE, COPD, CKD, diabetes, age > 70, cirrhosis and heart failure with preserved systolic function (diastolic dysfunction) • NTproBNP levels of < 400pg/ml in an untreated patient make heart failure unlikely and other causes for breathlessness should be sought particularly anaemia and COPD • Obesity, diuretics, ACE and ARB, and beta blockers can all reduce levels but are unlikely to normalise levels in a symptomatic patient.
Referrals	• Indications for referral : Recent onset of symptoms and signs of Heart Failure • Information to include in referral letter : please complete all details on the proforma • Investigations prior to referral: ECG, FBC, U & E, TFT, LFT, Lipids and glucose/ HbA1c, BNP, CXR • Referral Criteria PMH MI, or high NTproBNP (> 2000pg/ml) for URGENT referral via RSS • NTproBNP 400 - 2000pg/ml , no other cause and suitable to refer on the Cardiology, refer via RSS for echo and direct referral on to Cardiology if Echo abnormal • NTproBNP <400pg/ml clinical signs of heart failure, known condition which causes heart failure and abnormal ECG referral can be considered directly to cardiology. • This pathway is targeted at the detection of Left Ventricular Systolic Dysfunction (LV Ejection fraction <40%) where there is a strong evidence base for therapy, and structural causes of heart failure which may require intervention.
Patient Information	• Appropriate information will be given in clinics and by heart failure specialist nurses should the diagnosis be confirmed
Date reviewed	
Next Review Date	2019
Contact for this policy	CCG Service Improvement Team scrccg.rssifr@nhs.net

References:

- NICE Chronic Heart Failure Overview Pathway http://pathways.nice.org.uk/pathways/chronic-heart-failure last updated 16 March 2017
- Chronic heart failure: management of chronic heart failure in adults in primary and secondary care. NICE clinical guideline 108 (2010) http://guidance.nice.org.uk/CG108
- NICE Chronic Heart Failure in Adults (QS9) published June 2011 updated February 2016
- 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure European Heart Journal (2016), 2129-2200
- NYHA classifications http://www.gpnotebook.co.uk/simplepage.cfm?ID=523567156

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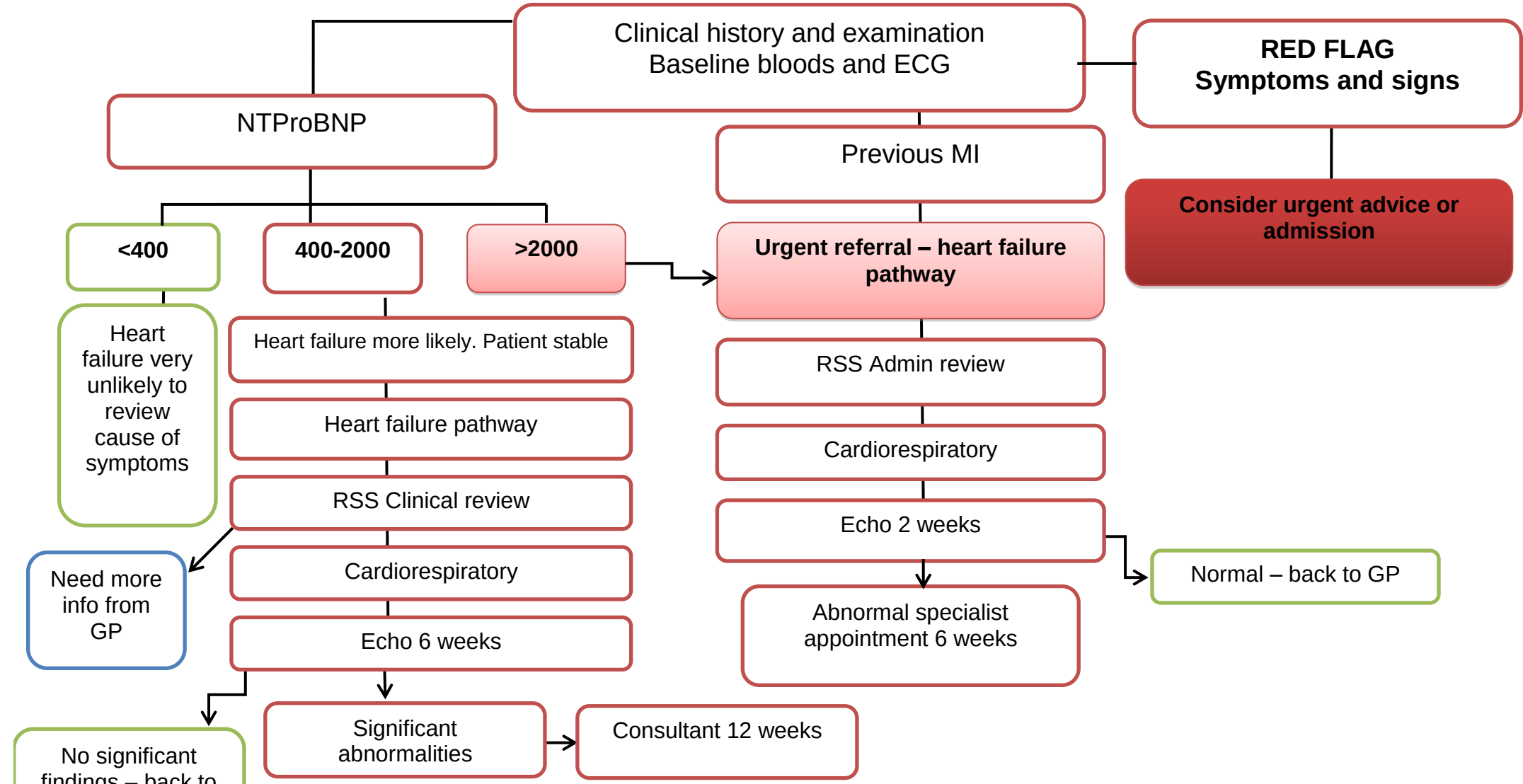
PATIENT WITH HEART FAILURE SYMPTOMS



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Responsible GP – Dr Greg Black & Dr Kathryn Griffith	Approved:
Responsible Consultant – Dr Tim Houghton	Date published:
Responsible Pharmacist – Ms Rachel Ainger, SRCCG Medicines Mngt	NHS Scarborough & Ryedale Clinical Commissioning Group

New York Heart Association (NYHA) Classifications used to grade the severity of functional limitations in a patient with heart failure		
Class I	**No limitation of physical activity**	Ordinary physical activity does not cause fatigue, breathlessness or palpitation (includes asymptomatic left ventricular dysfunction)
Class II	**Slight limitation of physical activity**	Patients are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, breathlessness or angina pectoris (symptomatically 'mild' heart failure)
Class III	**Marked limitation of physical activity**	Although patients are comfortable at rest, less than ordinary activity will lead to symptoms (symptomatically 'moderate' heart failure)
Class IV	**Inability to carry out any physical activity without discomfort**	Symptoms of congestive cardiac failure are present even at rest. Increased discomfort with any physical activity (symptomatically 'sever' heart failure)