Breaking the cycle: Tackling late heart failure diagnosis in the UK

Roche

Diagnosis of heart failure is often complicated in areas of high deprivation, often linked to higher prevalence. This increases late and misdiagnosis, thereby adding unnecessary pressure to already strained systems.

LACK OF ADHERENCE TO NICE GUIDELINES FOR CHRONIC HEART FAILURE[ii]

18.3% of heart failure patients had an NT-proBNP test recorded.

POORER PATIENT OUTCOMES[i]

Patients with breathlessness experience an average 2 year wait for diagnosis

50% mortality rate within 5 years.

HIGHER MISDIAGNOSIS RATES[iii]

Around 1 in 3

of heart failure patients are misdiagnosed, this rises to 43.9% in those under 45.

ADDITIONAL PRESSURE ON HEALTHCARE SYSTEM[iv]

1m inpatient days

5% of unplanned admissions per year

2% the total NHS budget

HIGHER RATES OF LATE DIAGNOSIS[v]

80% Diagnosed in emergency settings

Despite 40% having symptoms earlier

Current NICE guidelines for chronic heart failure in adults are not being followed universally, including using NT-proBNP tests which can rule out the need for an echocardiogram.

Cost/patient [vi]

£337 An echocardiogram

£28 NT-proBNP test

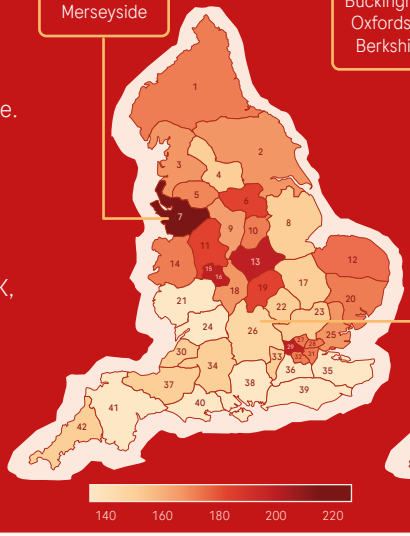
172,000 people in England were waiting for an echocardiogram in May 2022 - the highest recorded level.[vii]

Regional inequalities:[viii]

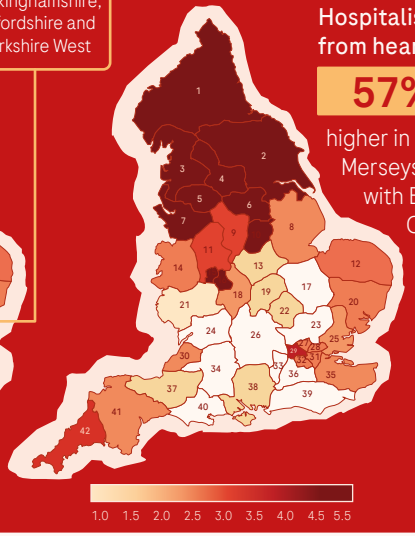
People of a lower socio-economic background are more likely to suffer and die from more severe instances of heart failure.

Average survival length after a diagnosis of heart failure **4.6 years** in the least deprived areas of the UK, and **4.1 years** in the most deprived areas[ix]

HEART FAILURE ADMISSIONS PER 100,000



INDEX OF MULTIPLE DEPRIVATION BY QUINTILE
(1= LEAST DEPRIVED, 5 = MOST DEPRIVED)



Hospitalisation rates from heart failure 57% higher in Cheshire and Merseyside, compared with Buckinghamshire, Oxfordshire and Berkshire West

[i] Taylor et al, 2019. Trends in survival after a diagnosis of heart failure in the United Kingdom 2000-2017. Population based cohort study. Available on bmj.com. [ii] IQVIA Medical Research Data, IQVIA Ltd, incorporating data from THIN, a Cegedim database, 2011 – 2021. [iii] Taylor et al, 2019. Trends in survival after a diagnosis of heart failure in the United Kingdom 2000-2017. Population based cohort study. Available on bmj.com. [iv] Focus on Heart Failure, 2016. APPG on Heart Disease. Available on bhf.org.uk. [v] NHS England, 2019. NHS Long Term Plan. Ch3, Cardiovascular disease. Available on longtermplan.nhs.uk. [vi] NHS England, National Cost Collection for the NHS, 2022. Available on england.nhs.uk. [vii] NHS England, 2022. Diagnostics Waiting Times & Activity. Available on england.nhs.uk/statistics [viii] Fingertips Public Health England data, various sources [ix] Taylor et al, 2019. Trends in survival after a diagnosis of heart failure in the United Kingdom 2000-2017. Population based cohort study. Available on bmj.com.

Breaking the cycle: Our recommendations to drive change

It is essential that partners from across the heart failure pathway come together and prioritise early diagnosis

NHS ENGLAND

NHSE should **prioritise CVD and heart failure as part of their upcoming Long Term Plan refresh,** with specific targets and milestones (akin to those already in place for stroke and cardiac arrest), to ensure ambitions outlined in the original plan remain a commitment.

The Network Contract Directed Enhanced Service (DES) for 2023/24 must **financially incentivise heart failure** in line with other key health areas to **ensure greater provision and prioritisation** of heart failure early diagnosis and management.

The **BEAT symptom checker –** Breathlessness, Exhaustion, Ankle Swelling, Time for a simple blood test – should be **universally agreed upon, recognised,** and promoted at all levels of the NHS.

HEALTH EDUCATION ENGLAND

Training for healthcare professionals should **promote the value of NT-proBNP testing** and the **appropriate diagnostic pathway in line with NICE.** Specific focus should be applied to ensuring detailed knowledge of the signs and symptoms of heart failure, including the risk of heart failure in women.

PRIMARY CARE NETWORKS AND CARDIAC NETWORKS

Cardiac Networks should **introduce breathlessness pathways using NT-proBNP testing** in line with NICE recommendations and work with PCN CVD leads to improve the early identification of patients with potential heart failure.

Collaboration between patient organisations, industry and the NHS should be prioritised to **ensure those who typically receive inequitable outcomes in healthcare receive quality resources and information on heart failure.** Patients should feel empowered to seek investigation from their GP if they have concerns.

INTEGRATED CARE SYSTEMS AND INTEGRATED CARE BOARDS

ICBs, PCNs and Cardiac Networks should work collaboratively to **ensure NT-proBNP testing is accessible** across primary care and in community diagnostic centres to ensure patients suspected of heart failure have timely access to testing that can inform whether an echocardiogram is needed.

Further **evaluation and adoption of digital technologies,** including **artificial intelligence** (AI) and **portable echocardiography,** to support earlier diagnosis of heart failure.

Industry should collaborate to **provide essential capacity and resource support** to system leaders and advocates, including information, research and tools that will **drive improved outcomes for people with heart failure.** This should focus on the entire patient pathway, from prevention and diagnosis, through to treatment.

These recommendations were developed by Roche Diagnostics based on the outcome of the *Breaking the cycle* report

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