February 2017

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Accordion:
NHS Lothian optimisation/ development of enhanced heart failure service

Project name: NHS Lothian optimisation/ development of enhanced heart failure service

Project period: February 2017 – April 2018

Project summary:

NHS Lothian is committed to optimising the Heart Failure patient journey. The Heart Failure team conducted a detailed scoping exercise of existing services, together with an audit of HF admissions over a 6 month period at two major hospital sites in Lothian (Edinburgh Royal Infirmary and St John's Hospital, Livingston).
The results indicated that the current service needs further development and greater support. In particular the audit identified an inequity of Cardiology input prior to discharge and a variance in the rate of readmission of Heart Failure patients.
The objective of the project is to introduce a hospital-based specialist HF service for patients admitted to Edinburgh Royal Infirmary (a large university teaching hospital and tertiary cardiology centre) for treatment of HF. The service will focus on prompt diagnosis, early treatment, rapid access to specialist care and planning for post-discharge monitoring and follow-up. The key priorities and aims for service development are:
1. To improve and streamline three phases of HF management related to an acute episode: the emergency treatment phase, the in-hospital phase and the discharge planning phase.
2. To increase the proportion of patients with HF who receive specialist review and ongoing follow-up in a specialist disease-management programme.
3. To improve compliance with the SIGN guideline 147 and provide a quality, person centred service.

Expected Patient Outcomes for this Project:

The expected outcomes from the project will be as follows, for patients admitted to Edinburgh Royal Infirmary for treatment of HF:
• Increase (by a mean of 2 days) the number of days spent alive and out of hospital at 90 days (this metric captures index length of stay, readmissions and mortality in a single summary measure)
• Reduce 30 and 90 day readmission rate by 25%
• Reduce total inpatient bed days for HF by at least 10%

• Increase the proportion of patients with LVSD receiving guideline-directed pharmacological therapies at 30 and 90 days post-discharge.

To assess the global impact of the intervention and to avoid any confounding influence from referral bias we will compare outcomes for all patients admitted with heart failure (irrespective of whether they are referred to the service) for 12 months prior to and following implementation of the new service. Patients with any ICD-10 discharge diagnostic code corresponding to heart failure during this period will undergo screening of electronic patient record. Only those in whom heart failure is deemed to have been the primary reason for admission will be included in the analysis.