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Designing a Hospital Cardiology Outreach Service

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The cardiology team at Sheffield Teaching Hospitals NHS Foundation Trust successfully designed and implemented an outreach service for heart failure patients in non-cardiology wards (National Institute for Health and Care Excellence 2014a). The service was required as cardiologists care for around 18-25 percent of heart failure patients, while 75-78 percent are under the care of non-cardiologists. In addition, outreach is recommended in the UK National Institute for Health and Care Excellence (NICE)'s acute heart failure guidelines (NICE 2014b). *HealthManagement.org* spoke to consultant cardiologist and service lead, Dr. Abdallah Al-Mohammad, to find out more.

How were cardiac patients in non-cardiac inpatient settings treated before the heart failure outreach service was set up?

Prior to the establishment of the heart failure multidisciplinary team meeting and ward rounds, patients with heart failure admitted into non-cardiac beds were treated by their physicians, who were attempting to follow the guidelines while addressing the multiple co-morbidities that these patients frequently have. However, not infrequently, the majority of these patients (72-75 percent) were not receiving evidence-based therapy mandated for those patients with heart failure with reduced left ventricular ejection fraction (HFREF). The chief reasons for the low uptake of these medications were concerns about low blood pressure and abnormal renal function in addition to remaining doubts amongst some physicians about the wisdom of beta-blockers in certain subgroups of patients with heart failure.

Why did you decide to set up a heart failure outreach service?

As a tertiary cardiac centre our specialist beds are in significantly high demand, preventing us from accommodating all patients with heart failure within our bed complement. In addition, I was dismayed by the very low percentage of uptake of therapies such as ACE inhibitors and beta-blockers amongst the patients with heart failure admitted under the care of non-cardiologists (these patients constitute the majority of the patients with heart failure in our hospital). I proposed that one could take cardiology expertise to these patients without taking over their care. Thus, we provide these patients with cardiology opinion and advice, while keeping them under the care of their respective physicians, who are best suited to look after their other co-morbid conditions. Thus we avoid using our tertiary centre cardiology beds for those with heart failure who do not require non-pharmacological cardiac interventions.

How did you set out to design this service? Who was involved?

I started by gathering support for the idea of the creation of a new heart failure service within my departmental management team. We then presented a paper outlining the aims of the service to the hospital's management team. The hospital's management set up a project that included two interested cardiologists, three general physicians (one diabetologist and two geriatricians), a nurse director, a nursing matron and a

manager. We set out the vision of the project based on my suggestions, and then we were tasked with looking into the steps needed to create the collaborative type of service that could work across departmental borders, with the aim to provide patients with heart failure who are under the care of non-cardiologists with the cardiology expertise needed to afford them the best evidence-based treatment for their heart failure.

We concluded after a few months with a service design that was agreed with the department of medicine and with the hospital management before we started applying the agreed changes. We appointed more heart failure specialist nurses and trained the general medical nurses, who will look after the majority of the patients. We tried to concentrate the patients in a geographical area within the department of medicine.

What did you perceive as the main barriers and challenges to setting up this service?

Physicians are naturally independent medical practitioners. While they welcome the help of certain specialists when they ask for that help, the model of our heart failure multidisciplinary team dictates in addition to responding to referrals from the physicians and the nurses in the general medical ward that we also seek out potential patients with heart failure even if not formally required to do so. In addition, our participation included further involvement with and advice provided to the patients and their caring nursing and medical teams without necessarily being asked to do so. Winning the trust of all these practitioners was at times difficult and required patience and perseverance along with exercising the utmost respect to the integrity and the independence of the caring doctors and their teams.

The service significantly increased my personal workload as I continued to provide general and specialist cardiology care to my own patients. Subsequently I was able to demonstrate that more help was needed to enable me to deliver the service that expanded significantly over time. Now the heart failure multidisciplinary team ward rounds are delivered by four cardiologists (instead of just one - I was doing this alone for a considerable length of time). We are about to expand the team to five cardiologists.

What are the critical success factors for this service?

- Collaboration and trust that was built with the physicians delivering the care to the majority of the patients with heart failure;
- Team working environment with the nurses and the administrators as well as the managers in the heart failure service;
- Continuing involvement of the managers and representatives of all those involved in a monthly meeting to manage any difficulties that may arise in the conduct of the service;
- Perseverance and commitment by the heart failure nurses and the cardiologists with an interest in heart failure;
- Creation of a learning environment for both the heart failure nurses and the junior cardiology staff attached to the team.

What makes for successful inter-departmental collaboration? How did you gain acceptance and get buy-in from other clinicians?

- Proving to colleagues that all I needed was to simply help them better manage their patients' conditions with no personal agenda beyond that;
- Proving to colleagues that the involvement of the HF team had actually resulted in better therapeutic uptake and better outcomes for the patients;
- Respecting everyone involved in the delivery of care for these patients as equal partners and avoidance of any implication that may be perceived as undermining their work or their authority;
- Setting up an annual meeting for the service where all those involved are invited to attend a review of the achievements by the service and the difficulties faced or perceived in order to openly discuss those and consider solutions.

You increased staffing for this service after the initial setup. What factors make this service sustainable?

We monitor the performance of the service and the difficulties encountered by the members of the team, and we attempt to persuade the management that further increases in the number of staff are genuinely required. We also work with the management on ways to ensure the best efficiency is achieved by the team prior to expansion as well as looking at ways to make any increase in the staff justifiable and paid for through improved direct or indirect productivity.

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