

Empowering care at home: Boosting clinician confidence and Patient outcomes with a Hospital-at-Home Heart Failure bundle

Dr Sovrila Soobroyen | Lead GP for One Bromley H@H
Dr Talitha Cosh | Gp SpR Bromley GP Alliance
Dr Lynette Linkson | Clinical Director for One Bromley H@H

Results

Between February 2023 and May 2024, **48** unique patients were seen (mean age 81, 28 hospital step-downs, 20 community step-ups). Initial clinician surveys showed **83%** lacked confidence, **75%** struggled with diuretic titration, and **60%** unsure about optimising prognostics. Baseline data from February 2023 to January 2024 showed an average LOS of **13 days** and a readmission rate of **15.7%**. Post-bundle implementation, average LOS reduced to **10.95 days**, and readmission rates dropped to **7%**. Clinician surveys reported increased confidence, and over 90% of service users rated their care as excellent.

Conclusion

The implementation of our HF bundle significantly **improved clinician confidence**, **halved readmission rates**, and **reduced LOS**, thereby increasing patient throughput and service capacity, and achieving a **41% reduction in cost per bed-day**. The study also contributed to the development of a dashboard to continuously monitor the effectiveness of these interventions and highlight areas of further development.

Introduction

Hospital-at-Home (HaH) is an **innovative** care model delivering hospital-level care to community patients. A key priority for Bromley HaH has been to streamline strategies, providing **integrated, individualised** care for patients with heart failure (HF). Our study revealed that our length of stay (LOS) exceeded the 7-day target, and readmission rates surpassed the 0-10% target. Recognising the complexities of managing HF in the community, we evaluated the impact of a new HF bundle to enhance clinician confidence, reduce LOS, and improve outcomes and service capacity.

Method

An adapted HF bundle was developed in **collaboration** with local cardiologists to integrate services. The bundle included standardised assessment/management tools, technology-enabled care (point-of-care and remote monitoring), and clear discharge criteria. It was implemented alongside departmental teaching, HF clinic/MDT attendance for experiential learning, and weekly consultant-led MDMs to build confidence. Retrospective data was collected before and after the bundle's introduction to assess impact on LOS and readmission rates.

