## Heart Failure Methodology

The National Heart Failure Audit collects data on all patients with an unscheduled admission to hospital in England and Wales who have a death or discharge with a diagnosis of heart failure in the primary position (i.e. heart failure is the main condition treated or investigated during the episode of care) with the following ICD-10 codes:

- I11.0 Hypertensive heart disease with (congestive) heart failure
- I25.5 Ischaemic cardiomyopathy
- I42.0 Dilated cardiomyopathy
- I42.9 Cardiomyopathy, unspecified
- I50.0 Congestive heart failure
- I50.1 Left ventricular failure
- I50.9 Heart failure, unspecified.

Patients admitted for elective procedures, for example elective pacemaker implantation or angiography, are not included. Patients must be 18-years and over to be eligible for inclusion in the audit.

Patients who are discharged alive with a length of stay of less than one day e.g., those who may have been treated in an Ambulatory Care Facility in the hospital, are included in the numerator and denominator for participation. However, they are excluded from the quality improvement aspects of the audit, as they do not remain long enough in hospital for the KPIs to be collected. They are tracked for mortality.