# Review of Cardiac Rehabilitation Provision in Cheshire & Merseyside 2014

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Authors: Louise Vernon; Dawn Hannah; Ruth Grainger

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## EXECUTIVE SUMMARY

The need for a scoping exercise to review the provision of cardiac rehabilitation services for patients admitted with coronary heart disease and following acute heart failure, across Cheshire & Merseyside, was identified as one outcome of the Strategic Clinical Network cardiovascular disease (CVD) work programme 2014-16.

Identified high level outcomes were to increase cardiac rehabilitation for patients admitted with coronary artery disease >65% and increase by >33% for patients admitted after heart failure.

To achieve the high level outcomes there are key deliverables required to ensure patients are receiving a high quality, equitable service;

- There must be an increase in the number of patients being offered cardiac rehabilitation
- There must be an increase in the number of patients completing cardiac rehabilitation
    - Resulting in a reduction in re-admissions (further cardiac event) and increasing patient satisfaction of the cardiac rehabilitation service received

Main Findings;

- The majority of services are menu based (Refer to Section 2)
- Services waiting times on the whole are within the NICE guidance – an area for sharing best practice or could be used for a business case for more staff?
- Majority of services include heart failure patients – why is there variance?
- Majority of services submit to the national audit of cardiac rehab (NACR) – why is there variance?
- Teams are offering cardiac rehabilitation to patient groups when it has not been commissioned
- Cardiac rehabilitation for Acute Coronary Syndrome (ACS), revascularisation and valve replacements are the most widely offered services, followed by stable angina, heart transplant and Implantable Cardioverter Defibrillator (ICD) implant, then heart failure, Grown Up Congenital heart disease (GUCH), and other cardiac conditions
- Teams are using NACR however there are missing data in terms of numbers of referrals, type of disease and reason for non-attendance or drops offs – data quality issues still present. There still remains resource /data quality/confidence with NACR.
- Apparent gaps in monitoring complying with NACR may offer an opportunity to develop a more in-depth understanding of services. Commitment to NACR required

- The offer of cardiac rehabilitation provision needs to match future needs of Cheshire and Merseyside population.

## 1. INTRODUCTION

This report has been prepared on behalf of the Cheshire & Merseyside Strategic Clinical Network to present scoping data to allow benchmarking of the provision of cardiac rehabilitation services.

The information contained in the report was gained through meetings with Cardiac Rehabilitation Leads and the completion of a scoping template regarding individual service specification. The report has been produced collaboratively between the North West Commissioning Support Unit (NWCSU), Cheshire and Merseyside Strategic Clinical Networks (CMSCN).

Linked to this, the Strategic Clinical Networks also commissioned a report in July 2014 to scope the provision of heart failure services in Cheshire & Merseyside. This demonstrated that the prevalence of heart failure is expected to rise as a result of an ageing population, improved survival of people with ischaemic heart disease and more effective treatments for heart failure (National Institute of Clinical Excellence (NICE) clinical guidelines 108, 2010).

This also follows on from a previous Network report in 2013 for which a task and finish cardiac rehabilitation group was formed in September 2012. The purpose of which was to address the shortfall in provision and improve access to cardiac rehabilitation for heart failure groups and other patient groups who did not fall into the mainstream of rehabilitation. This report commented on the number of providers who exclude certain diagnoses from (then) phase 3 rehabilitation, for heart failure was 15% in the 2012 report which has again fallen by a small margin to 14% in 2013[2].

Furthermore the numbers of hospital admissions due to heart failure are projected to rise by 50% in the next 25 years[1]. It is important therefore to have an understanding of current levels of activity and prevalence related to heart failure so that an accurate assessment on current position can be made and planning for the future can be developed, which includes the rehabilitation of these patients.

1. Owen et Al, 2006

2. The National Audit of Cardiac Rehabilitation Annual Statistical report 2013

## 2. CARDIAC REHABILITATION INTRODUCTION

Cardiac rehabilitation is described as a clinically supervised programme consisting of:

- a medical assessment to determine risk factors, patient needs and limitations
- a menu-based programme covering six components, namely:
    1. lifestyle
    2. risk factor management
    3. cardio-protective drug therapy and implantable devices
    4. psychosocial status and quality of life
    5. education
    6. long-term management.

The Department of Health's Commissioning pack on cardiac rehabilitation describes cardiac rehabilitation along a best practise care pathway using stages, rather than phases which has been used in the past and is still used currently in areas in Cheshire & Merseyside. The stages are reflective of the core stages in cardiac rehabilitation and are;

| | |
|---|---|
| Stage 0 | Identify and refer patient |
| Stage 1 | Manage referral and recruit patient to cardiac rehabilitation programme |
| Stage 2 | Assess patient for cardiac rehabilitation |
| Stage 3 | Develop patient care plan |
| Stage 4 | Deliver comprehensive cardiac rehabilitation programme |
| Stage 5 | Conduct final assessment |
| Stage 6 | Discharge and transition to long term management |

These stages are referred to in this report.

Rehabilitation can have a major impact on mortality, quality of life and long term costs. For example cardiac rehabilitation reduces all-cause mortality by 18% over 6-12 months and 13% over 12 months and readmissions by 31% (over 6-12 months[3].

It has to be recognized that currently, access to rehabilitation services varies nationally. At present only 44% of cardiac patient's access rehabilitation services. Department of Health analysis of NACR has identified that if this was extended to 65% of those estimated to benefit from rehabilitation, this could result in 380 fewer deaths and 1800 fewer hospital readmissions per year.

One of the areas with the greatest scope for improvement is in the provision of cardiac rehabilitation services to heart failure patients which currently make up only 2% (nationally) of the primary diagnosis[4].

Following the 2013 Annual Statistic Report from NACR is has been stated that 46% of patients reported with co-morbidities, which links to comments in the Cardiovascular Disease Outcome Strategy that there is a case for a more generic approach to rehabilitation.

3. Department of Health, Cardiovascular Disease Outcomes Strategy, chapter 5: Living with cardiovascular disease and end of life care 2013

4. National Audit of Cardiac Rehabilitation Annual Statistical Report 2013

## 3. DRIVERS FOR CHANGE

**The NHS Operating Framework 2014/5 states;**

***Domain 1 Preventing people from dying prematurely***

1a Potential years of life lost from causes considered amenable to healthcare

1b Life expectancy at 75

Reducing premature mortality from major causes of death

1.1 Under 75 mortality rate from cardiovascular disease

***Domain 2 Enhancing quality of life for people with long-term conditions***

2 Health related quality of life for people with long term conditions.

Ensuring people feel supported to manage their condition

2.1 Proportion of people feeling supported to manage their condition

***Domain 3 Helping people recover from episodes of ill health or following injury***

Helping older people recover their independence after illness or injury

3.6i Proportion of older people (65 and older) who were still at home 91 days after discharge from Hospital into reablement/ rehabilitation service

3.6ii Proportion offered rehabilitation following discharge from acute or community hospital.

***Domain 4 Ensuring that people have a positive experience of care***

Improving people's experience of integrated care

4.9 People's experience of integrated care

**CVD Outcome Strategy (2013)**

The CVD outcome strategy states that reductions in mortality and CVD events are the outcomes expected as a result of better control of risk factors.

The current problem is that patient outcomes are sub-optimal due to variation in the percentage of acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and percutaneous coronary intervention (PCI) patients receiving cardiac rehabilitation.

Nationally the scale reflects that 44% of patients receive cardiac rehabilitation which is below that which is reasonably expected of 65%, and it is estimated that the vast majority of heart failure patients do not receive cardiac rehabilitation.

The ambition of the strategy is to increase provision of cardiac rehabilitation to 65% for AMI, CABG and PCI patients and to increase provision from around 4% to 33% for heart failure patients.

**NICE Commissioning Guide – Cardiac Rehabilitation Services (Nov 2013)**

This guide comments on the new structure of clinical commissioning groups (CCGs) and NHS England working closely with Strategic Clinical Networks for CVD to improve Cardiac Rehabilitation. It includes a commissioning and benchmarking tool to determine the level of service that might be needed locally and commented on whether commissioners may wish to consider working with clinicians when using the CQUIN (Commissioning for Quality and Innovation) payment framework, to include the referral of cardiac rehabilitation as a clinical measure or discharge bundle as part of a CQUIN scheme for AMI or heart failure, and/or assessment of achievement

This guide also comments on using an integrated approach to commissioning high quality integrated cardiac rehabilitation, and considers the whole care pathway for cardiovascular disease and long term conditions.

**National Audit of Cardiac Rehabilitation (NACR)- Annual Statistical Report (2013)**

This is the final year of reporting at strategic health authority (SHA) level (data for 2013 report is taken from 2011-12), then reporting will change to Clinical Commissioning Group (CCG) level. NACR have developed a new platform alongside the health and social care information center (HSCIC) to ensure cardiac rehabilitation is fully embedded into the NHS accountability agenda, through which CCG's can benchmark how local services are performing.

**British Association for Cardiovascular Prevention and Rehabilitation (2012)**

*The seven core components of cardiac rehabilitation are stated as*;

1. The delivery of the seven core components employing an evidence-based approach.
2. An integrated multidisciplinary team consisting of qualified and competent practitioners, led by a clinical coordinator.
3. Identification, referral and recruitment of eligible patient populations.
4. Early initial assessment of individual patient needs in each of the core components, on-going assessment and reassessment upon programme completion.
5. Early provision of a cardiac rehabilitation programme, with a defined pathway of care, which meets the core components and is aligned with patient preference and choice.
6. Registration and submission of data to the National Audit for Cardiac Rehabilitation (NACR).
7. Establishment of a business case including a cardiac rehabilitation budget which meets the full service costs.

*The seven core components of cardiac rehabilitation as defined by BACRP Cardiovascular Disease and Prevention model are;*

1. Health behaviour change and education
2. Lifestyle risk factor management
   - Physical activity and exercise
   - Diet
   - Smoking cessation
3. Psychosocial health
4. Medical risk factor management
5. Cardio protective therapies
6. Long-term management
7. Audit and evaluation

## 4. CURRENT PROVISION IN CHESHIRE & MERSEYSIDE

| Name of Provider | Primary/Secondary/ Tertiary | Known as: |
|---|---|---|
| Aintree University Hospitals NHS Foundation Trust | Secondary Care | Aintree Hospital |
| Cheshire West and Cheshire NHS | Secondary Care | Countess of Chester Hospital |
| East Cheshire NHS Trust | Secondary Care | Macclesfield Hospital |
| Knowsley Community Cardiovascular Disease Service ( Provided by LHCH) | Primary Care | Knowsley CVD Service |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | Tertiary | LHCH |
| Mid Cheshire Hospitals NHS Foundation Trust | Secondary Care | Leighton Hospital |
| Royal Liverpool and Broadgreen University Hospitals NHS Trust | Secondary Care | RLBUHT |
| St Helens (Bridgewater Community) | Primary Care | St Helens (Bridgewater Community Care) |
| Southport and Ormskirk Hospitals NHS Trust | Secondary Care | Southport and Ormskirk Hospital |
| Warrington Community Cardiac Services (employed by Warrington and Halton Hospitals Foundation Trust) | Primary Care | Warrington Hospital |
| Warrington and Halton Hospitals NHS Foundation Trust | Secondary Care | Halton Hospital |
| Wirral Community NHS Trust | Primary Care | Wirral Heart Support |

## 5. PROVISION OUTLINE BY CLINICAL COMMISSIONING GROUP (CCG)

A scoping exercise was undertaken to determine current provision of cardiac rehabilitation and to identify any changes/proposed changes to services since the last baseline report in 2013. The content below is as a result of discussions with Cardiac Rehabilitation Leads and service specifications given (some of which are now out of date PCT specifications which have not been superseded)

| EASTERN CHESHIRE CCG | |
|---|---|
| Catchment Area | Cheshire East |
| Provider | East Cheshire NHS Trust |
| Service Lead | Paula Spray Clinical Nurse Practitioner - Cardiac Rehabilitation |
| Referrals from | Nurses, GP's, Cardiologists, other Physicians, Physiotherapists and Occupational Therapists |
| Service Description | The service provides the expertise that will enhance and improve the cardiology treatment of patients with acute myocardial infarction, undergone coronary revascularisation or who have had cardiac valve surgery. The service provides patients with a greater understanding of their cardiac condition and treatment, which aims to improves long-term patient compliance, reducing hospital readmissions and improving the health and well-being of cardiac patients and their families. |
| Menu based service? | We offer patients a home or group based programme which is determined depending on the individual needs and requirements of each patient.<br>All patients have an individual exercise plan. Education sessions which include; risk factor management, cardio-protective drug therapy, psychological support and stress management and long term management are provided and patients are advised they can attend all the sessions or only attend those appropriate/of value to them. |
| Stages Provided | Stages 0-5 |
| Planned changes in the next 12 months | We are in the process of writing a business case to expand the service to include those patients diagnosed with heart failure. |
| CQUIN attached to the service? | Not formally |
| NACR submission | Yes |
| Are waiting times in line with NICE-guidance? | We identify those patients diagnosed with an MI's in hospital and provide CR advice and support. Patients are then typically contacted within 5 working days of discharge or when referral received.<br><br>MI patients are invited to attend group or home based programme 4-6 weeks following diagnosis, 2 weeks following PCI and 6-8 weeks following CABG or valve surgery. |

| HALTON CCG | |
|---|---|
| Catchment area: | Halton District/Halton GP/Consultant |
| Provider | Halton Hospital |
| Service Lead | Carol Over |
| Referrals from | Warrington, Halton, LHCH, out of area referral (Leighton), private patients |
| Service Description | Service is delivered by the Trust at Halton Hospital and in accordance with the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) and NICE guidelines.<br>Our multidisciplinary team provides Ischaemic Heart Disease (IHD) and Heart failure (HF) rehabilitation programme in a superb purpose-built air conditioned department. IHD and HF programmes are tailor made (once or twice a week, 6, 8 or 10 weeks programme) to provide flexibility and to include wide range of client groups.<br>IHD group primarily includes ACS, NSTEMI (non ST elevation myocardial infarction), STEMI (ST elevation myocardial infarction), PCI, PPCI (primary percutaneous coronary intervention), CABG, Valve surgery, Heart transplant and ICD.<br>Our CR programme is based on bio-psycho-social model as recommended by BACPR and includes exercise and health promotion sessions to empower our clients to make positive and informed life style choices so that they can maintain their health long term.<br>Newly diagnosed HF patients are referred through HF community nurses, GP's and consultants.<br>On completing CR, patients are directed/referred to ongoing community exercise programme(Healthy living team)<br>Patient complete a patient satisfaction questionnaire prior to discharge and attend for 6 month and 12 month follow ups to provide us audit data regarding efficacy of service delivery.<br>In February 2014, an introduction group was set up where patients were invited within 10 days of discharge to visit CR department to be familiarised with CR and whereby increase uptake to the service. This initiative was to comply with NICE Guideline(2012) |
| Menu based service? | Yes |
| Stages Provided | 1,2,3,4,5,6 |
| Planned changes in the next 12 months | Integration of Halton staff with Warrington community staff in the development of a new heart failure rehabilitation service in Warrington district (awaiting decision by CCG at time of scoping) however, a planned pilot of two sessions will be implemented in June (funds provided) |
| CQUIN attached to the service? | No |
| NACR submission | Yes |
| Are waiting times in line with NICE guidance? | Yes |

| KNOWSLEY CCG | |
|---|---|
| Catchment area: | Knowsley Borough Council/Knowsley GP |
| Provider | Knowsley Cardiovascular Disease Service |
| Service Lead | Elaine Gossage/Sharon Faulkner |
| Referrals from | LHCH/Whiston/Aintree/RLBUHT/Primary Care |
| Service Description | Service is delivered in the community or home based locations.<br><br>Offered to the following groups of patients; MI, Chronic heart failure, ACS (to include unstable angina and NSTEMI), PCI, coronary bypass graft, ICD's.<br><br>Patients who are offered contacted within 48 hours of receipt of referral and an initial assessment within two weeks of discharge or diagnosis.<br><br>This is followed by 4 options for cardiac rehabilitation. 1) Home based; assessment with nurse and exercise physiologist. 2) Home based; telehealth with exercise. 3) Community group based; 6-10 week programme of exercise and education. 4) tailored groups; heart failure patients are included here.<br><br>On completion of the programme a referral is made to Activity to life self-management plan and discharged back to the GP or Heart Failure Teams.<br><br>HAD (hospital Anxiety Depression) scale completed at assessment and at the end of rehabilitation.<br><br>Within the service description we offer also offer to stroke patients within the cvd service and patients with PVD. We also have a merged group with pulmonary rehabilitation and offer titration clinics for all patients where this is part of their management plan. |
| Menu based service? | Yes |
| Stages Provided | Stages 1,2,3,4,5,6 |
| Planned changes in the next 12 months | None |
| CQUIN attached to the service? | No |
| NACR submission | Yes |
| Are waiting times in line with NICE Guidance? | Yes |

| LIVERPOOL CCG | |
|---|---|
| Catchment area: | Cheshire, Merseyside, North Wales, Isle of Man, Primaries – whole Country |
| Provider | Liverpool Heart & Chest Hospital (LHCH) |
| Service Lead | Jan Naybour |
| Referrals from | Only refer out from LHCH |
| Service Description | Identify and refer patients only. Referrals sent on day of discharge via automated emails and are red flagged if not sent by 2 days. |
| Menu based service? | Yes |
| Stages Provided | Stage 0, paid for by the Trust, not unbundled |
| Planned changes in the next 12 months | Specialist nurse review underway at time of scoping. Query banding change/hours increase/increased team size.<br>Business case for continuation of administration support, current support funding ends in July 2015. |
| CQUIN attached to the service? | No |
| NACR submission | No, however as submission will be mandatory by 2015, there will be a nominated IT staff member by 2015.<br>Initiating event information is current missing from the electronic patient records currently so working on this for data completeness. |
| Are waiting times in line with NICE guidance? | Yes |

| LIVERPOOL AND SEFTON CCGS | |
|---|---|
| Catchment area: | Liverpool and Sefton (no formal boundaries) |
| Provider | Aintree Hospital |
| Service Lead | Michelle Kerr |
| Referrals from | Locate inpatients via the troponin list, LHCH, Liverpool/Sefton GP's, other cardiac rehabilitation programmes, rapid access chest pain clinics. |
| Service Description | Service is delivered in the hospital for Liverpool patients and in the community for Sefton patients (option to attend the hospital programme - patient choice).<br><br>Offered to the following groups of patients; Acute coronary syndrome (including STEMI, NSTEMI and unstable angina, CABG, PCI and PPCI), new diagnosis or chronic heart failure with a step change in clinical presentation (stabilised). Patients who have undergone the following are also included in the programme, provided they have a primary diagnosis of ACS; ICD, CRT and heart valve replacement.<br><br>Referrals are within 3 days of receipt of referral, the initial assessment is within 10 days of the patient being ready and willing to attend. This is followed by a 6 or 8 week programme (patient needs dependent), exercise and education components.<br><br>Heart failure patients are monitored and review at each session.<br>A home based service is also offered (estimated that 5% of patients will utilise this)<br><br>HAD (hospital Anxiety Depression) scale completed at assessment and at the end of rehabilitation.<br><br>A long term management plan will be confirmed with the patient at the end of the programme.<br><br>A discharge letter will be sent to the GP.<br><br>The service is reviewed via key performance indicators (KPIs) on a monthly basis. |
| Menu based service? | Yes |
| Stages Provided | 0,1,2,3,4,5 |
| Planned changes in the next 12 months | New service commenced September 2014 as above. The devices and heart failure patients will be introduced in 2015 when additional staff are employed. |
| CQUIN attached to the service? | No |
| NACR submission | Yes but inconsistent |
| Are waiting times in line with NICE guidance? | Yes |

| LIVERPOOL AND SEFTON GP | |
|---|---|
| Catchment area: | Liverpool GP and South Sefton CCG GP |
| Provider | The Royal Liverpool & Broadgreen University Hospital |
| Service Lead | Joanne Brown |
| Referrals from | LHCH, Community, other Trusts, GP's |
| Service Description | Service is delivered at the Trust, in the community or can be home based.<br><br>Offered to the following group of patients ACS (including STEMI, NSTEMI and unstable angina, CABG, PCI, PPCI, MI, chronic heart failure with a step change, new diagnosis of chronic heart failure, primary diagnosis of ACS with an ICD, CRT (cardiac resynchronisation therapy) or heart valve replacement, heart transplant patients, VADS, patients who have undergone surgery for ICD therapy or CRT for reasons other than ACS or heart failure., heart valve replacement patients for reasons other than ACS or heart failure, patients with a confirmed diagnosis of exertional angina.<br><br>The service is flexible it is offered within core hours and also at weekends and evenings.<br><br>The exercise programmes are offered at the Royal Liverpool gym and Broadgreen gym; staff have access to the gym's 1.5 and 4.5 days respectively. The sessions are offered twice weekly to patients.<br><br>At the end of the programme a long term management plan is agreed, timescales for the programme are dependent upon patient's needs.<br><br>The patient is discharged back to the GP. |
| Menu based service? | Yes |
| Stages Provided | 0,1,2,3,4,5,6 (stage 0 sits outside of the pathway). |
| Planned changes in the next 12 months | Potential staffing increase; 2X Band 7 (part time). New service specification to be signed off.<br>Further enhancement to menu based programme.<br>Referral form to be used for heart failure patients from community |
| CQUIN attached to the service? | No |
| NACR submission | Yes – commenced February 2014 |
| Are waiting times in line with NICE Guidance? | No |

| ST HELENS CCG | |
|---|---|
| Catchment area: | St Helens (Geographical Boundaries)/ St Helens GP |
| Provider | Bridgewater – St Helens & Halton Division |
| Service Lead | Kerry Austin |
| Referrals from | Secondary Care, LHCH, Consultants, Practice Nurses, GP's |
| Service Description | This nurse led service is delivered in several ways; two community locations in St Helens, in community nurse led clinics, via telephone support or a home service is offered, dependant on co-morbidities. Offered to the following groups of patients; AMI; CABG, PCI, PPCI, angina, heart failure, ACS, valve repair or replacement, specialist interventions (i.e. cardiac transplant, LVAD (left ventricular assist device), ICD's CRT).<br><br>Patients who are offered are contacted within 4 days of discharge from hospital by telephone and face to face consultation within 4 weeks of leaving hospital. This is followed by a flexible programme which is delivered in core hours, within six weeks of referral/discharge.<br><br>The programme incorporates exercise and education on long term self-management.<br><br>A review appointment is offered to patients post completion of the programme.<br><br>On completion of the programme the patient is discharged back to the GP. |
| Menu based service? | Yes |
| Stages Provided | 1,2,3,4,5,6.<br>phase I referrals via fax & post.<br>Phase II is provided via telephone contact, clinics by the St Helens service<br>Phase III is provided via exercise/education sessions by the St Helens service |
| Planned changes in the next 12 months | None |
| CQUIN attached to the service? | No |
| NACR submission | Yes |
| Are waiting times in line with NICE guidance? | Yes |

| SOUTH CHESHIRE CCG | |
|---|---|
| Catchment Area | MCHFT |
| Provider | Macclesfield Hospital |
| Service Lead | Dawn Perkins |
| Referrals from | In -House, UHNS, other CR services around country. GP's, consultants other HC professionals & 'Self'. |
| Service Description | This service delivers all stages as per commissioning guide (NICE 2013) |
| Menu based service? | Not yet as it should be (future development as per business case) |
| Stages Provided | All stages as per Commissioning Guide (NICE 2013)<br>Established (historical) links with outside agencies for ongoing stage 6 |
| Planned changes in the next 12 months | Business case in progress to attract change from contract to tariff payment.<br>Allowing service to be adequately resourced to enable delivery of best practice. |
| CQUIN attached to the service? | Has been last year relating to patient/public involvement. |
| NACR submission | yes |
| Are waiting times in line with NICE-guidance? | No, patients waiting too long to access service due to demand out-weighing resources available. |

| SOUTHPORT AND FORMBY CCG | |
|---|---|
| Catchment area: | Southport, Formby (North Sefton) West Lancs (All) |
| Provider | Southport & Ormskirk Hospital |
| Service Lead | Joyce Jordan (Matron: Critical Care) Clare Hunter (Cardiac Rehab Sp Nurse) |
| Referrals from | GP/LHCH, West Lancs, Self-Referral, Community HF Nurses, Acute In-patients, Hospital HF Nurse, other CR providers |
| Service Description | The service is delivered at Southport & Ormskirk Trust, at the Spinal Injuries gym Southport Hospital and the Physiotherapy gym at Ormskirk Hospital, also home based for individual patients (with regular monitoring). Offered to the following groups of patients; ACS, PPCI, STEMI, NSTEMI, unstable angina, CABG, PCI, chronic stable heart failure or newly diagnosed heart failure, post permanent pacemaker insertion, ICD, CRT, heart transplant, left ventricular devices, valve repair/replacement surgery, confirmed diagnosis of exertional angina, adult congenital heart conditions. Patients who are referred are contacted within 3 days where they are offered advice and support throughout their recovery period via telephone or drop-in clinic sessions, at this stage they are invited to attend the Cardiac Rehabilitation Programme and/or Healthy Heart Day where applicable. The programmes run between 6-12 weeks. There is a daily review of the Troponin T results from the previous 24hrs thus allowing identification of in-scope patients, all efforts are made to see the patients on day of referral (Mon-Fri).<br><br>Weekly drop in clinic across sites are offered, no appointments are necessary – extremely useful for patient support.<br><br>Heart failure patients complete a quality of life questionnaire at the start and end of the programme using the Minnesota Living with Heart Failure questionnaire. Heart failure patients are risk stratified. Home programmes offered for some heart failure patients who are regularly contacted and assessed, with individualised plans.<br><br>HADS scoring is completed at initial assessment booking and on completion of the programme, then again at 12 months post programme.<br><br>Three attempts are made to recruit patients into the programme resulting in a very high uptake for cardiac rehabilitation in this catchment area.<br><br>Long term plans confirmed with patient and discharged to GP. All patients are reviewed 12 months post programme. |
| Menu based service? | Yes |
| Stages Provided | 0,1,2,3,4,5,6 |
| Planned changes in the next 12 months | Looking at and specifically monitoring numbers of heart failure patient referrals/take up/completion of cardiac rehabilitation for this group of patients, in line with DH service specification for Cardiac Rehabilitation Services 2013. Looking on clarity of how patients with mild/moderate heart failure are being assessed – difference in Southport compared to West Lancashire. |
| CQUIN attached to the service? | No |
| NACR submission | Yes |

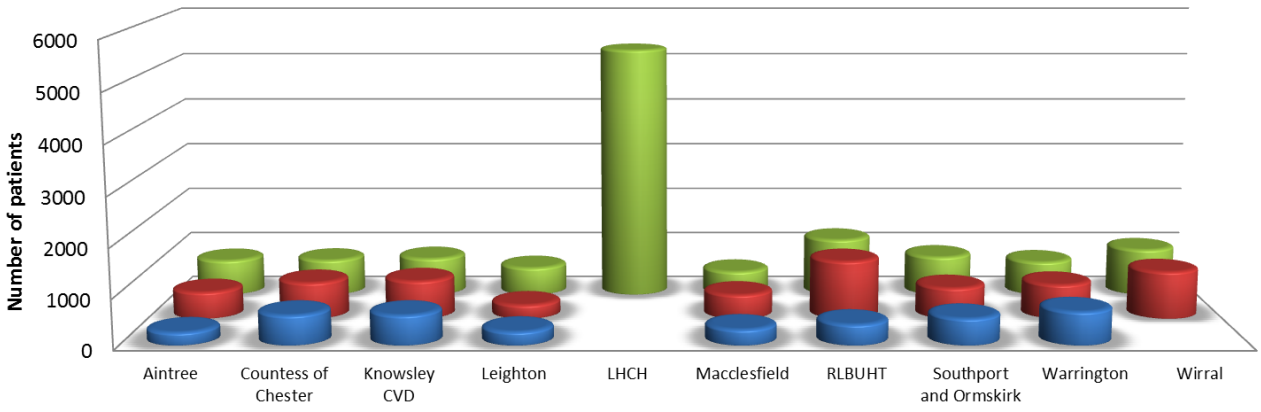
| WARRINGTON CCG | |
|---|---|
| Catchment area: | Warrington |
| Provider | Warrington & Halton Hospital |
| Service Lead | Sandra Dunne |
| Referrals from | Warrington Hospital, Cardiology Team, GP or LHCH |
| Service Description | The service is delivered at the Wolves Stadium in Warrington, offered to the following groups of patients; ACS post discharge (unstable angina, NSTEMI, STEMI), new diagnosis of IHD, post revascularisation PCI/CABG, post-surgery for valve replacement/aortic aneurysm repair, post insertion of permanent pacemaker, post heart transplant.<br><br>In-patients that are offered are contacted on the 4th day, and referred patients are contacted within 4 working days and are discharged back to the GP/Practice Nurse until they attend the cardiac rehabilitation programme.<br><br>The exercise component of the programme is delivered by BACR Instructor; the programmes offered are 6-8 weeks, and 1-2 sessions per week.<br><br>Heart failure patients are not included (inclusive of new diagnosis and ACS diagnosis)<br><br>HAD scoring is completed at first assessment and on final review. |
| Menu based service? | Yes |
| Stages Provided | 1,2,3,4,5,6 |
| Planned changes in the next 12 months | A 10 to 12 week pilot project to provide Heart Failure Cardiac Rehabilitation for Warrington patients is planned for 2015 |
| CQUIN attached to the service? | No |
| NACR submission | Yes |
| Are waiting times in line with NICE guidance? | Yes |

| WEST CHESHIRE CCG | |
|---|---|
| Catchment area: | All patients registered with West Cheshire CCG GP practices |
| Provider | Cheshire & Wirral Partnership/Countess of Chester NHS Foundation Trust |
| Service Lead | Sophie McIntosh |
| Referrals from | LHCH, in-patient, GP's, self-referral, out of area referrals including other rehabilitation practitioners |
| Service Description | This service is delivered at the trust, and in community locations. Offered to the following groups; Type 1 MI, CABG, PCI, valvular heart surgery, newly diagnosed LVSD (left ventricular systolic dysfunction), diagnosis or chronic heart failure with significant step change, CRT-P, CRT-D, out of area referral with diagnosis of MI/had cardiac surgery. Patients who are offered are contacted within 2 days and are seen within 10 days of discharge for initial assessment. This is followed by a flexible 12 week programme; the programme incorporates exercise, education and psychological counselling.<br><br>Heart failure programmes are run separately twice a week (separately commissioned service) targets the frail and elderly and the young/fit. These programmes are based at Ellesmere Port, Countess of Chester and University of Chester. This service provides HADS for all patients within the service.<br><br>Waiting time targets are met for this service. |
| Menu based service? | Yes |
| Stages Provided | 0,1,2,3,4,5,6 |
| Planned changes in the next 12 months | Tier 3 Bariatric Service – Physical activity component (change occurring at time of scoping) |
| CQUIN attached to the service? | No |
| NACR submission | Yes |
| Are waiting times in line with NICE guidance? | Yes |

| WIRRAL CCG | |
|---|---|
| Catchment area: | Wirral with Wirral GP (excluding South Wirral) |
| Provider | Wirral Heart Centre |
| Service Lead | Frieda Rimmer |
| Referrals from | LHCH, Arrowe Park, GP's AHP's, out of area, internal referral, other rehabilitation practitioners |
| Service Description | The service is delivered at Wirral Heart Support Centre, it operates a flexible programme outside of core hours on a Monday and Wednesday until 8pm. Offered to the following groups of patients; post MI, ACS, CABG PCI, pacemaker, ICD, bi-ventricular pacing. Referrals from primary care include; angina management, living with heart failure programme cardiac/high risk patients. Patients are contacted within 5 working days from discharge and follow a 6 week programme, a review is completed at week 7, patients are then offered a 12 week gym supervised exercise programme. Reviews are completed at 6 and 12 months post discharge.<br><br>Patient is discharged to the GP.<br><br>All heart failure patients are offered a bespoke 8 week programme with a referral to gym (if appropriate) as above cardiac rehabilitation. |
| Menu based service? | Yes |
| Stages Provided | 0,1,2,3,4,5,6 |
| Planned changes in the next 12 months | None |
| CQUIN attached to the service? | No |
| NACR submission | In full from April 2014 |
| Are waiting times in line with NICE guidance? | Basic CR – yes<br>Heart Failure patients – longer programme, 6/8 per year. It is not a rolling programme |

## 6. SCOPING TEMPLATE ANALYSIS

### NUMBER OF PATIENTS REFERRED, OFFERED AND COMPLETED CARDIAC REHABILITATION

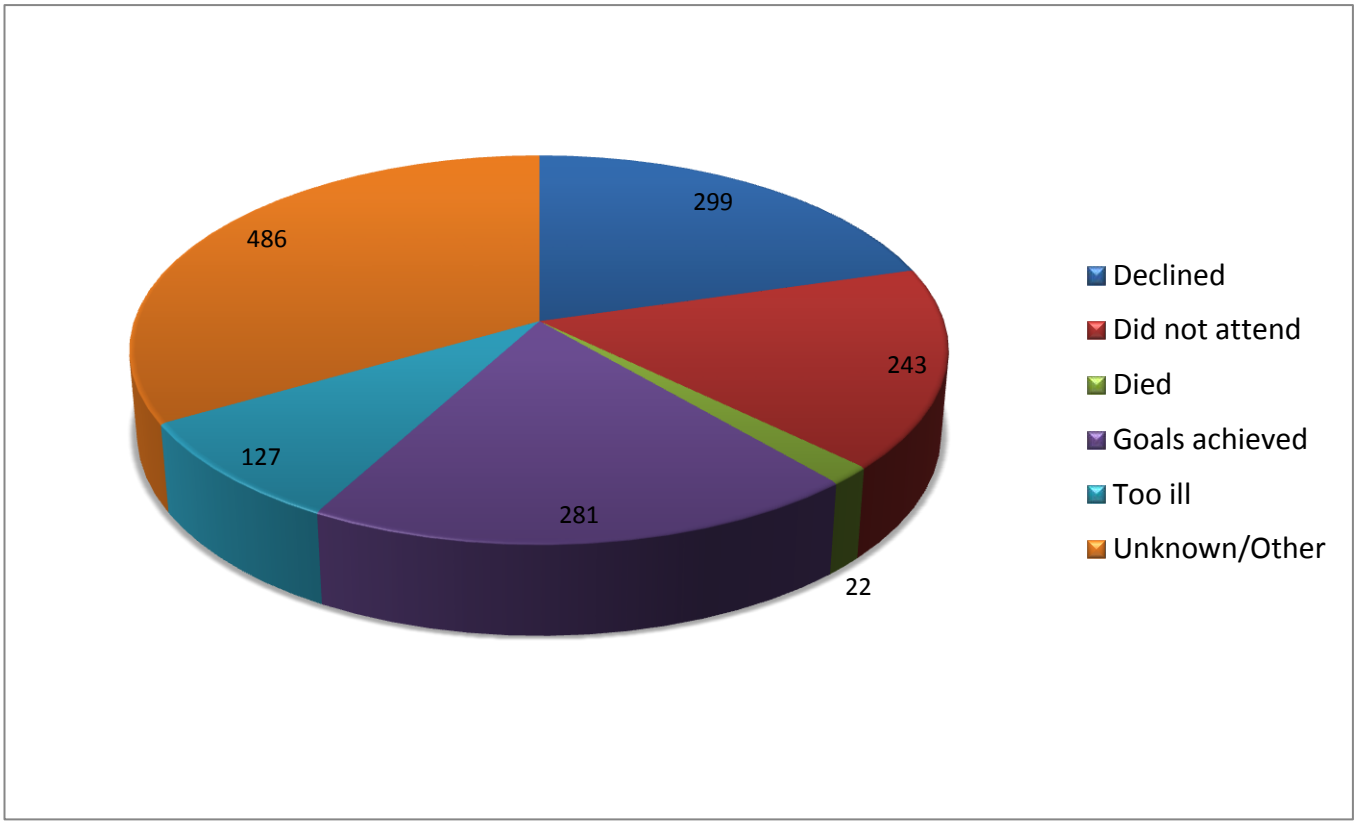



| | Aintree | Countess of Chester | Knowsley CVD | Leighton | LHCH | Macclesfield | RLBUHT | Southport and Ormskirk | Warrington | Wirral |
|---|---|---|---|---|---|---|---|---|---|---|
| Completed | 261 | 603 | 604 | 275 | | 320 | 420 | 539 | 674 | |
| Offered | 555 | 752 | 788 | 288 | | 501 | 1200 | 642 | 712 | 982 |
| Referred | 745 | 752 | 788 | 585 | 5282 | 501 | 1200 | 822 | 712 | 982 |

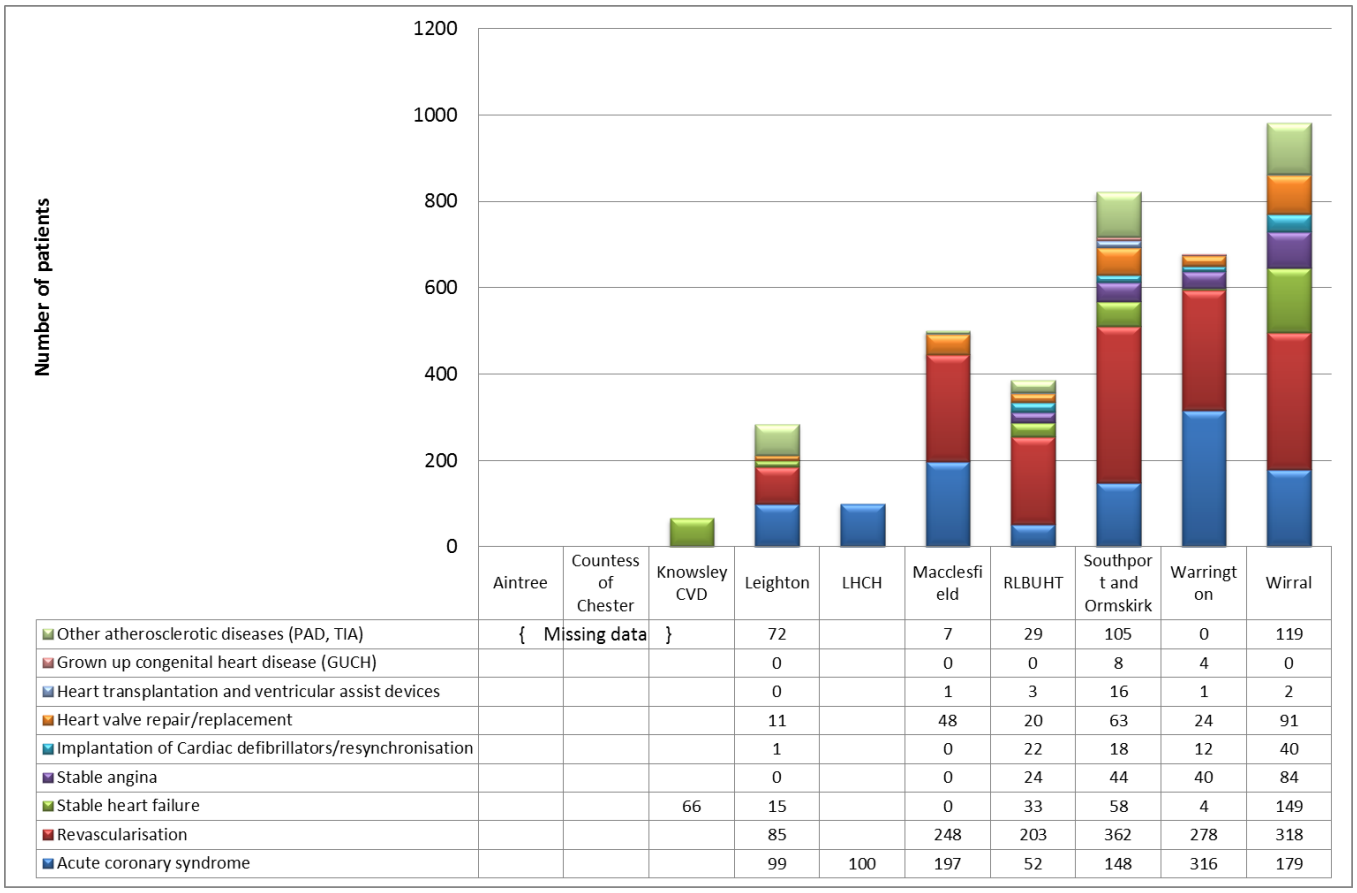
Completed Offered Referred

- Please note that LHCH is a Tertiary Centre

## REASONS FOR NON COMPLETION OF CARDIAC REHABILITATION



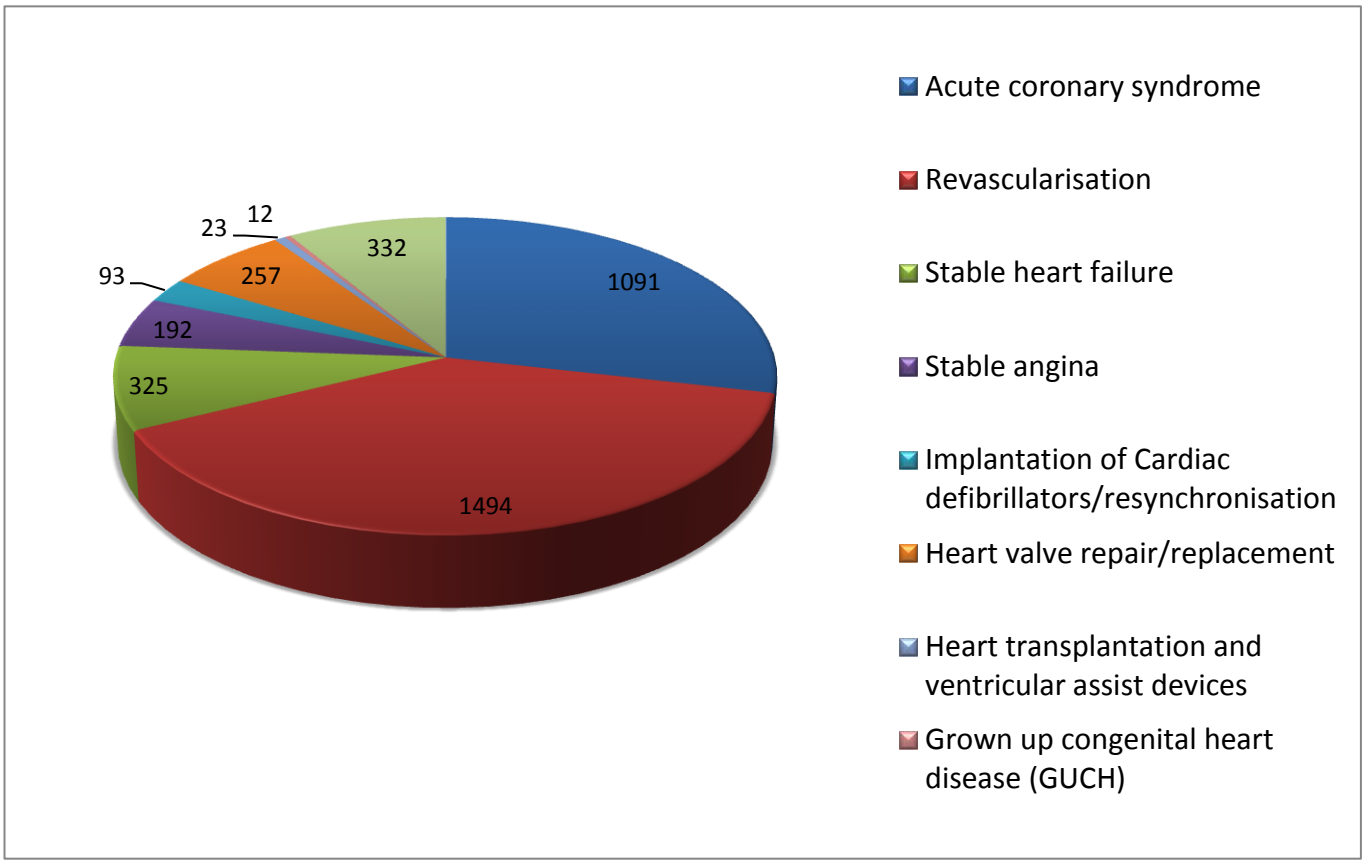

## NUMBER OF PATIENTS ATTENDING CARDIAC REHABILITATION BY DIAGNOSIS



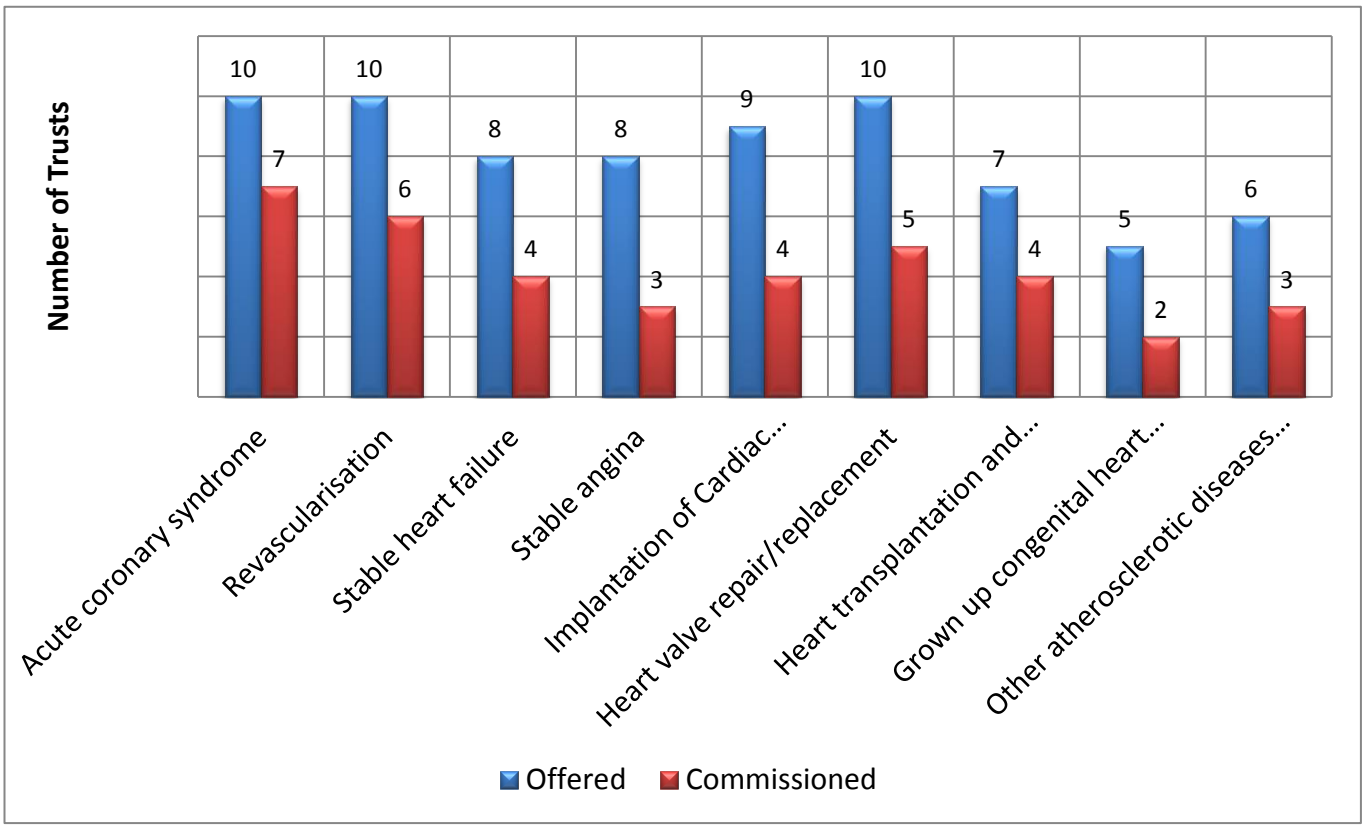

| | Aintree | Countess of Chester | Knowsley CVD | Leighton | LHCH | Macclesfield | RLBUHT | Southport and Ormskirk | Warrington | Wirral |
|---|---|---|---|---|---|---|---|---|---|---|
| Other atherosclerotic diseases (PAD, TIA) | { Missing data | } | | 72 | | 7 | 29 | 105 | 0 | 119 |
| Grown up congenital heart disease (GUCH) | | | | 0 | | 0 | 0 | 8 | 4 | 0 |
| Heart transplantation and ventricular assist devices | | | | 0 | | 1 | 3 | 16 | 1 | 2 |
| Heart valve repair/replacement | | | | 11 | | 48 | 20 | 63 | 24 | 91 |
| Implantation of Cardiac defibrillators/resynchronisation | | | | 1 | | 0 | 22 | 18 | 12 | 40 |
| Stable angina | | | | 0 | | 0 | 24 | 44 | 40 | 84 |
| Stable heart failure | | | 66 | 15 | | 0 | 33 | 58 | 4 | 149 |
| Revascularisation | | | | 85 | | 248 | 203 | 362 | 278 | 318 |
| Acute coronary syndrome | | | | 99 | 100 | 197 | 52 | 148 | 316 | 179 |

Data is incomplete for LHCH

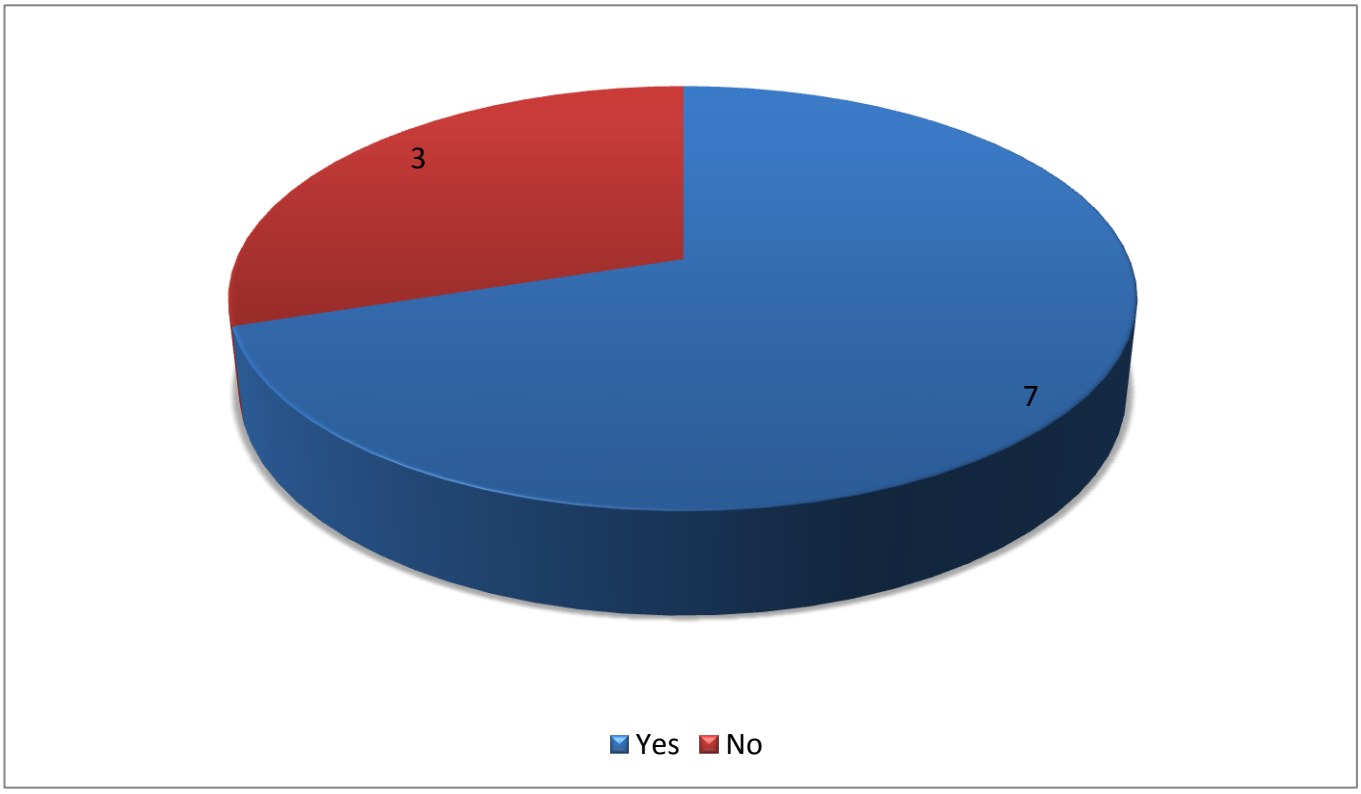
## DIAGNOSIS OF PATIENTS ATTENDING CARDIAC REHABILITATION



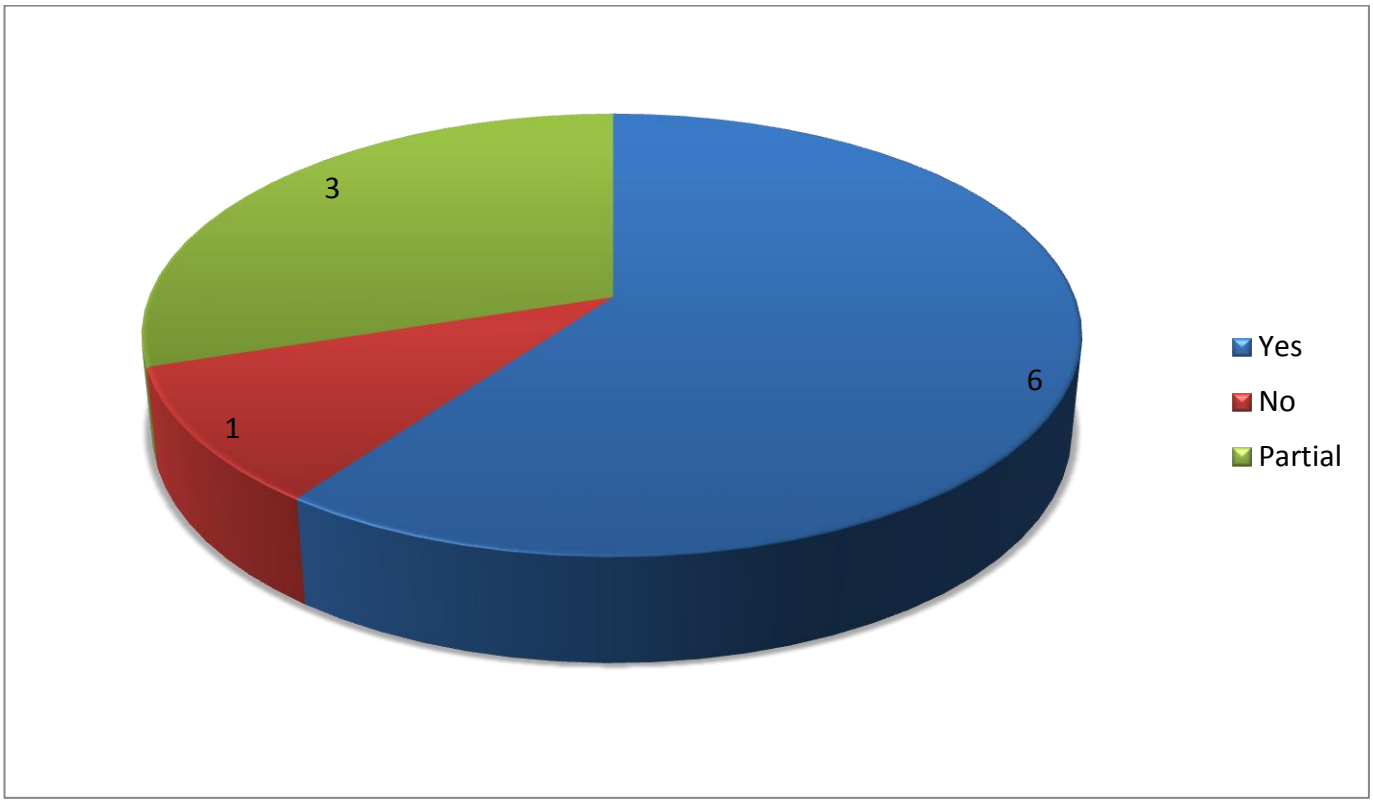
## CARDIAC REHABILITATION OFFERED VS COMMISSIONED



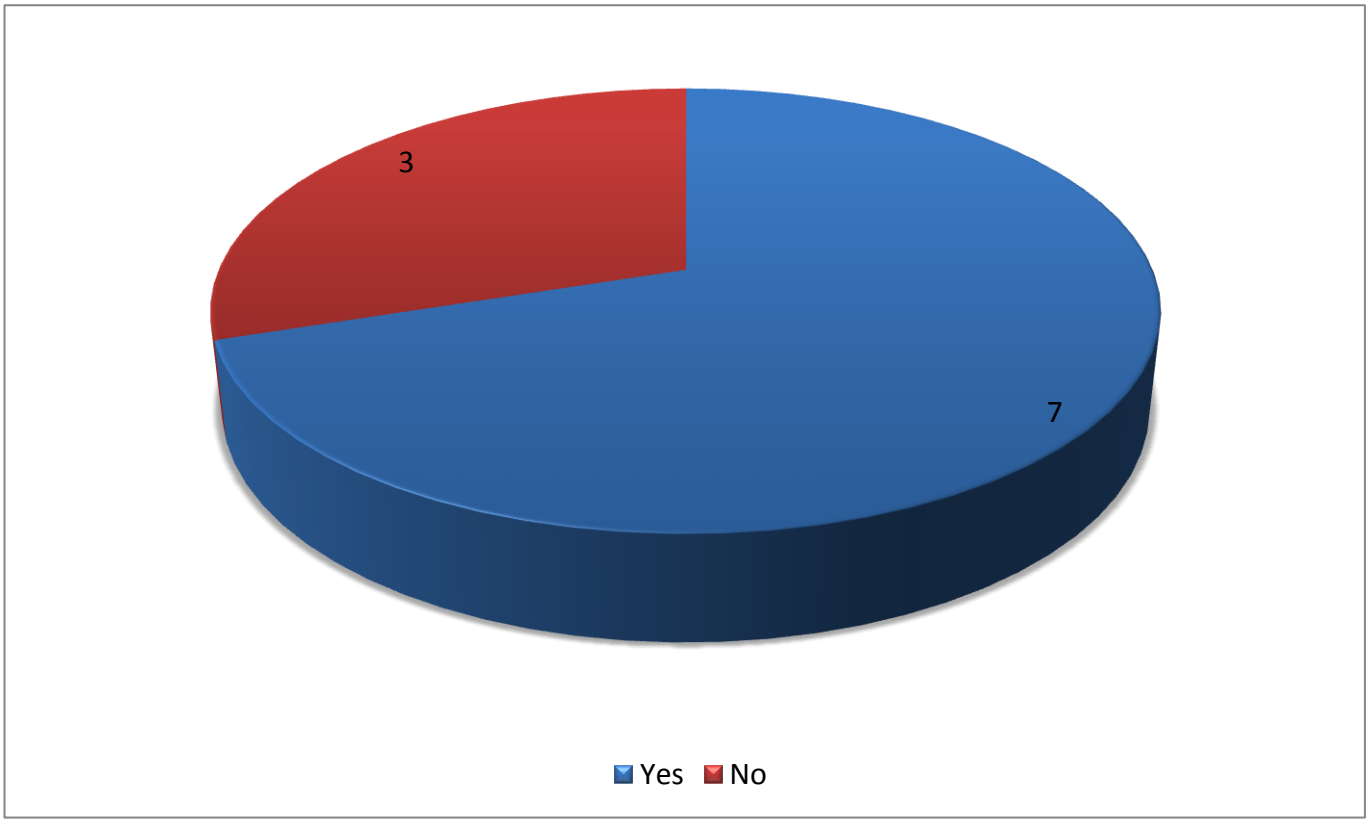

## IS THE CARDIAC REHABILITATION SERVICE MENU BASED?



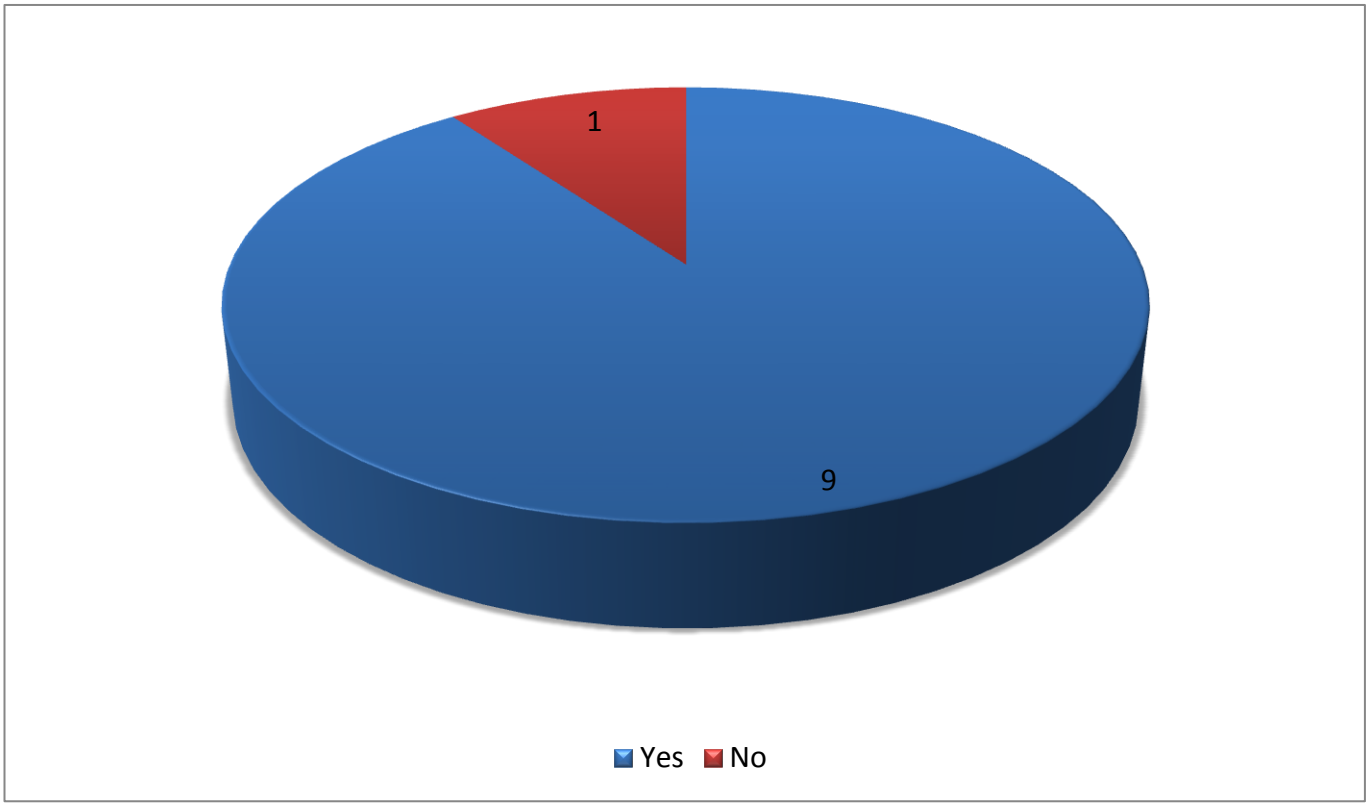

## ARE WAITING TIMES FOR THE SERVICE WITHIN NICE GUIDANCE?




## IS THE SERVICE AVAILABLE TO HEART FAILURE PATIENTS?



## IS DATA REGARDING THE SERVICE SUBMITTED TO THE NATIONAL AUDIT FOR CARDIAC REHABILITATION (NACR)?



## PROVISION OF SERVICES COMMISSIONED V'S OFFERED COMPARISON TABLE

| | Aintree | Countess of Chester | Halton | Knowsley CVD | Leighton | LHCH | Macclesfield | RLBUHT | St Helens | Southport and Ormskirk | Warrington | Wirral |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute coronary syndrome | | | | | | | | | | | | |
| Revascularisation | | | | | | | | | | | | |
| Stable heart failure | | | | | | | | | | | | |
| Stable angina | | | | | | | | | | | | |
| Implantation of Cardiac defibrillators/resynchronisation | | *** | | | | | | | | | | |
| Heart value repair/replacement | | | | | | | | | | | | |
| Heart transplantation and ventricular assist devices | ** | | | | | N/A | | | | | | |
| Grown up congenital heart disease (GUCH) | | | | | | | | | | | | |
| Other atherosclerotic diseases (PAD, TIA) | | | | | | | | | | | | |

East and Mid Cheshire Unknown

Commissioned & offered service

Not commissioned but offered

Not commissioned & not offered

* accepted on an individual basis

** Occasional referrals on an individual basis

*** If heart failure related and normal LV function

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Date: July 2015
Authors: Louise Vernon; Dawn Hannah; Ruth Grainger

## 7. RECOMMENDATIONS, CONCLUSIONS AND NEXT STEPS

**Recommendations**

- All commissioned services should submit a full data set to NACR however; due to resource issues this may be problematic in certain areas of Cheshire & Merseyside. Further discussion around service support must be made available to enable this.
- Gaps in monitoring/complying with NACR offer an opportunity to develop a more in- depth understanding of services, a commitment to NACR is required. Submission will be mandatory from 2015.
- Current provision for heart failure patients is variable. CCG's should take note of NICE Commissioning Guide (2013) when looking at the CQUIN payment framework to include the referral of cardiac rehabilitation as a clinical measure or discharge bundle as part of a CQUIN for MI and/or heart failure, and also align to the CVD Outcomes Strategy (2013) and the ambition to increase cardiac provision to 65% for AMI, CABG and PCI patients and for heart failure patients an increase from 4 to 33%.
- CCGs may wish to look at an analysis of future needs of their population to ensure there is a provision for providing an increasing number of patients with cardiac rehabilitation.
- Further examination of where services are offered but not commissioned needs to be undertaken.
- Support from senior management, Consultants and ward staff has to be achieved to support uptake and continued attendance at Cardiac Rehabilitation Services. It should be seen as a continuation of care and not an optional attendance. This point has to be reiterated to patients

  at every opportunity and by every member of staff throughout the pathway of care from the beginning of treatment through to and including discharge to the care of the GP.
- Strong communication links between services and GP practices should be established to ensure continuity of care. Information forwarded to GP's should include; plan of care; discharge from service letter. Copy of HAD'S. Information regarding attendance to Cardiac Rehab services should also be available to General Practice to support the engagement strategy of programme completion.
- A process for contacting those patients whose attendance at the service has dropped should be developed to support service development.
- A process for follow up following discharge from the service should be established to support the audit process and identify scope for further development.

## Conclusion

It is evident from the data submitted and included in this report that there is some variation in service delivery across Cheshire and Merseyside. This is an issue which needs to be addressed in order to reduce variation across the region.

The mandatory NACR submission from 2015 will support improvement in service delivery and quality. However, to enable this additional administrative support to enable accurate and timely data submission is essential.

It is also vital that Cardiac Rehabilitation is formally supported and promoted throughout the health care arena in both the clinical and management setting. Appropriate levels of funding has to be achieved if services are to fully meet the needs of patients and also support rehabilitation practitioners in the quest to provide a successful service and meet future needs.

## Next Steps

- Clear achievable objectives need to be identified and communicated across Primary and Secondary care, Service providers and Commissioners
- Administrative support needs to be implemented to support each service provider with data entry.
- Further work needs to be undertaken by service providers, commissioners and senior management to align the level and quality of each service to ensure equitable delivery across the region.