

National Advisory Board

Monday 24th of February

Vision for Cardiac Rehabilitation for 2020

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Recommendations:

National Advisory Committee on Heart Disease support the Vision for Cardiac Rehabilitation

National Advisory Committee on Heart Disease agree an Improvement programme for Cardiac Rehabilitation in Scotland to meet the demands of the 2020 vision

Summary

The remit of the Cardiac Rehabilitation (CR) Sub Group was to agree the way forward for CR in Scotland and to identify key drivers to facilitate service redesign. Consultation with key stakeholders across Scotland took place in November and a vision statement was developed. The vision statement states:

'All patients with heart disease should be supported by CR to live longer, healthier and independent lives.'

To support this, the vision also states that:

*'CR will be delivered by an integrated, clinically competent, multi-disciplinary team with a central focus **on specialist assessment** providing an **individualised programme of care** to improve patient outcomes.'*

This will be achieved by working in partnership with a range of providers across health and social care and the third sector. Currently services across Scotland vary considerably in their ability to attain this goal. Work is required to support service improvement within CR services.

Glossary of Terms

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| BACPR | British Association of Cardiovascular Prevention and Rehabilitation |
| CR | Cardiac Rehabilitation |
| SIGN | Scottish Intercollegiate Guidelines Network |

Situation

- 1.1 In Scotland, CR has been recognised, for a number of years, as a key element of healthcare for individuals with heart disease, following a step change in their condition.
- 1.2 CR is currently provided to nearly 9,000 individuals as part of their pathway of care following a cardiac event.
- 1.3 Data from a recent audit of CR services across Scotland show wide variation in the services offered to these individuals. In addition a large number who could benefit were unable to access this type of support, particularly if their primary diagnosis was Heart Failure or Angina.
- 1.4 A number of challenges within the services have been identified
 - The need for balancing the needs of assessment and intervention within services
 - Establishing links with wider services to ensure integration across all sectors
 - Robust protocols required to ensure patient safety
 - Infrastructure beyond health service will vary from area to area
 - Limited support for administration and communication
 - Financial constraints
 - Capacity and demand due to increasing numbers of patients and patient groups.
 - Limited support for psychological issues
 - Lack of CR competency framework and standardised educational programme for staff across all partnerships
 - Liaising with local/ community services to enhance and support maintenance of lifestyle change'
 - Limited application of improvement methodologies for improving care

Background

- 2.1 Cardiac Rehabilitation has been shown to reduce both mortality and morbidity by approximately 20-25% in a wide range of cardiac diagnoses. Commissioning documents released in England have suggested that CR reduces readmissions and is considered cost effective for a wide range of diagnoses including angina. A key objective of the heart disease action plan for Scotland was the provision of CR for individuals with a variety of cardiac diagnoses.
- 2.2 There are a number of drivers for change within CR in Scotland. These include both opportunities and challenges :

Opportunities

- Implementation of Quality Strategy and delivering 2020 Vision Route Map
- Integration of health and social care services
- Person centred programme
- Constantly emerging clinical evidence and best practice
- Need to review SIGN Guideline 57 in light of changes in evidence base
- BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation 2012

Challenges

- increased number of patients living with Long Term Conditions and multi-morbidities
- Achieve improvements in heart disease patient intervention, treatment and management
- Achieve significant reductions in the average length of stay within hospital
- Achieve improvements in long term management of patients with heart disease
- Changes to definition of Myocardial Infarction
- Healthcare Improvement Scotland (formally NHS QIS) Clinical Standards for Heart Disease (April 2010) resulting in increased patient groups eligible for CR

Assessment

- 3.1 During November members of the sub-group met with a wide range of stakeholders to develop a vision statement and to identify the key factors of a quality CR service.
- 3.2 A development day with leaders within the field of CR was held in December and further discussion took place at the CR subgroup in January
- 3.3 Consensus was reached that:
CR should aim to provide each patient with an **Individualised Programme of Care** that is tailored to their specific needs. To achieve this aim, services should have a primary focus on the **specialist assessment** for the patient with a corresponding range of rehabilitation outcome options. The rehabilitation outcomes should cover a wide range of options addressing all appropriate risk factor behavioural changes, which can be delivered across multi-agency providers and underpinned by the BACPR Standards.
- 3.4 An Individualised Programme of Care should be:
 - Tiered 'Case Management' approach with a range of outcome options

provided across the wider healthcare service and partnership organisations

- The length of the programme should be determined by need
- Promote independence and socialisation
- Early and strong focus on behavioural change
- Strong focus on condition and wellbeing self-management
- Tele-health options should be considered

3.5

Specialist Assessment should be:

- Based on needs of a patient with heart disease rather than diagnostic categories
- Timely and well planned early in the patients journey
- Undertaken via a variety of methods which includes tele-health options

3.6

An improvement programme should be developed that could include:

- Redesign of services to be truly person-centred by providing a specialist assessment that determines the component parts of each individual patient's rehabilitation programme of care rather than assessment for access to an established linear CR service
- Move away from model of 'service delivery' by adopting case management approach thus facilitating a programme of care across multi-agency providers
- Develop integrated team approach utilising skill mix appropriate to service provided
- Implement competency based workforce training which could include:
 - Low level psychological training
 - Self-management (condition and wellbeing)
 - Adult learning & behavioural change
 - BACR competencies for Physiotherapists
 - BVCs (Beliefs/Values/Commitments)
 - Physical examination & history taking
- Ensure that condition and wellbeing self-management is an integral part of the rehabilitation programme of care
- An evaluation of new model to ensure clinical effectiveness, service efficiency and positive patient reported outcome measures (clinical and quality of life)

3:7

Wider consultation on the detail of the improvement plan should take place.

Recommendations

4.1 The National Advisory Group is asked to:

1. support the Vision for Cardiac Rehabilitation
2. agree an Improvement programme for Cardiac Rehabilitation in Scotland