All Wales Cardiac Rehabilitation Conference

Improving Cardiac Rehabilitation Through Better Commissioning

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&
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NHS Improvement
• NHS Improvement - who are we?
• What does NHS improvement do?
• What are we doing in Cardiac Rehab, why and where are we doing it?
• The CR Commissioning Pack - what is its purpose?
• Our work – sharing the National picture
• What next?
• Sharing Key messages, the tools that we know help and lessons learnt
• Give you links to learn more
Who are we & what does NHS Improvement do?
Who we are & what NHS Improvement do?

• Part of a larger national team working with sites across England using service improvement tools & techniques to improve services nationally – heart, stroke, lung, cancer, diagnostics

• Small CR team of 3 National Improvement Leads

• 1 Director & 1 PA

• Range of backgrounds

• Clinical, managerial & service improvement across a range of services - national, SHAs, PCTs, acute sector & clinical networks

• We link with the Department of Health to support sites in using the CR Commissioning Pack (October 2010)
What are we doing in Cardiac Rehabilitation and why are we doing it?
Immortality guaranteed by 2026

Target achieved five years ahead of schedule

Circulatory Disease Mortality Target
Death rates from All Circulatory Disease in England 1993-2008 and target
Persons under 75

Death rate per 100,000 population

Progress since baseline:
A fall of 47.1%

40% minimum reduction from 1995-97 baseline rate
Why Cardiac Rehabilitation?

There is a wealth of evidence to support the fact that cardiac rehabilitation improves outcomes for many people with heart disease, enabling them to remain active for longer and manage their condition more effectively. Indeed, the Coronary Heart Disease National Service Framework (2000) included a separate chapter on cardiac rehabilitation to make it clear that it forms an intrinsic part of the cardiac pathway for eligible patients.
"Unfinished Business"

Table 5. Percentages of patients in the three main diagnostic groups attending CR in England, Northern Ireland and Wales 2007-8 and 2008-9

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>2007-8 %</th>
<th>2008-9 %</th>
<th>Improvement % point</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td>34</td>
<td>39</td>
<td>+5</td>
</tr>
<tr>
<td>PCI</td>
<td>30</td>
<td>28</td>
<td>-2</td>
</tr>
<tr>
<td>CABG</td>
<td>68</td>
<td>76</td>
<td>+8</td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td>41</td>
<td>+3</td>
</tr>
</tbody>
</table>

Table 2. The main diagnostic groups (% of all recorded in NACR)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2007-8 %</th>
<th>2008-9 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td>49</td>
<td>45</td>
</tr>
<tr>
<td>CABG</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>PCI</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>ACS</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Angina</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ICD patients</td>
<td>&lt;1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>All others</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>

(N FOR EACH YEAR RESPECTIVELY = 71,324; 92,750)
Why Commissioning?

......significantly fewer people are accessing the benefits a high quality CR service offers. Even for those who are, it is often insufficiently flexible or responsive to ensure all those who could benefit take up the offer.

This is due, in part, to the complexity of the service; the fact that it includes a range of services, in a variety of settings provided by different people and organisations does make it more challenging for non-specialists to understand and commission.....The NHS has a responsibility to ensure that those who are eligible and can benefit from CR are able to do so.
Crucial role of the CRCP…to design services to deliver best outcomes for patients, using money effectively

- CR Commissioning Pack launched in October 2010 by Health Secretary of State - Andrew Lansley
- To reduce unacceptable level of variation in current CR services – based on outcomes
- Using quality evidence base that CR works
- Improve on the number of patients who can benefit (uptake only 41%)
- Improve quality of data by removing variation in reporting

Why CR and why now….? ….Great potential for improvement
Cardiac Rehabilitation Commissioning Pack (DH 2010)

Service specification
Costing tool
Guidance:
Overview; planning agreeing & monitoring

Case for change
Patient information booklet
Business case
Procurement docs
What are the National CR Team in NHS Improvement doing now, and where?

National Project (Prototype) working with sites, Trusts and whole organisations across England……

…….testing the implementation of the Cardiac Rehabilitation Commissioning Pack
National CR Projects

Cardiac Networks in England

1. Anglia Stroke and Heart Network
2. Avon, Gloucestershire, Wiltshire and Somerset Cardiac and Stroke Network
3. Bedfordshire and Hertfordshire Heart and Stroke Network
4. Birmingham, Sandwell and Solihull Cardiac and Stroke Network
5. Black Country Cardiovascular Network
6. Cardiac and Stroke Networks in Cumbria and Lancashire
7. Cheshire and Merseyside Cardiac Network working with the stroke community
8. Coventry and Warwickshire Cardiovascular Network
9. Dorset Cardiac Network
10. East Midlands Cardiac and Stroke Network
11. Essex Cardiac and Stroke Network
12. Greater Manchester and Cheshire Cardiac and Stroke Network
13. Herefordshire and Worcestershire Cardiac and Stroke Network
14. Kent Cardiovascular Network
15. North and East Yorkshire and Northern Lincolnshire Cardiac and Stroke Network
16. North Central London Cardiac and Stroke Network
17. North East London Cardiovascular and Stroke Network
18. North of England Cardiovascular Network
19. North Thames Cardiac and Stroke Network
20. North West London Cardiovascular and Stroke Network
21. Peninsula Cardiovascular Stroke Network
22. Shropshire and Staffordshire Heart and Stroke Network
23. South East London Cardiovascular Network
24. South West London Cardiovascular and Stroke Network
25. South West London Cardiac and Stroke Network
26. Surrey Heart and Stroke Network
27. Sussex Heart Network
28. West Yorkshire Cardiovascular Network

L & C CSN withdrawn
NEY NL CSN
NEL CSN
SL CSN
E M CSN 1 main + 3 sub projects
Anglia SHN
NHS SOTW
NS NOTW withdrawn
L'pool & Sefton PCTs
Shrops & Staffs CSN
What is the purpose of the CR Commissioning Pack?
Commissioning Pack Key Objectives

• **Improve quality** of services for patients, through clearly defined outcomes and best practice service specification

• **Drive efficiency** by reducing unwarranted variation in services

• **Reduce bureaucracy** for commissioners by providing documents and templates and by bringing together the different aspects of commissioning in one resource:
  – Clinical, financial, commercial, contractual, procurement

....to make clinical commissioning easier
Key Service Outcomes

- Increase in number of patients offered CR
- Increase in number of patients completing CR
- Reduction in number of acute re-admissions due to secondary cardiac events and unplanned procedures
- Increase in the number of patients satisfied with the service they receive for CR
- NACR is recommended as the mechanism for data collection
So what’s different?
What’s Different?

• **Broader Scope** in line with NICE guidance – inclusion of Heart Failure in ‘high priority’ group

• **No ‘phases’** instead a pathway with **key stages 0-6** that are delivered across primary, secondary & tertiary care

• **No set time frames** for patients to complete CR

• **Focus on patient outcomes** rather than process but **quality** of process remains important

• Designed to achieve continuity and co-ordination of patient care across the pathway- **a seamless service**
The Cardiac Rehabilitation Pathway...
Cardiac Rehabilitation Pathway (all stages)

0. Identify and refer patient
1. Manage referral and recruit patient
2. Assess patient
3. Develop patient care plan
4. Deliver comprehensive *CR programme
5. Conduct final CR assessment
6. Discharge and transition to long term management

Sharing cardiac rehabilitation information (education) and Long Term Management Strategy with the patient

*CR = cardiac rehabilitation
Stage 1 – Manage Referral and Recruit Patient to Cardiac Rehabilitation Programme

1.1 Receive patient referral

1.2 Is patient in-scope?

1.3 Contact and invite in-scope patients to assessment

1.4 Is patient willing and clinically ready?

1.5 Re-offer CR assessment date

1.6 Confirm CR assessment booking

Patient continues to assessment and planning [2/3]

Discharge and transition to supported long-term management [3]
Stage 2 – Assess Patient for Cardiac Rehabilitation

2.1 Record patient attendance at assessment

2.2 Assess risk (immediate risk e.g. prognostic)

2.3 Assess patient against core components

Core Components

Patient care plan developed [3]
Stage 3 – Develop Patient Care Plan

3.1 Identify appropriate options to meet patient needs

3.2 Discuss patient preferences

3.3 Set goals with patient

3.4 Agree and document patient specific care plan

Book patient onto comprehensive evidence based programme

Patient commences cardiac rehabilitation programme

Delivery Model
Care Plan

- Lifestyle
- Risk factor management
- Cardio protective drug therapy & devices
- Psychosocial wellbeing
- Education
- Long-term management

PATIENT NEEDS

Patient preference

No ‘one size fits all’ approach

PATIENT PREFERENCES

Patient choice

EVIDENCE BASED APPROACHES
Stage 4 – Deliver comprehensive cardiac rehabilitation

4.1 Commence core components
4.2 Evaluate progress against goals
4.3 Adjust goals and programme (care plan)

Have goals been met?

4.4 Yes
4.5 Book patient into final assessment

Patient completed programme

Comence relevant activity with patient (core components)

Evaluate progress against goals and compliance to programme

Final CR assessment and long term management

Adjust goals and/or programme (incl. onward referrals)
Stage 5 – Conduct final assessment

5.1 Assess patient and record outcomes
5.2 Compare results to baseline clinical and patient goals
5.3 Analyse and report outcomes
Stage 6 – Discharge and transition to long term management

- 6.1 Confirm long term management plan with patient
  - Patient completed programme and final assessment

- 6.2 Produce discharge letter

- 6.3 Signpost patient to relevant services

- 6.4 Liaise with providers

- 6.5 Send patient Service Feedback Survey

Patient discharge and transitioned to supported long term management
But how do we get from where we are now to a CR service in new world….?

The Challenge…. 
The big challenge for CR providers......AND commissioners of CR services

Getting all those who can benefit into CR services
increase uptake from 41%

Supporting those in the service to ‘stick with the programme

Reduce the dropout rate to increase benefit
But how do we ‘tell’ people what to do?
In difficult economic times……

Do more for less

Serve the people better

Improve quality

Give more value for less money
and the solution........?
....by thinking differently....
start with….

• understanding your target market and **what they value**

• build a **relationship** with them

• Remember.. it is not just your patients who you need to target…
...think about your Cardiology colleagues

...do they actively promote CR or could they do more....

Do they know what you do?

.......What about the commissioners, clinicians and managers in primary and secondary care and other members of your healthcare teams, patient champions
Ask yourself the question…. 

• How can I create a service where the systems, the environment, products and services are **delivered effectively** and will help people change because they **value them**?

• and one that **others will promote** (and commission) because they know my service is good too
How are we working to change it?
Working with CR clinicians, commissioners, providers and patients

- Supporting development, implementation and roll out of the DH Commissioning Pack for CR by working with project sites in England - testing utility of the pack in real life settings
- Benchmarking **current CR service provision** against the CR Commissioning Pack service specification
- Working with teams to address **bridging the gaps** through service redesign and improvement
- **Data** collection methods and management of reporting requirements: **clinical & performance**
Working with Teams in Action....
Service Specification for Cardiac Rehabilitation Services
Costing and Cost Benefit Tool

Cardiac Rehabilitation

Costing & Cost Benefit

Model Version 2.0 DRAFT

16-Nov-10

Model prepared by Jason Smith & Turkan Ince
Process Mapping Liverpool
Rapid Improvement
South of Tyne
New models of delivery.....web-based CR in Leicester
What else have we done?
Previous CR work & publications...sharing the learning
Social Marketing for CR Event: March 2011

marketing alongside other concepts and techniques

systematic application

to achieve

social good

behavioural goals

French, Blair-Stevens 2006
….and what else are we doing?
Joint work with NACR

- Collaboration with NACR to test feasibility of modifying the existing NACR to capture information requirements
- Provide a ‘one-stop’ database for CR providers (clinical & service performance outcome data)
- Aim – produce a commissioner-focused report to help gauge progress towards the 4 key outcomes which will enable commissioners to manage performance effectively
Heart Failure CR – a clinical resource –
by Professor Patrick Doherty
(National Clinical CR Lead)

Available on our website
www.improvement.nhs.uk/heart/cardiacrehabilitation
What Next…. 
What next – ideas in the pipeline?

• Social Marketing in primary & secondary prevention
• A ‘how to’ guide for setting up a heart failure CR service
• CVD Conference in July
• Modelling the QIPP potential of CR
Modelling the QIPP Potential of CR

Cardiac Rehabilitation

Costing & Cost Benefit

The cost benefit compares the following two calculations:

Existing Cardiac Cost = Acute initial Admissions cost + Current CR Cost + Acute cost of Readmissions

Vs

New Cardiac Service Cost = Acute initial Admissions cost + Estimated CR Cost (based on higher volume) + Acute cost of Readmissions (based on lower volume)
CR service costs at 65% uptake of 08/09 data (applying 30% reduction in re-admissions)

1278 Readmissions Avoided
CR service costs at 65% uptake of 08/09 data (applying 30% reduction in re-admissions)

£4.6 million Saved

East Midlands Cardiac and Stroke Network
...so what have we learnt and what are our key messages to help other teams to improve?
Our 10 Top Tips for transforming your CR service.....

- Understand your service
- Engage with your stakeholders
- Involve patients and carers
- Enlist clinical leadership
- Collect, analyse and make use of robust data
- Specify your service requirements
- Commission effectively
- Use resources wisely
- Collaborate and network
- See the bigger picture

...based on learning from our projects
In Summary

• **The focus on CR is on – seize the opportunity**
• Learn from others – what works and what doesn’t
• Use the DH CR Commissioning Pack- it offers an opportunity to make a ‘step change’ in the commissioning of CR services
• Core feature is a clear, evidence-based, patient-centred and outcome-focused service specification
• Supported by a suite of bespoke guidance, tools and templates which covers all aspects of commissioning
• Enables both commissioners and providers to:
  – Understand what is required and from whom
  – Ensure that CR services are high quality & effectively meet peoples’ needs and expectations
Grasp the opportunity and Commit to making the change

Cardiac Rehabilitation Colleagues… Step-up… ..and make a real difference to real people’s lives
Further Information

NHS Improvement:

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Julie.harries@improvement.nhs.uk
Sarah.armstrong-klein@improvement.nhs.uk

Commissioning Pack for Cardiac Rehabilitation


Patient Guide