Review of Cardiac Rehabilitation

September 2010
### DOCUMENT INFORMATION

<table>
<thead>
<tr>
<th>Document Name</th>
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<tbody>
<tr>
<td><strong>Organisation / Further Information / Additional Copies</strong></td>
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<tr>
<td>Date of Issue</td>
<td>October 2010</td>
</tr>
<tr>
<td>Status</td>
<td>Final</td>
</tr>
<tr>
<td>Version</td>
<td>3.1</td>
</tr>
<tr>
<td>File Name</td>
<td>Cardiac Rehabilitation Review</td>
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### PROJECT INFORMATION

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<tr>
<th>Workstream</th>
<th>Cheshire &amp; Merseyside Cardiac Work Programme 2010/11</th>
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<tr>
<td>Project</td>
<td>Cardiac Rehabilitation</td>
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### VERSION HISTORY

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<td>Judy Arslanian</td>
<td>Aug 10</td>
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<td>Judy Arslanian</td>
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1. Executive Summary

The Cheshire and Merseyside Cardiac and Stroke Networks (CMCSN) in line with the Work Programme, carried out a review of Cardiac Rehabilitation (CR), over a 2 month period from July to August, involving Cardiac Rehabilitation Practitioners, both in the Community and the Acute Trusts.

The aim was to review the current service configuration and provision for CR across the Network, and to identify any service improvement required, relating to the delivery of CR provision.

To gather the information, meetings took place with individuals, who had volunteered to help the Network to deliver the Work Programme in A2 Cardiac Rehabilitation (Appendix 1) and A3 Heart Failure (Appendix 2). As the review progressed, it became apparent that the setting up of a Network Wide Working Group was paramount to developing the service. This group would be able to consider how to support identified areas for improvement of patient management across the whole pathway from primary to secondary and tertiary settings.

The review highlights areas of good practice; identifies gaps and areas for improvement with service delivery and also recognises that neither the provision of CR, nor the title CR Practitioner is standardised across the Network.

Finally the review raises some key considerations for planning services for CR for 2011.

I would like to thank all the participants for their involvement, through the course of the review and for their contribution of this report.

Anne Porter
Service Improvement Manager
Cheshire and Merseyside Cardiac and Stroke Networks
2. Introduction

If there were a pill that cost very little, reduced cardiac deaths by 27%, improved quality of life, and reduced anxiety and depression, every cardiac patients in Europe would expect to take it. There is no such pill, but taking part in cardiac rehabilitation programme can provide all these benefits - Prof Bob Lewin, 2005.

NICE 2007 – all patients regardless of age should be given advice and offered cardiac rehab with an exercise component.

The latest NACR report on CR found that only 41%, of suitable patients in 2010 were provided with the service.

CR is “the sum of the activities required to ensure the patient’s best possible physical, mental and social conditions so that they may by their own efforts preserve, or resume when lost, as normal a place as possible in the life of the community” WHO 1993.1

CR is more than exercise and post hospital recovery, it should deliver holistic and long term practical support with broad components of medical evaluation, prescribed exercise, risk factor modification, education and counselling.

CR is one of the priority areas contained in the Cheshire and Merseyside Cardiac and Stroke Network’s (CMCSN) Work Programme (2010/11). Due to the patient benefit and cost savings that can be gained from CR the review reflected the need to assess services in line with the Quality Innovation Productivity and Prevention agenda by planning to streamline healthcare delivery.

The review was conducted from July – August 2010, from initiation to completion.

The Review Process

1) Background research and information gathering

2) Meetings scheduled with key people involved in the Priority Setting Questionnaire, April 2010

3) Follow up registrations of interest to deliver the Work Programme

4) Commence the development of a Network Wide Working Group (NWWG)

5) Follow up other related issues as they presented in relation to problems in service delivery

6) Collation of information necessary to produce the final report

7) Develop a cardiac rehabilitation network strategy

1 World Health Organisation, Geneva WHO October 1991
3. Objectives

The overall objective of the review was to gain a clear understanding of the current configuration and provision for CR across the CMCSN. Given the real benefits that can be obtained from CR for patients and the cost implications and the low numbers nationally of patients receiving CR, to establish what changes could be made to help with the patient pathway.

4. Current Services

There is no current database/document available, which contains a complete breakdown of CR provision in the Network. Patients can access the nearest CR provider, by following the link www.cardiac-rehab.net but this is not specific to this Network.

5. Guidance/Drivers

NSF for CHD – Standards 11 and 12 (2)
NHS Improvement – CR (previously Heart Improvement Team)
BACR (British Cardiac Rehabilitation) Standards and Core Components for CR 2007
NICE – Commissioning guide for CR and Clinical Guidelines
NACR – Publication of Data/benchmarking 2010
BHF – National Campaign for Cardiac Rehab
NHS Improvement Heart – Transforming Cardiac Rehabilitation August 2010
Menu Driven Care
Heart Failure Rehabilitation links with Heart Failure Cardiac Work Stream

6. Provider Engagement

Interviews were carried out with the CR practitioners listed below in Table 1. A schedule of the meetings held is in Appendix 3.

<table>
<thead>
<tr>
<th>Name/Job Title</th>
<th>Locality</th>
<th>Acute/Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carol Over / Clinical Lead/Team Manager for Cardiac Rehabilitation</td>
<td>Halton General Hospital</td>
<td>Acute</td>
</tr>
<tr>
<td>Corinne Hughes/ Nurse Consultant for Cardiology</td>
<td>Whiston Hospital</td>
<td>Acute</td>
</tr>
<tr>
<td>Elaine Gossage/ CHD Coordinator</td>
<td>Knowsley Community CVD Service LHCH</td>
<td>Community</td>
</tr>
<tr>
<td>Frieda Rimmer/ Clinical Services Manager</td>
<td>Wirral PCT</td>
<td>Community</td>
</tr>
<tr>
<td>Jan Naybour/Cardiac Rehab Practitioner/Health Promotion Nurse</td>
<td>Liverpool Heart and Chest Hospital (LHCH)</td>
<td>Acute</td>
</tr>
<tr>
<td>Joanne Brown/ Cardiac Rehab Facilitator</td>
<td>Royal Liverpool and Broadgreen</td>
<td>Acute</td>
</tr>
<tr>
<td>Sandra Dunne/Cardiac Team Leader (HF and CR)</td>
<td>Warrington PCT</td>
<td>Community</td>
</tr>
<tr>
<td>Sophie McIntosh / Cardiac Rehabilitation Specialist</td>
<td>Countess of Chester (CoC) and Community Care Western Cheshire PCT</td>
<td>Acute/Community</td>
</tr>
</tbody>
</table>

Table 1 Key CR Practitioners
7. The 4 core phases of Cardiac Rehabilitation

CR is more than exercise and post hospital recovery; it should deliver holistic and long term practical support with broad components of medical evaluation, prescribed exercise, risk factor modification, education and counselling. Table 2 describes the current four phases of CR.

<table>
<thead>
<tr>
<th>Phase</th>
<th>When it should take place</th>
<th>What happens</th>
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<tbody>
<tr>
<td>Phase 1</td>
<td>As an inpatient after Cardiac Event</td>
<td>Initial Assessment and Risk Identification</td>
</tr>
<tr>
<td></td>
<td>(2 days after the Cardiac Event)</td>
<td>Referral to CR Team</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Post discharge</td>
<td>Full assessment for ongoing management</td>
</tr>
<tr>
<td></td>
<td>(Within 7 days post discharge)</td>
<td>Pt contacted/visited by a CR nurse</td>
</tr>
<tr>
<td>Phase 3</td>
<td></td>
<td>Structured Rehabilitation Programme – should be provided, along with access to psychological services, health education and further consultations</td>
</tr>
<tr>
<td>Phase 4</td>
<td></td>
<td>Long term maintenance. Lifestyle and treatment recommendations need to be maintained with reviews to achieve optimal results</td>
</tr>
</tbody>
</table>

Table 2 Core phases of CR

8. Outcomes of CR Meetings held

1. Provision of CR is not standardised across the Network and varies as follows:

   a) Phase 1, though normally carried out whilst the patient is in hospital, by Specialist Practitioners in the Acute setting, is actually carried out by the Community Team who visit the hospital on a daily basis (Warrington PCT)

   b) Phase 1 can be facilitated either by a Specialist Practitioner (Royal Liverpool and Broad green) or by a member of the ward staff who has been trained (LHCH)

   c) The role of the CR Practitioners varies from being responsible for ensuring Phase 1 is carried out (LHCH), to actually carrying out phases 1-3 (Warrington PCT)

   d) CR provision can include counselling and specialist dietetic advice (Halton General) or neither counselling nor specialist dietician are funded (Countess of Chester)

2. It was agreed that a reduced review of the service should be carried out as a full review would be unachievable given the time constraints of the project

3. The Network facilitated the CR Practitioner’s meetings which have been well attended. It was suggested that a standardised format for presenting the service delivered by each team, could be utilised as a form of Peer Review in future meetings

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2 BACR Standards and Core Components for Cardiac Rehabilitation 2.2.1 and 2.2.4
4. The provision of CR for heart failure patients was not standardised across the Network. It was also acknowledged that it would be extremely difficult to streamline the pathway for Heart Failure patients as they require a different programme, for both the educational and exercise aspects

9. Good Practice identified

1. CR at Halton is truly multidisciplinary. Counselling is provided “in house” as the Manager is a fully qualified counsellor. Allowing patients to access support in a timely fashion, avoiding any delays in the system.

2. All patients referred for CR to Whiston and St Helens are contacted within 1 week on receipt of the referral

3. Royal Liverpool and Broadgreen have a very proactive and innovative approach eg: planning to trial a shortened course for patients who had had a Primary Percutaneous Intervention (PPCI)

4. CR at Warrington PCT is covered equally by Heart Failure and CR nurses, who are able to provide cross over

5. Countess of Chester are able to offer an “on site” specialist smoking cessation facility which the patients can access in the Coronary Care Unit, then are followed up in CR

10. Areas for Service Improvement in CR

1. Discharge documentation issues, highlighted by the CR Practitioner at Liverpool Heart and Chest Hospital, relating to discharge documentation generated by IHCH ie incomplete data; sent to the wrong provider; inaccurate data; no data – all affects how and when a CR provider can access the patient.

2. No funding for a specialist dietician or counselling service at the Countess of Chester

3. Rehabilitation service at Warrington PCT is run jointly by CR Nurses and Heart Failure Nurses, however Heart Failure patients are not funded to access this service

4. Extending the service to provide CR for Heart Failure patients

5. In order to increase the uptake of CR, considerations are being made to fast track patients who have had a Primary Percutaneous Cardiac Intervention, because their recovery tends to be much quicker than those patients who access CR through elective routes

6. Entering data onto the National Audit for CR (NACR) is time consuming and is an issue when there is a shortage of staff and or lack of admin support

7. After discussion with some CR providers, there is a need for CR Practitioners/Managers/Clinicians to spend time looking at their services and jointly making improvements to become more efficient and effective

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3 BACR Standards and Core Components for Cardiac Rehabilitation 2.2.11
4 NICE Chronic Heart Failure quick reference guide 2010
5 NHS Institute for Innovation and Improvement – Quality and Service Tools - Empowerment
11. Network wide working Group\(^6\) (NWWG) Registrations of Interest

On receipt of the CMCSN Work Programme June 2010 – 2011, a number of practitioners and clinicians registered an interest in working with the Network Work Programme and improve services across Cheshire and Merseyside for patients with CR. A multidisciplinary network wide working group was established to help to improve these services. The role of the NWWG will be to facilitate, disseminate information received and support the group. Initially the constitution of this group will be to represent specialties across the Network, in Acute – Secondary and Tertiary Care - and the Community. When appropriate, representatives from other specialities will be sought.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Name</th>
<th>Place of Work</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Cardiologist (Tertiary Setting)</td>
<td>Archi Rao</td>
<td>Liverpool Heart and Chest Hospital</td>
<td><a href="mailto:Archana.rao@lhch.nhs.uk">Archana.rao@lhch.nhs.uk</a></td>
</tr>
<tr>
<td>Heart Failure Specialist Nurse</td>
<td>Barbara Stephens</td>
<td>Wirral Community</td>
<td><a href="mailto:Barbara.Stephens@wirralpct.nhs.uk">Barbara.Stephens@wirralpct.nhs.uk</a></td>
</tr>
<tr>
<td>Heart Failure Nurse</td>
<td>Carole Roscoe</td>
<td>Whiston Hospital</td>
<td><a href="mailto:Carole.Roscoe@sthk.nhs.uk">Carole.Roscoe@sthk.nhs.uk</a></td>
</tr>
<tr>
<td>Principal Pharmacist</td>
<td>Dave Thornton</td>
<td>Aintree Hospital</td>
<td><a href="mailto:Dave.Thornton@aintree.nhs.uk">Dave.Thornton@aintree.nhs.uk</a></td>
</tr>
<tr>
<td>Director of Public Health Outcomes</td>
<td>Ewan Wilkinson</td>
<td>Liverpool PCT</td>
<td><a href="mailto:Ewan.Wilkinson@liverpoolpct.nhs.uk">Ewan.Wilkinson@liverpoolpct.nhs.uk</a></td>
</tr>
<tr>
<td>Consultant Cardiologist (DGH)</td>
<td>Jason Pyatt</td>
<td>Royal Liverpool and Broadgreen</td>
<td><a href="mailto:Jason.Pyatt@rlbuht.nhs.uk">Jason.Pyatt@rlbuht.nhs.uk</a></td>
</tr>
<tr>
<td>GPSI – Cardiology</td>
<td>Phil Jennings</td>
<td>West Wirral Group Practice Irby Surgery</td>
<td><a href="mailto:Philip.jennings@nhs.net">Philip.jennings@nhs.net</a></td>
</tr>
<tr>
<td>Public Health Development Manager</td>
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<td>NHS Sefton</td>
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<tr>
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<td>Ruth Grainger</td>
<td>Cheshire and Merseyside Cardiac and Stroke Networks</td>
<td><a href="mailto:Ruth.Grainger@cissu.nhs.uk">Ruth.Grainger@cissu.nhs.uk</a></td>
</tr>
<tr>
<td>Palliative Care Heart Failure Specialist Nurse</td>
<td>Rebecca Telfer</td>
<td>Whiston and St Helens</td>
<td><a href="mailto:Rebecca.Telfer@sthk.nhs.uk">Rebecca.Telfer@sthk.nhs.uk</a></td>
</tr>
<tr>
<td>Commissioner</td>
<td>Sue McGorry</td>
<td>Liverpool PCT</td>
<td><a href="mailto:Sue.McGorry@liverpoolpct.nhs.uk">Sue.McGorry@liverpoolpct.nhs.uk</a></td>
</tr>
<tr>
<td>Cardiac Rehab Specialist</td>
<td>Sophie McIntosh</td>
<td>Countess of Chester and Community Care Western Cheshire PCT</td>
<td><a href="mailto:Sophie.McIntosh@coch.nhs.uk">Sophie.McIntosh@coch.nhs.uk</a></td>
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<tr>
<td>Practice Based Commissioning Programme Manager</td>
<td>Stephen Astles</td>
<td>NHS Sefton</td>
<td><a href="mailto:Stephen.Astles@sefton.nhs.uk">Stephen.Astles@sefton.nhs.uk</a></td>
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</table>

Table 3 Network Wide Working Group for both Heart Failure and Cardiac Rehabilitation

\(^6\) CMCSN Work Programme A2 Action 1.
8. Conclusion

This review has provided the Network with:

- A deeper understanding, though not complete, of the provision of CR.
- An opportunity to standardise some of the variances between services using the evidence of good practice by others.
- The rationale behind the development of a Network Wide Working Group.
- Suggestions on how to maximise the forum of the CR Practitioners and improve sharing of best practice and peer support.
- An opportunity to use Patient Public Engagement (PPE) to evidence improvements for patients.
- The need to address inputting of data onto NACR\(^7\).
- A platform to support the baseline for the next work programme 2011/12 for the Cheshire and Merseyside Network.
- An understanding that there is clearly a need for extra funding, for either specialist provision where a shortfall in service provision has been identified and or administrative support to complete the NACR database.

\(^7\) NACR Annual Report 2010
9. Recommendations

- Present the findings of the review to the CR Practitioners Forum
- Identify and address what the issues are in relation to the poor discharge documentation from LHCH. A majority of CR referrals will be generated from this hospital.
- Benchmark the current provision of CR across the Network
- The review is only a snapshot, therefore each CR provider should be contacted to identify any gaps in service across the Network
- Highlight where additional specialist input into CR ie: Dietician and Clinical Psychologist, is required
- Report, circulate and discuss outcome of NWWG to the Cardiac Advisory Board
- Report, circulate and discuss outcome of CR review to the Cardiac Advisory Board
- Use CMCSN website for improved communication
- Maximise the potential of the CR Practitioners Group to problem solve. Assist the CR Practitioner to develop a strategy to promote and support their service
- Set up a Study Day where good practice within the Network can be shared with the Multidisciplinary Teams
- Develop a questionnaire to baseline the current provision of CR in the Community for HF patients. Action results
- Utilise the NWWG to discuss the Department of Health Commissioning Pack for CR

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8 CMCSN Work Programme A2 Action 6
**A2. CARDIAC REHABILITATION**

**GOAL:** Increase access to, equity of provision and uptake of cardiac rehabilitation for all cardiology pathways. Minimise unwarranted variations within and among programmes and between different patient cardiac pathways. Cardiac rehabilitation is integrated into all cardiac care pathways where all patients who can benefit have an assessment of individual needs and ability (menu-driven). The project will be delivered in line with World Class Commissioning and the Quality, Innovation, Productivity and Prevention agendas.

**Drivers:**
- NSF for CHD – standards 11 and 12 [2]
- NHS Operating Framework – Priority 2.58 [3]
- Heart Improvement Team - Priority work programme [4]
- BACR – Standards and core components for cardiac rehabilitation [5]
- NACR – Publication of data/benchmarking [7]
- BHF – National campaign for cardiac rehabilitation [8]
*Heart Failure Rehabilitation links with Heart Failure Cardiac Work Stream (A3)*

**Action:**
1. Facilitate and support the development of a Network wide multidisciplinary working group to develop and take forward recommendations.
2. Carry out a review of current service configuration and provision for cardiac rehabilitation across the Network.
3. Support implementation of NACR database in all organisations to improve data quality/ submission timelines.
4. Support the development of a Network wide model of service that will support all patients who have an acute Cardiac event to access cardiac rehabilitation.
5. Explore expanding routine cardiac rehabilitation to other groups e.g. heart failure (linking with HF work stream).
6. Develop cardiologist clinical leadership for referral to cardiac rehabilitation.
7. Support delivery of educational events for commissioners, practitioners, nursing and medical staff.

**Measure of success:**
- Development of report to analyse impact / relevance of project on WCC competencies and the QIPP agenda
- Group membership that is representative of all organisations and appropriate stakeholders; Attendance at meetings, actions completed and reported to Cheshire & Merseyside Cardiac Board.
- Baseline report of existing service provision across Network – demand, current and future capacity and workforce.
- Development of proposed model of services with standardised protocols to support joint agreement, planning and commissioning of services across hospital trusts, GP practice and commissioners.
- Integration with heart failure work programme; Reported patient referral numbers/types of patients for cardiac rehabilitation.
- Cardiologist clinical leadership in all organisations across Network.
- Participation of all sites in NACR database.
- Number of educational events facilitated by Network Support Team; Number of healthcare professionals attending, and Evaluation of, educational events.

**Timescales**
- July 2010 – May 2011
### A3. HEART FAILURE

**GOAL:** Improve knowledge and communication to increase the identification of patients with heart failure and inclusion upon practice based registers to allow for optimisation of therapy. Support the Acute and Primary Care Trusts heart failure teams to enable patients with heart failure to receive efficient and effective care delivered through an integrated approach from diagnosis through to end of life stages and palliative care. The project will be delivered in line with World Class Commissioning and the Quality, Innovation, Productivity and Prevention agendas.

**Drivers:**
- NSF for CHD – standard 11 [2]
- Heart Improvement Team - Priority work programme [4]
- *Heart Failure Rehabilitation links with Cardiac Rehabilitation Cardiac Work Stream (A2)

**Benchmarking and the 18 week Pathway**

**Action:**
1. Facilitate and support the heart failure team to develop a Network wide multidisciplinary heart failure working group to improve the service and identify gaps.
2. Work with commissioners and providers to support the successful implementation and delivery of agreed streamlined pathways across primary and secondary care.
3. Work with commissioners to support identification and appropriate registration and validation of patients with heart failure in primary care.
4. Agree Network guidance and recommendations to streamline access to diagnostics (Echo and BNP) for the identification of patients with suspected or existing heart failure within primary and secondary care.
7. Review options for secondary care databases for patients with heart failure and support implementation of an agreed database across the Network.
8. Support/promote implementation of the Gold Standards Framework, Supportive Care Registers/Care Profiles for End of life Care and the Liverpool Care Pathway for patients with heart failure within primary and secondary care.
9. Assist in the delivery of advanced communications courses for primary and secondary care practitioners for end of life and palliative care.

**Timescales**
June 2010 - May 2011

**Measure of success:**
1-9 Development of report to analyse impact / relevance of project on WCC competencies and the QIPP agenda
1. Network wide group established that is representative of all perspectives; Attendance at meetings, actions completed and reported to Cheshire & Merseyside Cardiac Board.
2. Development of resources/information/tools to support commissioners and providers in implementation.
3. PCT validation of heart failure registers.
4-7. Agreed Network wide guidance and recommendations disseminated and tool developed to gauge successful implementation.
8-9. Number of healthcare professionals attending, and evaluation of, conference/courses.
## Appendix 3  Meetings/Conversations arranged with Cardiac Rehab Teams by Anne Porter July/August 2010

<table>
<thead>
<tr>
<th>Cardiac Rehab Teams/Comments</th>
<th>Tues 13.7.10</th>
<th>Fri 16.7.10</th>
<th>Thurs 22.7.10</th>
<th>Mon 2.8.10</th>
<th>Thurs 5.8.10</th>
<th>Mon 23.8.10</th>
<th>Wed 25.8.10</th>
<th>Fri 3.9.10</th>
<th>Mon 13.9.10</th>
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</table>
| **Elaine Gossage – Knowsley and St Helens**  
Gen intro for me at the beginning, then able to pursue more questions in detail at the 2nd meeting | am | | | am |
| **Jan Naybour – LHCH Acute**  
– just does phase 1 CR; has probs with referrals from the wards – electronic from Sept | | | 11am | |
| **Carol Over – Halton Acute – OT**  
Provides true MD Cardiac Rehab. Discussed Priority Setting Questionnaire – Not using the doc at all for her current practice. Suggested presentations as a form of peer review at Network Meetings | | am | | |
| **Sophie McIntosh – COCH Acute – Exercise Physiologist – True MD Cardiac Rehab.**  
Did not want to waste her time on anything which didn’t affect the pt. Felt that Network Meetings should directly affect CR. Shortfall of 2 hrs Clinical Psychologist and Specialist Dietician | | | | pm |
| **Frieda Rimmer – Wirral Heart Centres**  
– phone call re input into Priority Setting Questionnaire. Not using the Priorities to affect practice. Main Concern – want to follow up their own PPCI patients, but Reluctance from LHCH + poor doc from LHCH. | | | | |
| **Corinne Hughes – Whiston Hospital**  
– Cardiology Nurse  
Consultant – over Cardiac Rehab and Heart Failure. Poor Documentation from LHCH | am | | | |
| **Joanne Brown – Cardiac Rehab Facilitator – Royal Liverpool and Broad Green** – re Priority Setting. Felt it difficult to complete.  
Felt all aspects were useful. No issue with Documentation from LHCH | | am | | |
| **Greg Cattin – Exercise Physiologist – Halton** – pursuing his interest of working with the Network | | | | am |
| **Dr Bashir Matata – LHCH** – Research doctor  
To discuss a Research Proposal to increase the uptake of cardiac rehab in the network | | | | am |
| **Sue McGorry – Commissioner – Liverpool PCT**  
To discuss the Cardiac Rehab Pathway | | | | pm |
## Appendix 4

Questionnaire to establish the provision of Cardiac Rehabilitation for patients with Heart Failure  

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Place of Work</th>
<th>Acute/Community</th>
</tr>
</thead>
</table>

1) Do you provide CR for patients with Heart Failure?  

2) If no, please state the reasons why.  

3) If yes, are there any restrictions and if so, what are they?  

4) Which catchment area do you cover?