# South East Wales Cardiac Network

## Cardiac Rehabilitation

### Action Plan and Strategy

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**Purpose and Summary of Document:**

An Action Plan for the development and delivery of Cardiac Rehabilitation in South East Wales based on an assessment of need against standards set by the Cardiac Disease NSF, Quality Requirements and NICE using the NPHS need and capacity tool.

**Publication/Distribution:**

- Cardiac Network, Board, Clinical Collaborative Group
- Cardiac Networks Co-ordinating Group
- Regional Office
- Welsh Assembly Government
NETWORK LEVEL ACTION PLAN AND STRATEGY FOR THE DEVELOPMENT OF
CARDIAC REHABILITATION SERVICES IN SOUTH EAST WALES

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1. EXECUTIVE SUMMARY OF FINDINGS

- There are some good CR services in SE Wales – with North Gwent funded to offer an exemplary service
- There are great inequities in services and patient access in CR services across SE Wales including inequities in:
  - patient groups referred
  - staffing levels and skill mix
  - budgets / resources – no clear funding streams
  - no service is meeting NSF standards to provide CR for all patients
  - some services not offering CR to priority patient groups
  - variation in models of service
- Services need systems in place to identify all potential eligible patients
- Services need robust clinical audit data to demonstrate lifestyle changes and outcomes
- All services need an identified cardiologist champion
- All services need to be responsive to patient needs
- Health communities in SE Wales should offer same, equitable high quality provision of cardiac rehabilitation to all eligible patients
- All new LHBs should offer CR to priority patient groups
- CR should be specified as part of the planned definitive patient treatment pathway and included in any targets set
- The development of CR services should be specified in LDPs and adequate resources made available
- All services should undertake a modernisation review / process mapping to ensure service improvement and best practice
2. BACKGROUND

In the first CHD NSF (2001) Key Action 20 specified a comprehensive Cardiac Rehabilitation (CR) programme for “all ACS patients some of whom have had a revascularisation programme”. However Cardiac Rehabilitation did not have its own standard and it has had a relatively low profile compared to other cardiac interventions. Specific funding has been minimal and patchy, and development has been uneven particularly as CR is not considered part of “treatment” in Assembly Referral to Treatment targets. There has been heavy reliance on short term Lottery and Inequalities in Health funding, which has undermined its sustainability.

However, the emphasis has begun to change, as a result of a developing evidence base, stronger policy drivers and political awareness raising by patients themselves including the campaign co-ordinated by the British Heart Foundation.

2.1 Policy drivers - Cardiac Disease NSF, Assembly directives and Cardiac Strategic Framework

The updated interim Cardiac Disease National Service Framework and related Quality Requirements give Cardiac Rehabilitation in Wales its own Standard 6 for the first time: “Everyone with established coronary heart disease is offered an appropriate evidence-based cardiac rehabilitation plan and has the high quality, multi-disciplinary cardiac rehabilitation support they need to achieve this plan.”.

On 29/2/08 a letter headed “Developing Cardiac Rehabilitation Services in Wales” was sent from the Assembly to LHB Chief Executives informing them of the need for local “cost and clinically effective cardiac rehabilitation services” as part of “an integral part of the package of care for people at risk of or who have cardiac disease”. The letter requested “each LHB in each of the 3 regions, working together through the Cardiac Network, to assess current cardiac rehabilitation provision against the requirements of the NSF Standards and submit a Network level action plan for the delivery of the NSF Standards to the relevant Regional Office by 31 December 2008.” In addition to requiring action plans the letter specified the need to take into account the projects previously funded by Lottery and Inequalities in Health funding and the need for joint working with Stop Smoking Wales and the National Exercise Referral Scheme.

Key Action 29 of the Cardiac Disease Strategic Framework published with EH/ML/011/08 requires Cardiac Networks to: “Develop and implement a strategy (by Dec 2008) for the systematic referral of all clinically appropriate patients to Cardiac Rehabilitation Teams staffed and providing services in accordance with agreed guidelines as set out in the Quality Requirements. Guidelines should be based on Cardiac Network-agreed guidance.” The South East Wales Regional Office agreed to extend the deadline for the development of a strategy to March 2009.

2.2 Process / methodology

In response to the above Assembly directives, the South East Wales Cardiac Network prioritised the development of a Network level action plan for Cardiac Rehabilitation as part of its work-programme. It established a Cardiac Rehabilitation Sub Group of the SEWCN Clinical Collaborative Group chaired by the Network Lead Nurse, including all stakeholders: LHBs, Trust CR multi-disciplinary professionals, a cardiologist, academics, Network Manager, primary care and patient representation.
At an all Wales level the Cardiac Networks Coordinating Group engaged NPHS to undertake a needs / capacity analysis by LHB and Trust in order to help health communities assess future numbers and resource needs for the different patient groups.

The All Wales Cardiac Rehabilitation Working Group (AWCRWG) was asked to agree patient pathways and provide a consensus statement in relation to the priority order in which different patient groups should be offered Cardiac Rehabilitation. It was also asked to make recommendations on the minimum number of sessions to be offered in Phase 3. This was to ensure professional agreement that developments across Wales were broadly based on the same principles.

Data on outcomes on a regional basis was requested from the National Audit of Cardiac Rehabilitation report 2008 covering the period to March 2007.

Findings from BHF Focus groups have also fed into the patient perspective to cardiac rehabilitation in a structured way.

2.3 What is Cardiac Rehabilitation?

As defined by the World Health Organisation, Cardiac Rehabilitation (CR) is “…the sum of activities required to influence favourably the underlying cause of the disease as well as the 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 community.”

In practice this means an assessment of patients’ individual requirements and a structured programme of advice and education on nutrition, exercise, lifestyle, psycho-social needs and medication. Historically cardiac rehabilitation has been described in terms of 4 phases:

- Phase 1 – in hospital consultation and advice
- Phase 2 – post discharge home visit and / or telephone consultation to assess patient needs and preferences
- Phase 3 – structured class programme or home programme
- Phase 4 – long term self management and exercise.

However, the terminology is changing to reflect the need for greater flexibility in programmes offered.

2.4 Evidence base for benefits of Cardiac Rehabilitation – BACR, NICE

There is now strong evidence that Cardiac Rehabilitation can be of great benefit to the quality of life of patients enabling people to self manage, resume normal life and return to work, and also to service providers in terms of reduced admissions and readmissions and thereby reducing demand on acute and specialised services.

The evidence base is now sufficiently developed for NICE to have published its clinical guideline in May 2007 MI: secondary prevention. Secondary prevention in primary and secondary care for patients following a myocardial infarction. This contains detailed evidence which indicates that post MI, CR reduces mortality, morbidity and hospital readmissions and is highly cost effective.

NICE has also produced a guide on commissioning a cardiac rehabilitation service. Whilst this tool is not available to NHS Wales, it does recommend that commissioning an effective
comprehensive cardiac rehabilitation service will, based on the evidence, confer the following benefits: greater survival, improve exercise tolerance and quality of life, reduce unplanned hospital admissions, improve clinical outcomes, provide efficient clinical management, reduce inequalities and be better value for money.

2.5 National Audit of Cardiac Rehabilitation (NACR)

The evidence base for CR is being strengthened by the establishment of the National Audit of Cardiac Rehabilitation funded by the BHF and part of the CCAD (Central Cardiac Audit Database) programme. All cardiac rehabilitation services in Wales are now inputting data to this database, which reports annually on a UK basis. Each centre can access its own data and local and regional reports are available. National reports for 2005/6 and 2006/7 have been published. However, some centres have not been fully participating from the start and it is clear that the data is not yet sufficiently robust to use as the basis for strong claims and there have been some inaccuracies in the reporting of Wales data. However, as the database becomes more fully used and verified, it will be invaluable for reporting on outcomes over time.

2.6 British Association of Cardiac Rehabilitation - Standards for cardiac rehabilitation 2007

The British Association of Cardiac Rehabilitation – the national professional body - published in 2007 Standards and Core Components for Cardiac Rehabilitation. This report acknowledges that the practice and science underpinning cardiac rehabilitation are constantly evolving, that services vary and are almost universally under-resourced.

The document sets out 6 minimum standards for the successful delivery of cardiac rehabilitation. In addition it indicates the core components for cardiac rehabilitation.

The document also defines the target patient population which comprehensively includes patients with CHD, exertional angina, ACS, pre and post revascularisation (PCI and surgery) stable heart failure and cardiomyopathy, congenital heart disease, following implantable device interventions. Whilst all these patient groups may benefit from cardiac rehabilitation, in terms of planning and developing services, there is no indication of whether any or which patient groups would benefit more and therefore are a priority when resources are scarce.

2.7 All Wales Cardiac Rehabilitation Working Group (AWCRWG) recommendations on a staged approach to developing services and management pathways

The baseline review of CR services across Wales has indicated that services are variable and inequitable in terms of staffing, patient groups referred, budgets, and programmes offered to patients. Although the NSF Standard 6 aims to offer cardiac rehabilitation to all patient groups it is recognised that it would be unrealistic to expect to achieve this improvement immediately, and that guidance on the prioritisation of patient groups and phasing of developments is essential.

There is no guidance in the Cardiac Disease NSF or BACR standards which advises on any prioritisation of patient groups which would benefit more than others from CR. Chapter 7 of the CHD NSF for England published in 2000 sets as an initial goal that “more than 85% of people discharged from hospital with a primary diagnosis of AMI or after revascularisation are offered cardiac rehabilitation Once trusts have an effective system for identifying, treating and following up people who have survived an MI or who have undergone coronary revascularisation (coronary artery bypass graft and percutaneous coronary intervention) they should extend their rehabilitation services to people admitted to hospital with other...
manifestations of CHD”. This guidance is reiterated in the NICE commissioning guidance for cardiac rehabilitation.

The AWCRWG has agreed to recommend a staged approach to commissioning cardiac rehabilitation services, whilst acknowledging that all patients should be offered CR. It acknowledges that the development of services may vary in some areas as this will be influenced by existing services and that it would be inappropriate to disengage services in a particular area simply because it does not comply with the ‘Stages’ below. The ‘Stages’, serve as guidance to inform future commissioning of Cardiac Rehabilitation services and will serve to promote greater equity in service development across Wales. The ‘Stages’ as they are arranged are consistent with commissioning advice outlined in the ‘NICE – Cardiac Rehabilitation Commissioning Toolkit’.

Stage 1  Acute Coronary Syndromes; Post Revascularisation (to include post CABG & post primary, rescue & elective PCI).

Stage 2  Newly diagnosed Angina; Heart Failure.

Stage 3  Established Stable Angina; Pre-hab (pre-CABG/elective PCI); Valve and other Cardiac Surgery, specialised Interventions (e.g. ICD implant, transplant).

Simplified Management Pathways

The AWCRWG has also agreed Simplified Management Pathways covering Appendix Phases 1 to 4 of Cardiac Rehabilitation – see Appendix iv

3. BASELINE REVIEW OF CARDIAC REHABILITATION SERVICES ACROSS SOUTH EAST WALES

A baseline review of current services based largely on the CHD NSF Quality Requirements was developed initially by Mid and West Wales Cardiac Network with contributions from all Cardiac Networks. It was completed in May 2008 by all CR services in Wales, including the 8 services in South East Wales. The baseline review has provided each service with an indication of the extent to which they are achieving the Quality Requirements as well as providing comparative benchmark of CR services across the region identifying areas of inequality. This has assisted with identifying the areas for priority in the production of this strategy “for the systematic referral of all clinically appropriate patients to Cardiac Rehabilitation Teams staffed and providing services in accordance with agreed guidelines as set out in the Quality Requirements.” in order to meet the Cardiac Disease NSF Standards by 2011.
### 3.1 Summary of funding required to deliver CHD NSF Standard 6

**SOUTH EAST WALES CARDIAC NETWORK SUMMARY**

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>Cardiff &amp; Vale</th>
<th>Gwent</th>
<th>Cwm Taf</th>
</tr>
</thead>
<tbody>
<tr>
<td>To sustain current position</td>
<td>£301,625</td>
<td>£821,241</td>
<td>£525,520</td>
</tr>
<tr>
<td>To achieve Stage 1</td>
<td>£243,101</td>
<td>£202,658</td>
<td>£600,000</td>
</tr>
<tr>
<td>To achieve Stage 2</td>
<td>£117,123</td>
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<td>To achieve Stage 3</td>
<td>£225,844</td>
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<tr>
<td><strong>Total additional costs to</strong></td>
<td><strong>£586,068</strong></td>
<td><strong>£1,032,658</strong></td>
<td><strong>£600,000</strong></td>
</tr>
<tr>
<td><strong>deliver Standard 6 of</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHD NSF</strong></td>
<td></td>
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**STAFFING SHORTFALL**

- 2.4 on current nos
- 7.69
- 7.64 CT North
- 9.18 CT South

**DEMAND**

- No of current patients referred: 1653, 2115, 977
- No of projected additional patients (NPHS tool): 2159, 3453, 2154

**POTENTIAL SAVINGS**

- Example of admissions prevented in 12 months in Gwent: 216, CT South only
- Potential savings Resource: £172,368
3.2 Key Issues and recommendations identified in Baseline Review for SE Wales

Inequities and variations

- the need for cardiac rehabilitation is far greater than the number of referrals received at most centres.
- inequities and variations in CR services and access to services across the South East Wales Network area
- in patient groups offered CR
- in staffing levels and skill mix – not all referred have access to a full multidisciplinary team of professionals
- in funding available for CR
- in models of service
- in referral to CR
- in where patients live - the patients post code

The patient groups commonly not offered rehabilitation:

- Heart Failure
- Implantable Cardiac Defibrillator (ICD)
- Pacemaker

Other groups not offered rehabilitation in all centres:

- Post PCI
- Angina
- Valve replacement Surgery.

Key recommendations:

a. All appropriate patients should have access to a high quality multi-disciplinary cardiac rehabilitation programme.

b. That the Network health communities work towards meeting the NSF and Quality Requirements in a phased manner, moving from existing service provision towards achieving the standards in the NSF by 2011.

c. Investment is needed to provide for equitable service delivery across the region and to meet the CHD NSF standards.

d. That any additional funding for CR should be targeted first at those areas with lowest CR provision in order to work towards equity across SE Wales

e. That health communities follow the recommendations of the AWCRWG in initially offering cardiac rehabilitation to post MI, post surgery and post PCI patients in line with the Consensus Guidelines agreed by AWCRWG on prioritisation of patient groups using a staged approach

f. Documented referral guidelines and robust referral criteria that are consistent with network-agreed guidance must be developed as a high priority

g. The BACR ‘Core Components for Cardiac Rehabilitation’ should be implemented - as a minimum, a Cardiac Rehabilitation service should consist of ‘a comprehensive Cardiac Rehabilitation team of appropriately qualified core staff including; a cardiac specialist nurse, physiotherapist, dietician, administrator and a designated clinical lead

h. Staffing levels need to be increased in line with BACR Standards to provide an adequate establishment for service provision and enable teams to provide for adequate cover arrangements.
i. The BACR ‘Core Components for Cardiac Rehabilitation’ recommendation that a designated clinical lead cardiologist or GP specialist in cardiology for each service should be implemented.

j. The use of consensus Simplified Management Guidelines for Cardiac Rehabilitation developed by AWCRWG, should be implemented and used to guide local service redesign

k. That all services should undertake a modernisation review to ensure maximum efficiency
### 3.3 An example of outcomes demonstrated in local services (Gwent)

**Gwent performance indicators - performance indicators**

<table>
<thead>
<tr>
<th></th>
<th>North Gwent Nevill Hall</th>
<th>South Gwent St Woolos</th>
<th>Pontypool County</th>
<th>Caerphilly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average % improvement in HRQL Phase III</td>
<td>20</td>
<td>18</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Average % reduction in anxiety and depression Phase III</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Average % improvement in functional capacity Phase III</td>
<td>20</td>
<td>18</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Reduction in % cardiac admissions 90 days</td>
<td>36</td>
<td>24</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Admissions prevented post CR up to one year</td>
<td>75</td>
<td>19</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>
3.4 Patient involvement and feedback

In October 2008, the British Heart Foundation ran three focus groups of individuals who had had personal experience of Cardiac Rehabilitation Services in different parts of Wales, including in Newport, Gwent. The main pointers for service development and improvement cover the issues below:

a. Earliest possible engagement with the Rehabilitation Service is critical to achieving best possible outcomes from the patient's perspective.

b. The presumption should be that all cardiac patients get access to rehabilitation services if they want it and there are no clinical obstacles.

c. Referral processes should be clear and uniform within NHS.

d. Clear statements of what patients might expect from rehabilitation, and on what timescales should be available at the earliest opportunity.

e. Flexibility in designing programmes to the individual's needs is valued as against any 'one-size fits all' tendency.

f. Good communication between different elements of sometimes complicated NHS structures/arrangements is essential to avoid delay and confusion.

g. Programmes should be pro-active and accommodating in relation to relevant participation by family/carers.

h. Rehab. groups and classes should as far as possible be locality based, and this most particularly with reference to rural areas

i. Arrangements for Phase 4 exercise programmes should be reviewed so that 'partnerships', e.g. with local authorities and other providers are secure and uniform in all areas, including the matter of charges.

j. The final point in response to being asked about the strengths of their local Rehabilitation Service is that, notwithstanding all other factors, it is the quality of staff on the ground that makes their experience of rehabilitation positive and successful.

3.5 Links with National Exercise Referral Scheme (NERS)

All CR services in SE Wales are liaising with their local NERS in relation to Phase 4 CR.

However there are concerns regarding NERS access criteria which are potentially excluding a large group of the population who have had previous MIs but have not been recently assessed as to their suitability for exercise. Current NERS criteria are too rigid to incorporate these patients.

3.6 Links with Stop Smoking Wales

There is currently no direct link between Cardiac Rehabilitation services and the Stop Smoking Wales programme. Stop Smoking Wales contact cards are available in CR clinics and handed out to patients. Within CR services smoking cessation is provided directly by smoking cessation specialists. However discussions have been initiated with Stop smoking Wales in order to improve links between the two services.
EXECUTIVE SUMMARIES OF HEALTH COMMUNITY ACTION PLANS

4.1 Cardiff and Vale

Cardiff and Vale Executive Summary

The Cardiff and the Vale Cardiac Rehabilitation (CR) service is well established benefiting from a dedicated team of highly trained, experienced staff consistently achieving high quality patient standards; evident through the achievement of national awards and presentations. Dedication to PPI in the continual improvement of patient care is apparent through partnership working with focus groups, patient evaluations and the use of patient stories.

Due to an increase in funding through the Big Lottery Fund (2004-2007) specific areas of service provision within the community were developed, providing greater choice and access for patients, improving chronic conditions management. This funding was not recurrent and therefore since 2007 these services are no longer offered.

Due to inadequate staffing levels the services across Cardiff and the Vale of Glamorgan fail to meet the NPHS estimated capacity (2007) for patients post MI, invasive therapy, heart failure and angina by 71%.

Although across Cardiff and the Vale of Glamorgan capacity does not meet demand, CR for those seen (2007) results in the following outcomes;

- At 90 days after commencing multidisciplinary CR unscheduled cardiac admissions for patients who comply with the service is 6.0% as opposed to 35% for those who decline
- On completion of the programme functional capacity improved by 24%, health related quality of life improved by 25% and reduction of anxiety by 10%, patient satisfaction as reported by the National Association of CR data base demonstrates a consistent significant improvement.

If the total number of Cardiff and the Vale patients admitted with MI, revascularisation, heart failure and angina are included as potential referrals to CR, the above advantages only apply to 29% of patients who reside within C&V.

The immediate recommendation is for sustainability of the current provision at a cost of £301,625 (May 2008) and to reduce inequity in the first instance for patients recovering from MI and cardiac surgery at a cost of (£76,472) (09/10 gross/gross) and establish a service for PCI patients at a cost of £160,629.

The aim in the medium to long term is to provide a service that achieves the required quality requirements where CR is viewed as a cohesive method of chronic disease management for CHD patients – not as a single intervention, providing a CR service for patients with angina, and heart failure and in the long term to offer a CR service for ICD patients.

CR is a finite course of treatment providing an opportunity for patients to receive optimal support in making long term positive health behaviour changes and self care management. Spanning the whole health care community this optimal model of care supports the principles within Designed for Life 06, Clinical Futures and the Designed to Improve Health and the Management of Chronic Conditions in Wales 08 and the NSF 07.
4.2 Cwm Taf

Cwm Taf Executive Summary

The Cardiac Rehabilitation Services provided by Cwm Taf NHS Trust are well established, high quality services delivered by a team of highly experienced professionals. Patient satisfaction is high.

A recent baseline review conducted by the South East Wales Cardiac Network demonstrates some inequities in terms of access to Cardiac Rehabilitation (C/R) for some patient groups, differences in staffing levels and skill mix, funding sources and costs.

There is clear evidence that there is a gap in the numbers of patients discharged from both Cwm Taf North and Cwm Taf South DGHs and those that are actually referred to the services.

The key issues from the review show that patients with Heart Failure (HF) are the priority group to focus on for future provision of CR.

Although there is a gap in service provision those that do access the services have demonstrated measurable outcomes and benefits including unproved functional capacity, quality of life and reduction in anxiety.

Re-admission data:
Those patients who are referred to cardiac rehabilitation have a lower re-admission rate within 90 days of referral than those patients who are not referred or who decline the service (see P7 for calculation). A total of 216 re-admissions were “prevented” in a 12 month period in Cwm Taf South.

The associated cost savings amount to approx £172,368 for Cwm Taf South alone.

The immediate recommendation is for:

- Sustainability of current services
- Address staffing levels and skill mix across Cwm Taf-
- Facilitate access to Cardiac Rehabilitation for patients with Heart Failure
- Address access to community venues for rehabilitation programmes

Projected staffing requirements and costs for potential increase in patients groups and referrals total £329,492 for Cwm Taf North and £248,150 for Cwm Taf South.

The additional funding will help to meet the standards and Quality Requirements of the National Service Framework for Cardiac Disease, the Management of Chronic Disease in Wales and ensure improved equity and access across the Cwm Taf Trust.
4.3 Gwent

Gwent Executive Summary

Gwent Cardiac Rehabilitation (CR) service is well established benefiting from a dedicated team of highly trained, experienced staff consistently achieving high quality patient standards; evident through the achievement of national awards and published research. Dedication to PPI in the continual improvement of patient care is apparent through partnership working with two registered charities, focus groups and the use of patient stories.

Due to an increase in funding through the IIH fund (2001-8) specific areas of service provision such as heart failure and angina management have become integral to secondary care, community services and chronic conditions management. Due to inadequate staffing levels the services in south Gwent (Caldicot/Chepstow/Newport/Pontypool) and Caerphilly fail to meet the NPHS estimated capacity (2007) for patients post MI, invasive therapy, heart failure and angina by 70%. Where staffing meets the basic minimum requirement, as in the north, the team is best equipped to meet performance indicators such as activity benchmarks, a marked reduction in hospital admissions, an improvement in patient’s health related quality of life and a high level of satisfaction with the service. Based on 2007 figures the current service is cost effective but fails to reach its full potential.

The immediate recommendation is for sustainability of the current provision at a cost of £813,241 WTE (09/10 gross/gross) and to reduce inequity in the first instance for patients recovering from MI and re-vascularisation at a cost of £202,658 WTE (09/10 gross/gross).

The aim in the medium to long term is to provide a service that achieves the required quality requirements where CR is viewed as a cohesive method of chronic disease management for CHD patients – not as a single intervention. For patients not to view CR as a finite course of treatment but as an opportunity to receive optimal support in making long term positive health behaviour changes and self care management. Spanning the whole health care community this optimal model of care supports the principles within Designed for Life 06 Clinical Futures and the Designed to Improve Health and the Management of Chronic Conditions in Wales 08 and the NSF 07.