SCHEDULE 2 – THE SERVICES

Service Specification No.	03/CVDS/0011
Service	Cardiac Rehabilitation Stage 4 and 5 – lifestyle advice and exercise
Commissioner Lead	Clinical Commissioning Programme for Cardiovascular Disease and Stroke
Provider Lead	Service Review, Design and Delivery
Period	1ST April 2013 to 31st March 2014
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Cardiovascular Disease (CVD) accounts for over one third of all deaths in the UK each year. The main forms of CVD are coronary heart disease (CHD) and stroke. Just under half (48%) of all CVD deaths are from Myocardial Infarct (MI) or angina, making CHD the most common cause of death in the UK. Although death rates from CHD have fallen steadily in the UK since the 1970's, recent statistics from the British Heart Foundation indicate that there is some evidence to suggest that these rates are beginning to plateau in younger age groups.

Cardiac rehabilitation can improve health outcomes and quality of life for people with coronary heart disease. Evidence suggests that it can reduce mortality by as much as 20-25 per cent over three years. Rehabilitation offers people comprehensive and tailored help with changing their lifestyle, involving education and psychological input, as well as exercise training (National Service Framework for Coronary Heart Disease; chapter seven cardiac rehabilitation 2000)

Cardiac rehabilitation is defined by the World Health Organisation as:

"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 people may, by their own efforts preserve or resume when lost, as normal a place as possible in the community. Rehabilitation cannot be regarded as an isolated form or stage of therapy but must be integrated within secondary prevention services of which it forms only one facet".

The provision and uptake of cardiac rehabilitation has been a priority both nationally and locally for some time as demonstrated below;

- The National Service Framework for Coronary Heart Disease, chapter Seven Cardiac Rehabilitation,March 2000
- National Service Framework for Coronary Heart Disease, chapter six Heart Failure, 2000
- National Service Framework for Long term Conditions, 2005
- NICE clinical guideline for Chronic Heart Failure CG5, 2003
- NICE clinical guideline for Chronic Heart Failure CG108, 2010
- MI: Secondary prevention NICE clinical guideline 48, May 2007
- Chapter 57, Cardiac rehabilitation, a national clinical guideline, Scottish

Intercollegiate Guidelines Network, January 2002

- Heart Failure. A quick guide to quality commissioning across the whole pathway of care. NHS Improvement, 2009
- Cardiac Rehabilitation Commissioning Pack. Department of Health, 2010
- British Association for Cardiovascular Prevention and Rehabilitation standards and core components for cardiovascular disease prevention and rehabilitation 2012.
- NHS white paper, Liberating the NHS, Equity and Excellence, DOH 2010
- National Audit of Cardiac Rehabilitation Annual Statistical Report 2012
- Cardiovascular Disease Outcomes Strategy – Improving outcomes for people with or at risk of cardiovascular disease. Department of Health, 2013

This service specification covers Stage 4, the delivery of a comprehensive cardiac rehabilitation programme and Stage 5, the final assessment of the seven stage pathway described in the Cardiac Rehabilitation Commissioning Pack, DOH 2010. It links with the preceding Stages 0 -3; the identification, recruitment, referral, assessment and development of a personalised care planandStage 6, transition to long term self- management in a seamless and integrated individual pathway of support for patients.

Service users and clinicians have been actively involved in the development of this service specificationas a result of the Cardiac Rehabilitation Service Improvement Plan (February 2013).

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

2.2 Local defined outcomes

- Integrated care closer to home
- To reduce emergency admission rates particularly for patients with heart failure
- Increased uptake and completion of cardiac rehabilitation for lifestyle management and secondary prevention and promote a return to a full and normal life in the community post cardiac event/diagnosis.
- Improved Quality of Life outcomes

3. Scope

3.1 Aims and objectives of service

The aim of the service is to reduce the risk of secondary cardiac problems and promote the return to a full and normal life in the community post cardiac event/diagnosis.

This will be achieved by educating patients with a history of coronary heart disease including myocardial infarction, before and after revascularisation procedures (angioplasty and CABG), stable angina, chronic heart failure and other specialist interventions such as transplant, in self-care through information and advice on lifestyle changes including the management of risk factors and secondary prevention.

Service provision will be equitable, accessible and responsive for residentswithin Dorset Clinical Commissioning Group localities.

The pathway will beevidence based, clinically and cost effective with the following outcomes;

- improved cardiac function and cardiovascular health / fitness
- reduced major cardiac risk factors
- reduced long term cardiac mortality
- decreased secondary coronary events
- reduced number of unplanned re – admissions
- improved take up and accessibility of the service
- a sustainable service
- enhanced experiences for patients and their carer(s)
- enhanced quality of life
- increase self-management skills

The service will support patients to integrate back to work, family life and social activities.

3.2 Service description/care pathway

The service will provide stage 4 and 5 of the pathway. It will deliver information, help and advice on health education and secondary prevention, health promotion and lifestyle, relaxation, diet and weight management, physical activity and exercise levels, smoking cessation and alcohol consumption, psychological and social support, cultural and vocational needs and the needs of family and carers.

This will be delivered in a personalised service with a choice of;

- group session
- Heart manual
- Individual ‘one to one’ basis

Whilst it is recognised that all patients should receive an individually designed ‘menu driven’ programme relevant to their needs, the service should provide:

- A rehabilitation service coordinator.
- The right to choose, with information, advice and support, and in agreement with the cardiac rehabilitation team, which parts of the service patients wish to access

based on their individual need and suitability

- All services will be culturally sensitive e.g. targeting under-represented and hard to reach groups – BME, women, carers and patients with class II and III left ventricular systolic dysfunction heart failure
- All services will endeavour to accommodate patients with special needs

Patients will be encouraged to choose a cardiac rehabilitation programme that suits their individual needs based on a comprehensive assessment of their cardiac risks (stages 2 & 3)prior to beginning (stage 4) cardiac rehabilitation.

All patients, partners and carers will have access to education sessions covering the following:

- physical activity
- relaxation
- psychological interventions / change management
- health promotion / lifestyle advice
- vocational advice
- basic life support
- social services and benefits advice

In addition to this a comprehensive patient profile will be compiled. This will include:

- risk stratification
- current cardiac status
- past medical history
- current medication and review
- personalised secondary prevention plan

All patients will undertake an exercise assessment for both screening and exercise prescription purposes before starting the exercise training programme, followed by the use of evidence based sub maximal protocol. The assessments will be repeated at discharge for evaluation and referral on to stage 6, long term self-management type activities.

All patients will complete the EQ5D5L and NACR patients reported outcome measures at stage 3 and stage 5 of the pathway.

All patients will receive an individually designed exercise programme that will encourage them to exercise a minimum of three times per week with access to supervised exercise sessions at least twice a week for a minimum of 6 weeks (NSF recommendation). Duration should be subject to individuals needs and be consistent with patient plans e.g. return towork, carer responsibilities. On-going advice will be available to all patients on increasing physical activity and their functional capability.

Exercise sessions will be delivered in the community setting, generally delivered in groups in accordance with the most recent British Association of Cardiac Prevention and Rehabilitation (BACPR) guidelines or individually at home utilising the Heart Manual or similar as appropriate and depending on patient's preferences and circumstances.

Patients who have a confirmed diagnosis of LVSD Heart failure, NYHA II/III and have been stable for 3-4 weeks with no changes in medication except up titration of Beta Blockers/ACE will be able to access Heart Failure cardiac rehabilitation in a group setting or individually at

home. The use of telemedicine and telehealth will support the patient at home.

Patients and carers will be referred to (stage 4) cardiac rehabilitation by a cardiologist, GPwith Special Interest in cardiology, cardiac rehabilitation nurse or Heart Failure Specialist Nurse (in the case of patients with heart failure)following a comprehensive assessment of their cardiac risks.

Group sessions of one hour duration will be held twice weekly, in locality venues across the County, for a period of 7-12 weeks although the programmes aim to give patients choice by offering options such as shorter duration programmes, education only and fast track to stage 6 classes, based on the outcomes of individual assessment.

Patients who decline or 'drop out' of stage 4 cardiac rehabilitation will be offered a follow up assessment of their medical, social and psychological needs. The programme will welcome patients in to the service if they wish to resume/start at a later stage due to personal circumstances.

The service will run a rolling programme to enable improved uptake and completion.

Cardiac rehabilitation for patients with heart failure will be provided in a block of 12 weekly 2 hour sessions in a location close to home. There will be open access opportunity to attend for further blocks in the future as needs change following reassessment.

Patients receiving cardiac rehabilitation via the Heart Manual will receive one clinic appointment and at least two follow up telephone calls.

Patients will have a final assessment (stage 5) encompassing all aspects relevant to stage 4 cardiac rehabilitation programme (group, heart manual and heart failure rehab). A discharge summary and individualised care plan will be forwarded to the patients General Practitioner, and the stage 6 long term self-management coordinator. All patients will be asked to complete NACR Assessment 2 and the EQ5D5L assessment to help inform the cardiac rehabilitation and commissioners of the effectiveness of the cardiac rehabilitation service.

On completion of (stage 4) cardiac rehabilitation, all patients will be referred to stage 6, long term self-management type cardiac rehabilitation within the patient's locality. This requires robust communication pathways (including with family and carers) to allow a seamless transition.

The aim is for all participants to be exercising independently daily and not to be reliant on the on-going care of a health professional.

3.3 Any acceptance and exclusion criteria and thresholds

The service is open to adult patients registered with Dorset Clinical Commissioning Group General Practitioners;

Inclusion criteria;

- MI - 4 weeks post incident (if uncomplicated)
- PCI – 1 week post intervention (if uncomplicated)
- Cardiac Surgery – 8 weeks post-surgery

- ICD (if underlying coronary disease or valve surgery) – 8 weeks post intervention
- Patients with a confirmed diagnosis of LVSD, NYHA II/III and have been stable for 3-4 weeks with no changes in medication except up titration of Beta Blockers/ACE.
- Diagnosed with stable angina
- Other specialist interventions such as cardiac transplant

Exclusion Criteria

- Unstable angina
- Systolic BP above 200mmHg
- Severe aortic stenosis
- Acute infection
- Hypertrophic obstructive cardiomyopathy unless ICD fitted
- Aortic aneurysm >5.5 cm or those who are symptomatic or awaiting/being considered for surgery
- Unmanaged ventricular arrhythmia
- Uncontrolled atrial arrhythmia affecting cardiac function
- 3rd degree AV heart block without pacemaker
- Active or suspected myocarditis or pericarditis
- ICD activated and not yet interrogated
- Phaeochromocytoma- adrenaline/noradrenaline increase

Exclusion criteria for patients with **heart failure**

- Significant co-existing valvular disease
- Progressive worsening of exercise tolerance or dyspnoea at rest over the previous 3-5 days
- Resting BP Systolic >200 or diastolic>110
- Uncontrolled tachycardia >100bpm
- Significant ischaemia at low work rates
- Febrile illness

Relative contra-indications

- Systolic BP – 180 – 200 mmHG
- Diastolic BP – above 110 mmHG
- Significant unexplained drop in BP during exercise
- Resting heart rate above 100 bpm
- New or recurrent breathlessness, palpitations, dizziness or lethargy
- Moderate aortic stenosis
- Symptomatic CHF
- ICD patients HR above 85% of threshold for defibrillation

The safety of the patient should be paramount when agreeing the most appropriate form of exercise training. A full risk assessment of the premises must be undertaken in advance of services being provided from the site. This inspection should include an assessment of temperature control systems, as well as telephone availability and emergency access points within the premise and specific rooms.

3.5 Interdependence with other services/providers

- Service users and carers
- Secondary care clinicians
- Primary care clinicians
- Commissioners
- Leisure centres/other local amenities
- Exercise Instructors providing stages 4 & 6 cardiac rehabilitation and long term self-management
- The British Association of Cardiac Prevention and Rehabilitation
- The British Heart Foundation
- Other third sector organisations

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

Applicable service standards include:
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- The National Service Framework for Coronary Heart Disease, chapter Seven Cardiac Rehabilitation, March 2000
- The National Service Framework for Coronary Heart Disease, chapter six Heart Failure, 2000
- National Service Framework for Long Term Conditions (2005NICE clinical guideline for Chronic Heart Failure CG5, 2003
- MI: Secondary prevention NICE clinical guideline 48, May 2007
- NICE clinical guideline for Chronic Heart Failure CG108, 2010

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Chapter 57, Cardiac rehabilitation, a national clinical guideline, Scottish Intercollegiate Guidelines Network, January 2002
- British Association for Cardiovascular Prevention and Rehabilitation standards and core components for cardiovascular disease prevention and rehabilitation 2012.
- Cardiac Rehabilitation Commissioning Pack. Department of Health, 2010
- NHS Outcomes Framework 2013- 2014
- Cardiovascular Disease Outcomes Strategy – Improving outcomes for people with or at risk of cardiovascular disease. Department of Health, 2013

The provider will meet and continue to meet any registration standards that apply and must be able to demonstrate this to the commissioner and hold details of relevant standards e.g. from professional bodies.

The patient to staff ratio will be appropriate to the patient's needs, conforming to British Association of Cardiac Prevention and Rehabilitation (BACPR) workforce standards. This ratio may need to be lower for groups of higher risk patients e.g. patients with heart failure.

There should be a locally agreed (including relevant resuscitation training officer) medical emergency protocol for all locations hosting group exercise sessions. This protocol will outline the requirements for the staff in attendance to an appropriate mix of basic life support, immediate life support and advanced life support training with access to back up from emergency services.

Trained staff should be Advanced Life Support (ALS) trained and able to access and use the following equipment:

a. defibrillator
b. oxygen
c. resuscitation equipment

Providers shall demonstrate a clinically effective and appropriate skill-mix of staff.

All staff shall be appropriately trained, qualified and registered to undertake their roles and responsibilities. For structured exercise programmes exercise instructors must be BACPR trained. For home based programmes staff must be trained as per the programmes protocols.

Lines of managerial and clinical accountability shall be clearly outlined. A medical lead for the service is required with responsibility for overseeing the clinical governance framework and processes.

The clinical personnel should be able to provide evidence that they have the experience and qualifications to undertake the procedure/s and all personnel providing the service are competent to provide those aspects of the service for which they are responsible and will keep their skills up to date

The British Association of Cardiac Prevention and Rehabilitation (2010) recommends that 'specific experience, knowledge and skills are required to lead a safe and effective exercise component within a cardiac rehabilitation programme'. These essential competencies are listed below and may be met by one exercise professional that has all these competencies and therefore can lead the exercise component, or may be met collectively by the cardiac rehabilitation team including the exercise professional.

Experience of

- delivering exercise in a cardiac rehabilitation environment
- planning, leading and evaluating exercise sessions for the cardiac population
- working effectively as a team member

Knowledge of:

- relevant national standards, policies and guidelines, and application to practice in this field
- health related benefits of regular physical activity and exercise

- an applied understanding of cardiovascular anatomy and exercise physiology and principles of exercise prescription for cardiovascular training
- coronary heart disease (including signs and symptoms and recognition of progression of disease) and its implications for risk stratification and exercise programming
- a range of cardiovascular conditions and co-morbidities encountered on a typical cardiac rehabilitation programme; the programming adaptations and contraindications to exercise
- cardiovascular medications and any exercise related considerations
- common cardiac investigations and interventions and relevance of results to exercise programming
- the process of behaviour change and appropriate models and strategies that are used to assess a patient's current state of physical activity behaviour and support change towards achieving long term adherence to a physically active life

Skills and Abilities to

- make clinical decisions regarding the suitability, eligibility and adaptability of each patient's exercise programme (clinical leadership)
- conduct screening and a comprehensive assessment, including interpretation of clinical investigations, conducting appropriate submaximal tests to provide a baseline assessment of functional capacity and apply these findings to exercise programming
- risk stratify and prescribe safe and effective exercise programmes that are appropriately individualised
- competently lead and instruct the exercise component
- monitor, evaluate and adapt an individual's exercise programme whilst considering co-morbidities and the complexity of their cardiac condition
- respond and manage emergency situations including cardiac arrest (i.e. hold an appropriate qualification - a minimum of 'Immediate Life Support')
- choose and use appropriate educational, counselling and motivational techniques with individuals and groups of patients in order to guide individuals to be physically active
- give appropriate evidence based advice for discharge planning in relation to long term activity goals / independent activity

Minimum qualifications and registration requirements;

There are a range of qualifications and registration that each exercise
Professional may hold. To lead exercise in early cardiac rehabilitation, in addition to the competences outlined above, exercise professionals should fulfil at least one of the following:

- Degree/diploma in Physiotherapy with current HPC registration, membership of CSP and recommended membership of Association of Chartered Physiotherapists in Cardiac Rehabilitation (ACPICR)
- Degree in Sport and Exercise Science or Exercise Physiology, registered as a British Association of Sport and Exercise Sciences (BASES) Certified Exercise Practitioner or BASES Accredited Sport and Exercise Scientist
- Recognised REPS Level 4 Cardiac Disease (Rehab) qualification in exercise and fitness e.g. BACR Phase IV Exercise Instructor Training qualification and current registration with REPs at Level 4.

- In addition all exercise professionals must demonstrate evidence of relevant CPD.

4.2 Applicable local standards

The three data metrics that the provider of the community cardiac rehabilitation service will be expected to report on a regular basis are:

- Clinical outcomes and process
- Patient related outcome measures
- Patient experience
- Completed is defined as attending > 50% of the programme

Review meetings with the CCG shall be held on a quarterly basis after the initial mobilisation period, during which these meetings will be monthly.

Outcome measures should be demonstrated by clinical audit data performed annually on all referrals during a 2 week period. The following are taken from the NSF audit standards:

- Total number and percentage of those recruited to cardiac rehabilitation who, one year after discharge report:
    a. regular physical activity of at least 30 minutes duration on average five times a week
    b. not smoking
    c. BMI <30kg/m2

The NSF sets a target of a minimum of 50% of patients achieving the above outcomes. As well as this all relevant data will be inputted into the NACR on a regular basis but no more than quarterly in arrears.

The NACR patient assessments are required to be used throughout cardiac rehabilitation services; at stage 3, at stage 5 (12 weeks/post rehabilitation) and at 12 months. The EQ5D5L PROM should also be completed by patients at Stage 3 and Stage 5. It is a requirement of the service provider to coordinate this work, and ensure that all patients are sent the relevant documentation, and reminders as appropriate. Bi – annual reports from these datasets will be required by commissioners.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at:

This service is to be provided for patients registered with a Dorset Clinical Commissioning Group GP and will be delivered in appropriate venues to meet the needs of people living in

localities of North Dorset, Mid Dorset, West Dorset, Weymouth and Portland , East Dorset, Purbeck, Poole, Christchurch and Bournemouth.
Delivered within either;

- A group environment close to home
- Individually supported via the Heart manual

7. Individual Service User Placement

Not applicable