Cardiac and Pulmonary Rehabilitation

‘Co-designing a vision for Cardiac and Pulmonary Rehabilitation in Leeds for 2020-2025’

16th December 2019
Who’s Who?

Freya Redrup
Clinical Pathway Development Manager – Leeds CCG

Lindsay Springall
Commissioning Lead for Long-Term Conditions – Leeds CCG

Charlotte Coles
Commissioning Lead for Respiratory – Leeds CCG

Katherine Hickman
Clinical Lead for Respiratory – Leeds CCG

Nicola Simpson
Cardiac Rehabilitation Lead - LCH

Diane Burke
Head of Long-Term Conditions – Public Health

Hanna Kaye
Advanced Health Improvement Specialist – Public Health

Bryan Power
Clinical Lead for Cardio-vascular Disease– Leeds CCG

Jane Slough
Lead Nurse for Respiratory Conditions- LTHT

Caroline Stocks
Head of Service for Respiratory, Cardiac, CIVAS, TB and HHIT- LCH

Emma Crossland
Pulmonary Rehabilitation Lead - LCH

Patient Representatives

Katherine Hickman
Clinical Lead for Respiratory – Leeds CCG

C CG – Clinical Commissioning Group
LCH – Leeds Community Healthcare
LTHT – Leeds Teaching Hospitals Trust

*House Keeping

NHS
Leeds
City Council

NHS Leeds
Clinical Commissioning Group
<table>
<thead>
<tr>
<th>Timing</th>
<th>Item</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30 - 9.00am</td>
<td>Arrival and Refreshments</td>
<td></td>
</tr>
<tr>
<td>9.00 - 9.20am</td>
<td>Welcome and Introductions. <em>including the objectives for the day, and setting the local and national context</em></td>
<td>Bryan Power/ Katherine Hickman</td>
</tr>
<tr>
<td>9.20 - 9.45am</td>
<td>Overview - Cardiac Rehabilitation Service. <em>Current position</em></td>
<td>Nicola Simpson</td>
</tr>
<tr>
<td>9.45 - 10.10am</td>
<td>Overview - Pulmonary Rehabilitation Service. <em>Current position</em></td>
<td>Emma Crossland</td>
</tr>
<tr>
<td>10.10 - 10.30am</td>
<td>What is the need? Review of Leeds Public Health Data, National Evidence and Best Practice</td>
<td>Diane Burke/ Hanna Kaye</td>
</tr>
<tr>
<td>10.30 - 10.45am</td>
<td>Refreshment Break</td>
<td></td>
</tr>
<tr>
<td>10.45 - 12.10pm</td>
<td>Group Work</td>
<td>Freya Redrup</td>
</tr>
<tr>
<td>12.10 - 12.25pm</td>
<td>Closing and Next Steps</td>
<td>Bryan Power/ Katherine Hickman</td>
</tr>
</tbody>
</table>
Objectives for the Day

‘Co-designing a vision for Cardiac and Pulmonary Rehabilitation in Leeds for 2020-2025’

• To review the local and national context for cardiac and pulmonary rehabilitation.
• To understand the current offer of cardiac and pulmonary rehabilitation in Leeds.
• To share national evidence and best practice for cardiac and pulmonary rehabilitation.
• To begin designing our vision for cardiac and pulmonary rehabilitation in Leeds.
• To prioritise opportunities for enabling this vision.
Outcomes for the Day

To take the initial steps towards co-designing cardiac and pulmonary rehabilitation services in Leeds for 2020-2025, and to progress outputs from the day via a new **Cardiac and Pulmonary Rehabilitation Working Group**.
National Context

The NHS Long Term Plan 2019

- Access and Uptake varies across England
  - Nationally 52% take up the offer of cardiac rehab – ambition: 80% by 2028
  - Nationally 13% of patients with COPD are offered Pulmonary Rehab – ambition: not yet defined
- Joint Programmes
- Personalised Care
- Digital Tools
- Mental Health
- Lifestyle Changes
- Deprivation
- Medicines

And more... (wider context)

*Based on the assumption that Leeds is roughly 1% of the total population in England. This is an estimate only.

National Context

NHS LTP Implementation Framework 2019

- Encouraged to test the use of technology to increase referrals and uptake to Cardiac rehab (national monies from 2021/22).

- NHSE will provide targeted funding for a number of sites in 2020/21 and 2021/22 to expand pulmonary rehabilitation services and test new models of care for breathlessness management in patients with either cardiac or respiratory disease.

QOF 2019/20

- New Indicators – Pulmonary Rehabilitation

Five Year Framework 2019

- National Service Specs – CVD; prevention, diagnosis and management

- CVD Prevention Audit 2021/22

Commissioning Guide

- Rehabilitation as prevention or early intervention

- Person-centred approach

- Partnership working

National Context

Patient Expectations of Good Rehabilitation Services

• Knowledge and access
• Focus on my needs
• Improved experiences and outcomes
• Self-care and self-management
• Clear, meaningful and measured goals
• Support to reach my potential
• Self-referral
• Single point of contact
• Support for people important to me
• Information on my progress

Principles of Good Rehabilitation Services

• Optimise physical, mental and social wellbeing
• Recognise carers
• Instil hope, support ambition and balance risk
• Individualised, goal-based approach
• Early and ongoing assessment
• Self-management (Personalised Care – PCSP)
• New and established interventions
• Integrated multi-agency pathways
• Leadership and accountability
• Best practice

Local Context

• Based on The NHS Long Term Plan – expanding our access, uptake and offer of cardiac/pulmonary rehabilitation in Leeds is a priority commissioning intention for 2020 and beyond.

• Current waiting times/workforce/uptake (presentations to follow)

• ICS Pulmonary Rehabilitation Opportunity
Cardiac and Pulmonary Rehabilitation

What is the need?
Review of Leeds Public Health Data and National Evidence and Best Practice

Diane Burke & Hanna Kaye
Public Health, Leeds City Council
What is the need?

- Leeds has a GP registered population of 916,418, and a resident population of 789,194
- There are over 191,000 people in Leeds who live in areas that are ranked amongst the most deprived 10% nationally
- 10 year life expectancy gap between the most deprived and most affluent areas
- Conditions associated with service provision have been analysed to understand the prevalence and new incidences for 2018/19
- All data within this document has been extracted from the Leeds Data Model, and representative as at the end of March 2019. Diagnoses are identified from both primary and secondary care data sets

Public Health
COPD

- Prevalence of diagnosed COPD in Leeds at the end of March 2019 was 2.4%. Approximately 22, 274 people, 18,856 people diagnosed in primary care, and an additional 3,418 in secondary care.

- Expected prevalence for Leeds is 2.8%. Suggesting a gap of approximate 5, 476 people which needs to be taken into account for planning future service provision

- Of those with COPD, 3% (664) have Serious Mental Illness, and 0.4% (97) have a Learning Disability

- 4,667 (21%) received diagnosis in 2018/19

- LS25/LS26 has the highest number of people with COPD (2,272) compared to all PCN’s, while Middleton and Hunslet has the highest prevalence (4.4%)
Total and 2018/19 counts of COPD diagnoses by PCN
Gender, Age and COPD

- COPD is slightly higher in females (51.6%) compared to males (48.4%)

- The age band with the highest proportion with COPD is 70-74 (16.8%) for both females and males.

- 2018/19 diagnoses increased in younger age bands up to and including band 60-64
Ethnicity

- Ethnicity data shows 75% of those diagnosed are from a white background.
- But must be viewed with caution as 25% of people are recorded as Not Known/Not Stated or ethnicity is missing from the data, therefore this doesn’t represent a complete picture.

Deprivation

31% of people with COPD live within the most deprived 10% areas nationally.

Just over half (50.8%) live within deciles 1-3.
Pulmonary Rehabilitation & Eligibility

- 16,096 people diagnosed have an MRC scale coded
- 48% have an MRC 3+ recorded
- Presuming the offered is based on eligible people – 35.5% have been recorded as offered the programme (ever).
- 61.3% of those to have been offered pulmonary rehab have declined rehabilitation
- 28% have a recorded code for attending pulmonary rehab.

Public Health
Cardiac

- For the purpose of data extraction – a cardiac condition is defined by a diagnosis of Myocardial Infarction (MI), Heart Failure (HF) or has had Heart Bypass/valve surgery (secondary care recorded procedure).

- Only the last 5 years of secondary care procedure data has been available to supplement this definition.

- Prevalence of cardiac cohort in Leeds at the end of March 2019 was 2.5%, 22,650 people.

- Of those with cardiac condition, 2% (460) have SMI, and 0.5% (106) have LD.

- 3,486 (15.4%) had a diagnosis recorded in 2018/19

Public Health
Cardiac Cohort Prevalence

York Road
Otley
Seacroft
LS25 / LS26
Morley and District
Wetherby
Yeadon
West Leeds
Cross Gates
Middleton and Hunslet
Bramley, Wortley and Middleton
Armley
Beeston
Central North Leeds
Holt Park
Chapeltown
Woodsley
Burmantofts, Harehills and Richmond Hill
LSMP & The Light

Leeds

Public Health
Total and 2018/19 counts of Cardiac diagnoses by PCN

Public Health
Age, Gender and Cardiac

- Cardiac conditions is higher in males (60.9%) compared to females (39.1%).

- 80-84 (15.3%) is the highest proportion age group overall.

- However, the highest proportion age band for males and females differs, with age bands 70-74 in males and 90+ in females.
Ethnicity

- Again, as with COPD ethnicity data shows 75% of those diagnosed are from a white background.
- But must be viewed with caution as 20% of people are recorded as Not Known/Not Stated or ethnicity is missing from the data, therefore this doesn’t represent a complete picture.

Deprivation

21.4% live within an LSOA in the most deprived 10% areas nationally.

There is variation across all other deciles with higher proportions in less deprived areas.
Cardiac Rehabilitation

• In the cardiac cohort, only 6.6% (1478) have a primary care recorded code indicating a cardiac rehab referral or offer.

• 7.5% (111) of those to have been offered cardiac rehab have declined, with 24.9% (368) having a recorded code for attending cardiac rehab.
Cardiac Rehabilitation
National Audit

• We know these programmes are evidence based and demonstrates a positive impact on cardiovascular mortality, improved quality of life and reduced hospital readmissions
• However, uptake isn't as it should be and the barriers to why need to be explored
• The National Audit Cardiac Rehabilitation (NACR) 2018 report based on submitted data has made the following key recommendations for programme delivery:
  - Recruit more female patients and programmes are better tailored to the needs of female patients
  - Carry out a comprehensive CR assessment prior to, and on completion of, CR
  - Offer facilitated home-based modes of CR delivery for all CVD patients, including those with heart failure
  - Ensure programmes are working to certification standards and aim to secure certified status for the delivery of CR

Public Health
Pulmonary Rehabilitation
National Audit

National COPD Audit 2018 made the following recommendations for programme provision:

• Offer to all eligible patients across range of severity of exercise limitation (MRC breathlessness grades 2–5).
• Improve written information about its benefits for patients and patients and referrers, to improve uptake
• Ensure adequate, long-term funding frameworks that will allow an appropriate skill mix.
• Ensure that services are offered supervised treatment for eligible patients due to other chronic respiratory diseases.
• PR programmes should review their programme structure (frequency and duration) and content to ensure that they are providing treatment in line with BTS quality standards
• Review of discharge processes to ensure each patient receives a written, individualised plan for ongoing exercise and maintenance when they finish rehabilitation

Public Health
‘Breathlessness’ A symptom based model

• Most evidence based on the provision of a joint service for CHD and COPD patients due to the symptom overlap and patient cohort similarities
• Cardiac rehab often attracts a heterogeneous population younger with high exercise tolerance - whereas COPD and CHF older frail patients who both experience ‘breathlessness’
• Exercise is a component that most benefit from but not always the most important – needs to sit alongside wider wellbeing education including anxiety
• Leeds have piloted this approach
• Leicester have implemented this model – embedded a holistic approach for people with shared symptoms
• A feasibility trial proposed with a view to influence routine delivery
• It’s the ambition in the LTP

Public Health
An assessment based model of rehabilitation

- Scotland developed their 2020 vision to be:
  “CR should aim to provide each patient with an Individualised Programme of Care that is tailored to their specific needs. The rehabilitation outcomes should cover a wide range of options addressing all appropriate risk factor behavioural changes, which can be delivered across multi-agency providers and underpinned by the BACPR Standards.”
- As a result they have updated their National Clinical Guideline for Cardiac Rehabilitation published by Scottish Intercollegiate Guidelines Network (SIGN) in 2017.
- The guideline for delivery places emphasis on:
  - An assessment to build an individualised care plan
  - Assess motivation and confidence to achieve what is important to them
  - Then based on need, offer a wide range of options to aid recovery and support in managing the health condition
Personalised Care – could this be the future for Leeds?

• Could this approach be a consideration for Leeds?

• Building on the successful Collaborative Care and Support Planning (CCSP)/Better Conversation approach

• Could this be expanded wider to management of cardiac/pulmonary patients?

• Holistic assessment

• Patient Activation Measure

• Development of individualised goals

• Offer of menu based flexible model of rehabilitation options
Digital & Web Based Models

- A menu based model should offer where and how to attend rehabilitation
- Centre vs home based programmes – evidence suggests equally effective and that choice should be offered
- There is a growing evidence base for web/app based interventions for chronic conditions
- This can provide new opportunities to increase uptake
- Currently use myCOPD in Leeds
- Leicester building web based programme based on the SPACE Manual for PR – but uptake was low.
- Activate your Heart/myHEART/The Heart Manual
- Evidence base is emerging
- Digital literacy needs to be considered when implementing such approaches

Public Health
Cardiac/Pulmonary Rehabilitation
Is it time for a change?

• The impact rehabilitation can bring is evidence based and we need to increase uptake
• Is the delivery model of two separate programme achieving the best outcomes?
• This workshop gives us an opportunity to explore innovative and flexible models for future commissioning
• It should be a holistic and individualised approach - people with the same diagnosis have very different abilities and needs based on wide number of determinants
• Research suggests avoid disease centred approaches - but translation into practice can be challenging
• An assessment based model could help to achieve this approach and tailor interventions using the provision we already have in the city
• A flexible menu based programme is likely to accommodate the needs of different ages, ethnicities, diseases and symptoms.

Public Health
Next Steps and Closing

‘Co-designing a vision for Cardiac and Pulmonary Rehabilitation in Leeds for 2020-2025’

- **16th December 2019**
  - Hold Workshop

- **December 2019**
  - Summarise key outcomes from workshop

- **January 2020**
  - Project Planning /agreement of priorities with pathways/post acute groups

- **February – June 2020**
  - Work commences commissioning plans developed if required

Patient & Staff Engagement

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Thank you

Any questions?

Please complete evaluation form