



# After the event:

Getting care right for patients after a heart attack





## About Heart UK



HEART UK is the nation's cholesterol charity and aims to prevent premature deaths caused by high cholesterol and cardiovascular disease. The charity works to raise awareness of the risks of high cholesterol, lobbies for better detection of those at risk, and supports health professional training.

The charity's aims are to:

- Improve public awareness of high cholesterol conditions and provide support through HEART UK's services
- Improve awareness of HEART UK's expertise with the public, healthcare professionals and the media
- Be recognised experts in training healthcare professionals and the public about high cholesterol conditions

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## Summary of key findings

### Recording of patients that are offered and accept invitations to cardiac rehabilitation services

More than 95% of providers offer cardiac rehabilitation to patients after they have had a heart attack and those that do not have measures in place to refer patients to a different provider for cardiac rehabilitation. However, this finding also suggests that 2,100 patients across England are not offered rehabilitation.

HEART UK's audit found that among those providers that were able to provide information, the percentage of patients that accepted invitations to cardiac rehabilitation ranged from just 36.7% in Mid Cheshire Hospitals NHS Foundation Trust to 99.8% in Royal Devon and Exeter NHS Foundation Trust.

The National Audit of Cardiac Rehabilitation (NACR) found that the percentage of patients who received cardiac rehabilitation following discharge from hospital ranges from just 27% in London to 50% in the North East.

The reasons for poor uptake include lack of engagement, lack of effective referral, scarcity of service provision and practical reasons. Providers that responded to our audit did not provide detailed information to patients on the benefits of cardiac rehabilitation after their heart attack nor was there evidence of providers following guidance from NICE that states that follow up telephone calls should be undertaken.

### Ensuring high quality cardiac rehabilitation services

There is variation in the level of cardiac rehabilitation offered by providers. Not all providers offer all four phases of cardiac rehabilitation which are set out in the National Service Framework for Coronary Heart Disease.

Patients are being offered choice in where they can access cardiac rehabilitation in order that it can meet their lifestyle needs. This includes choice of cardiac rehabilitation in the home, hospital or community setting.

Choice in provider for cardiac rehabilitation however tends to focus on locality rather than the type or quality of service on offer. If providers are to support the choice agenda within the NHS reforms, they will need to develop protocols on the provision of information to patients on cardiac rehabilitation options to support informed choice in where they access cardiac rehabilitation.

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The content of cardiac rehabilitation services varies between areas but these generally support the NICE guidance on secondary prevention following a heart attack. Medication advice and support is also a major element of support offered to patients to try and encourage greater concordance with treatment regimen and improve patient outcomes.

### **Improving the quality of cardiac rehabilitation services**

The reforms to the health service offer a number of opportunities to support improvements in the quality and participation levels of cardiac rehabilitation. National leadership and an outcomes strategy for cardiovascular disease could be used to ensure seamless care for patients by setting out how the reforms should apply to cardiovascular disease, defining the role of cardiac networks and ensuring coordination across public health, NHS and social care.

The NHS, Public Health and Adult Social Care outcomes frameworks should encourage a greater focus on cardiac rehabilitation and joined up working across the health service through their measures on reducing mortality from cardiovascular disease, improved focus on lifestyle and reablement support for older people when they are discharged from hospital.

Cardiovascular disease will need to contribute around £1.6 billion savings in order for the NHS to deliver the required £20 billion efficiency savings to the NHS and there are opportunities to contribute to these savings through effective commissioning of cardiac rehabilitation services. The cost of cardiac rehabilitation ranges from £17 to £2186 per patient, but high quality cardiac rehabilitation can be delivered for around £550 per patient.

25 providers selected indicators under the Commissioning for Quality and Innovation framework (CQUINs) that should support better cardiac rehabilitation. It is vital that these measures support high quality services rather than rewarding standard practice.

The Commissioning Outcomes Framework and Commissioning for Quality and Innovation Payments could incentivise commissioners and providers to purchase and deliver high quality, cost effective cardiac rehabilitation. The Quality and Outcomes Framework could also ensure that GPs are incentivised to encourage their patients to take up cardiac rehabilitation invitations.

22 providers selected quality accounts that are relevant to cardiac rehabilitation. There was little correlation between the measures selected for CQUINs and those selected for quality accounts. Shared indicators would encourage better reporting from providers on the measures on which they are being incentivised.

The information revolution will be key to monitoring and driving improvements in post-event care yet key data sources are not currently publicly available. These include data from the Myocardial Infarction National Audit Programme (MINAP) on whether a cardiac rehabilitation appointment is made for a patient and whether they are seen by a cardiologist after discharge from hospital. Data on readmissions after 28 days of discharge after a heart attack is also not currently published.

The development of a quality standard on secondary prevention following a heart attack is welcome however it is important that it is developed without delay. An interim standard should be considered to provide the framework for commissioning post-event care before the final quality standard is published by NICE.

## Summary of key recommendations

**Recommendation 1:** Commissioners should require providers to monitor whether patients accept and complete cardiac rehabilitation programmes in their service contracts. Information on this should be provided to the NHS Information Centre and published on an annual basis.

**Recommendation 2:** Healthcare professionals should receive communications skills training to support them in advising patients about recovery and the importance of cardiac rehabilitation following a heart attack.

**Recommendation 3:** Patients should be provided with a personalised care plan to ensure continuity of care across providers and care settings and improve participation in cardiac rehabilitation. Written information leaflets on the benefits of cardiac rehabilitation and follow up phone calls should also be deployed without delay.

**Recommendation 4:** All providers should ensure that patients are offered every phase of cardiac rehabilitation with choice of where they access it in a format that suits them, whether it be in a hospital, community or home setting.

**Recommendation 5:** Providers should ensure that patients are provided real choice in cardiac rehabilitation and this should be incorporated into the national choice mandate with information for patients to support them in making an informed choice.

**Recommendation 6:** Patients should be given information, support and advice about their medication to help them to concord with their treatment regime.

**Recommendation 7:** Providers should be flexible in the treatments that they offer to patients so that new treatments are made available to patients as soon as they have been deemed to be clinically and cost effective.

**Recommendation 8:** The Department of Health should introduce a national outcomes strategy for cardiovascular disease to support improved outcomes for cardiovascular disease.

**Recommendation 9:** The Department of Health should consider introducing an improvement area on recovery from cardiovascular events and a national cardiovascular patient experience survey to support improvements in cardiovascular services within the NHS Outcomes Framework.

**Recommendation 10:** The Department of Health should consider introducing proxies for outcomes in the NHS Outcomes Framework and Commissioning Outcomes Framework to support commissioners in taking steps to reduce mortality from heart disease.

**Recommendation 11:** Cardiovascular networks should consolidate their ongoing role in supporting commissioning by helping clinical commissioning groups to make informed decisions about the care of patients after they have had a heart attack.

**Recommendation 12:** NICE should secure the support of clinical expertise in defining the Commissioning Outcomes Framework, which should include measures that both improve outcomes from cardiovascular disease and deliver efficiency savings.

**Recommendation 13:** CQUIN payments should reward efficiency on the part of providers, when this is combined with delivering high-quality care such as the provision of cardiac rehabilitation within discharge planning.

**Recommendation 14:** The BMA and NHS Employers should consider revising the General Medical Contract guidance so that it includes reference to the role of GPs in increasing participation in cardiac rehabilitation programmes.

**Recommendation 15:** NICE should ensure that indicators on treatments are flexible in order that new treatments can be included in the QOF process in a timely manner.

**Recommendation 16:** Data on readmissions within 28 days of discharge following a heart attack should be collected and published on an annual basis.

**Recommendation 17:** MINAP should publish data on post-event care without delay to support patients, commissioners and providers in benchmarking performance between providers.

**Recommendation 18:** Providers should ensure that patients are provided with sufficient support to understand data and information so that they make informed decisions about their care.

**Recommendation 19:** The quality standard on secondary prevention of myocardial infarction and cardiac rehabilitation should be published without delay to ensure a framework is in place for commissioners to ensure that people can access the necessary care and support after they have had a heart attack.

**Recommendation 20:** Local HealthWatch should target resources so that patients from equality groups are supported in making informed decisions about their care.

## Chapter 1: Introduction

Coronary heart disease (CHD) is the UK's biggest killer - around one in five men and one in seven women die from the disease. Each year, there are around 94,000 deaths from CHD in the UK and around 2.6 million people are living with the condition<sup>1</sup>.

Encouragingly, in the last 10 years there has been nearly a 50 per cent reduction in mortality from CHD<sup>2</sup>. This was, in large part, due to the National Service Framework for CHD which led to huge improvements in acute care and secondary prevention, as well as to reductions in smoking prevalence. The King's Fund has stated that the rate of improvement in outcomes from heart attacks has been the fastest in Europe<sup>3</sup>.

The NSF was published in 2000 in an era when NSFs included clear targets for local NHS organisations to deliver on. Its publication led to:

- New centres and more cardiologists so that more people can now see a specialist in a centre that has state-of-the-art facilities after a heart attack
- Over 70 per cent of people with heart attack symptoms are treated with 'clot busting' drugs within one hour of calling for help - compared to around 24 per cent before the NSF for CHD's introduction
- Around 4 million people now receive statin drugs - saving an estimated 10,000 lives every year<sup>4</sup>

Good treatment needs to be coupled with cardiac rehabilitation if optimal recovery is to be achieved for patients<sup>5</sup>. Cardiac rehabilitation is a programme of exercise and information sessions that help people to get back to everyday life as quickly as possible after a heart attack or heart surgery. These programmes are designed to help people to:

- Understand their condition
- Recover from surgery or a heart attack
- Make lifestyle changes to help improve their heart health
- Understand and concord with their post-event treatment regime
- Reduce the risk of a heart attack<sup>6,7</sup>

The potential benefits of effective cardiac rehabilitation are significant:

- Greater survival for people with CHD who participate in comprehensive cardiac rehabilitation
- Reducing unplanned hospital admissions
- Improving clinical outcomes through enabling people to become active self-managers of their condition
- Providing efficient clinical management for patients as they recover from their heart attack<sup>8</sup>

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However, although cardiac rehabilitation was included in the NSF for CHD, it has not been a policy priority and therefore less progress has been made in supporting the recovery needs of those patients who have suffered a heart attack. The latest report from the National Audit of Cardiac Rehabilitation (NACR) found that only 40 per cent of patients who had suffered a heart attack received cardiac rehabilitation and the proportion of patients receiving cardiac rehabilitation ranged from 27 per cent in London to 50 per cent in the North East<sup>9</sup>. Fewer than fifty per cent of patients are being offered cardiac rehabilitation and there is also significant regional variation in the percentage of people receiving cardiac rehabilitation.

NICE has also identified ongoing inequalities in the way people access the services that are available. Its guidance for commissioners sets out that “Women, minority ethnic groups, the elderly and people with more severe CHD are all under-represented among users of rehabilitation services<sup>10</sup>”. It has also found that in many parts of the country, there is a shortage in services which means people start cardiac rehabilitation some time after they are ready to which means that their return to normal life can be delayed<sup>11</sup>.

There have been some recent steps aimed at increasing the percentage of people being offered cardiac rehabilitation:

- The National Institute for Health and Clinical Excellence (NICE) published its Cardiac rehabilitation service commissioning guide which provides support for the local implementation of NICE clinical guidelines in 2010<sup>12</sup>
- £150 million has been directed to local health and care services to help people leave hospital more quickly and support links between the NHS and social care<sup>13</sup>

A lot remains to be done however and the next challenge for heart disease is consolidating progress made in the last decade and ensuring that post-event care is addressed - including ongoing medication, discharge planning and reablement. By delivering on this, the NHS will not only improve the experience and outcomes for patients but also save money by reducing unnecessary emergency admissions, therefore contributing to the £20 billion efficiency savings that the NHS in England must deliver between 2011 and 2014<sup>14</sup>.

This report is intended to complement the existing research in the area from the NACR and Myocardial Ischaemia National Audit Project (MINAP) and provide a comprehensive assessment of:

- The cardiac rehabilitation services that are currently being offered by NHS providers
- Commissioner and provider priorities that are relevant to supporting patients after they have a heart attack
- The potential impact of the health reforms and how this may impact on cardiac rehabilitation services

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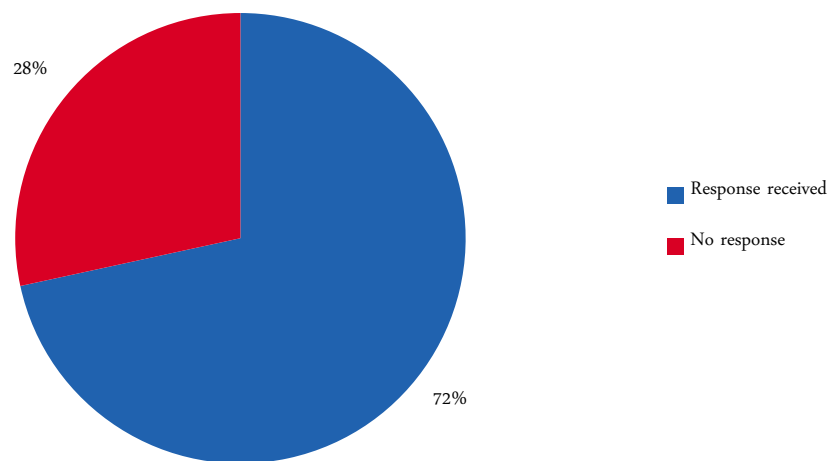
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## Chapter 2: Methodology

This report is largely based on responses to a series of Freedom of Information requests submitted by HEART UK to providers in England. Overall, 168 NHS foundation trusts and NHS trusts were sent requests and 121 of these were able to provide some kind of response, this represents over two thirds of all trusts as can be seen in Figure 1. A list of providers that were contacted, and details on whether they responded is included in Annex 1.

**Figure 1- Provider response rate**



We are grateful to those NHS organisations that were able to respond however it is disappointing that not all NHS organisations did so. As public authorities, these organisations are required by law to respond to Freedom of Information requests in a timely manner and we hope that in future, these trusts will make additional efforts to respond.

As NHS organisations are not duty-bound to respond to Freedom of Information requests in a set format, the information we received was not directly comparable. The analysis used in this report is therefore based on HEART UK's own interpretation of the evidence received.

HEART UK has also undertaken an analysis of the priorities identified by the local NHS through Commissioning for Quality and Innovation payments (CQUINs) and Quality Accounts which is included in this report.

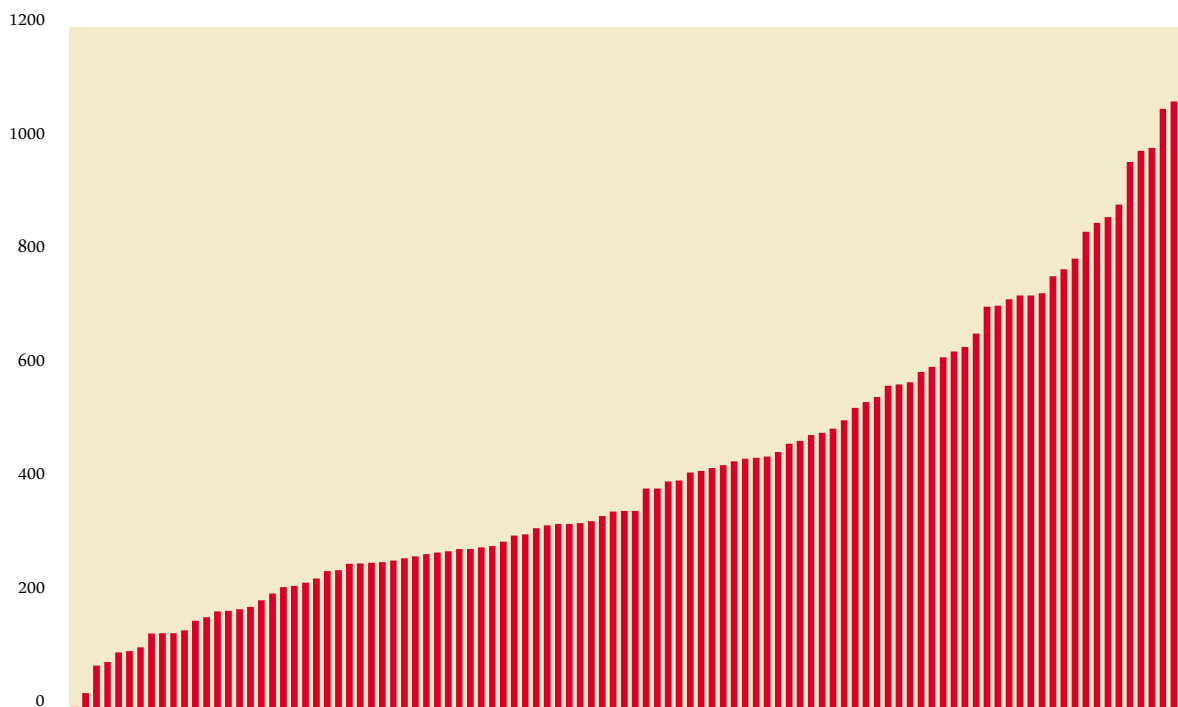
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## Chapter 3: Recording of patients that are offered and accept invitations to cardiac rehabilitation services

There is a large variation in the number of patients admitted with a primary diagnosis of myocardial infarction to each provider in England - ranging from just two in South Warwickshire NHS Foundation Trust to 2,069 in The Royal Wolverhampton Hospitals NHS Trust. This range is illustrated in Figure 2. A number of those providers with fewer admissions have systems in place whereby patients are automatically admitted to another provider if they have symptoms of a heart attack. A large number of the trusts with more admissions are from areas with deprived communities and higher risk factors for CHD.

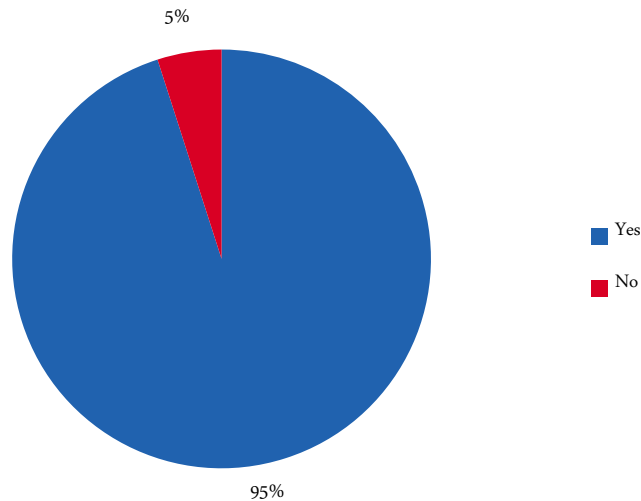
**Figure 2 - Patients admitted with a primary diagnosis of acute myocardial infarction in 2010 by provider**



Overall, 95 per cent of trusts offer cardiac rehabilitation to patients after they have had a heart attack and those providers that do not offer cardiac rehabilitation tend to have measures in place to refer patients onto a different provider (see Figure 3).

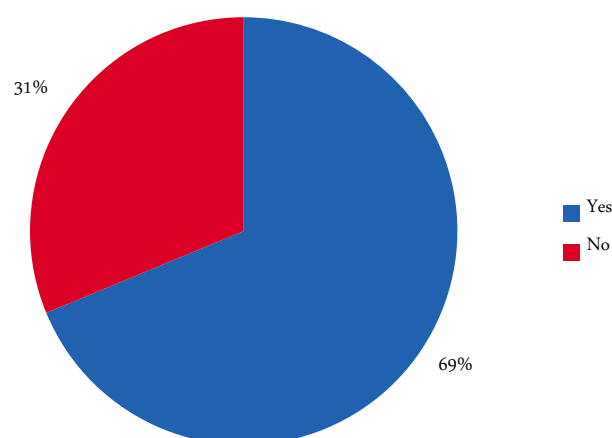
It is encouraging that such a large proportion of providers offer this service to patients - it may be a reflection of its inclusion within the NSF for CHD and the specific measure that states that more than 85 per cent of patients should be offered cardiac rehabilitation after a heart attack<sup>15</sup>. However, this finding also suggests that 2,100 patients across England are not offered rehabilitation.

**Figure 3 - Providers which offer cardiac rehabilitation to patients after they have had a heart attack**



Accurate record keeping is essential in documenting and accounting for the quality of care offered to patients, as well as in ensuring that patients are offered continuity of care across different settings and providers. It is therefore concerning that almost one third of providers do not keep records on the number of patients who accept or decline cardiac rehabilitation services, as set out in Figure 4.

**Figure 4 - Providers that keep records on the number of patients who accept or decline cardiac rehabilitation**



Although patients may be offered cardiac rehabilitation by their local provider, there does not appear to be sufficient follow up to ascertain whether or not this is being taken up. It may be a result of the heritage from the CHD NSF which did not include a specific target on the number of patients that participated in cardiac rehabilitation but rather stated only that patients should simply be offered it: “Every hospital should ensure a) that more than 85% of people discharged from hospital with a primary diagnosis of AMI or after coronary revascularisation are offered cardiac rehabilitation; and b) that 1 year after discharge at least 50% of survivors are non-smokers, exercise regularly and have a BMI < 30 kg/m<sup>2</sup>; these should be demonstrated by clinical audit data no more than 12 months old<sup>16</sup>”

**Recommendation 1:** Commissioners should require providers to monitor whether patients accept and complete cardiac rehabilitation programmes in their service contracts. Information on this should be provided to the NHS Information Centre and published on an annual basis.

### **Uptake of cardiac rehabilitation**

Table 1 shows the providers which had the highest and lowest levels of acceptance of cardiac rehabilitation. This shows that where providers were able to supply data on the number of patients that accepted or declined cardiac rehabilitation, there is an almost three-fold range in the percentage of patients that accepted their invitation. This may be a result of variations in the quality of support which is provided to patients considering rehabilitation.

Table 1 - Providers with the highest acceptance of cardiac rehabilitation (2008/9-2010/11)

| Provider  | Accepted | Declined | Percentage accepted (%) |
|---|----------|----------|-------------------------|
| Royal Devon And Exeter NHS Foundation Trust                           | 2126     | 4        | 99.8                    |
| Frimley Park Hospital NHS Foundation Trust                            | 948      | 18       | 98.1                    |
| The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust | 1334     | 60       | 95.7                    |
| Salford Royal NHS Foundation Trust                                    | 254      | 16       | 94.1                    |
| Yeovil District Hospital NHS Foundation Trust                         | 1051     | 95       | 91.7                    |
| County Durham And Darlington NHS Foundation Trust                     | 308      | 49       | 86.3                    |
| Dartford And Gravesham NHS Trust                                      | 61       | 10       | 85.9                    |
| Bedford Hospital NHS Trust  | 594      | 108      | 84.6                    |
| Royal Free Hampstead NHS Trust  | 586      | 145      | 80.2                    |
| Imperial College Healthcare NHS Trust                                 | 760      | 209      | 78.4                    |

Table 2 - Providers with the lowest acceptance of cardiac rehabilitation (2008/9-2010/11)

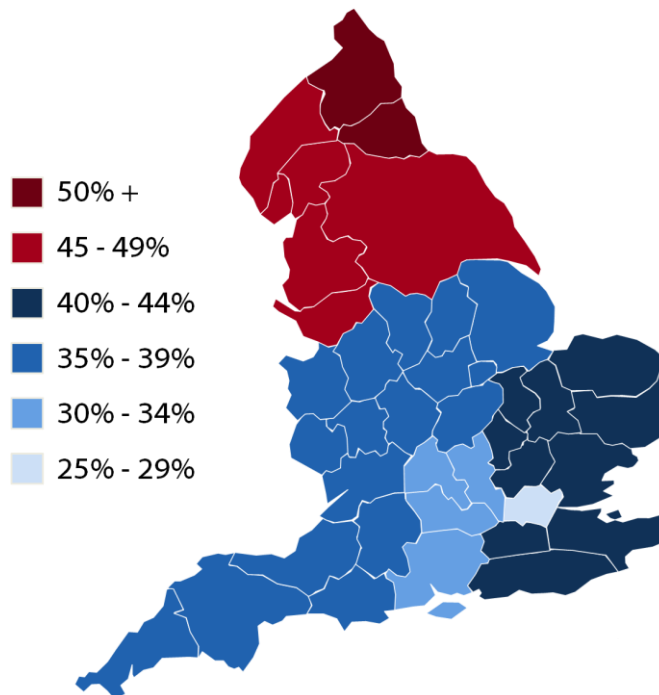
| Provider  | Accepted | Declined | Percentage accepted (%) |
|---|----------|----------|-------------------------|
| Mid Cheshire Hospitals NHS Foundation Trust       | 620      | 1069     | 36.7                    |
| Stockport NHS Foundation Trust                    | 322      | 345      | 48.3                    |
| Southend University Hospital NHS Foundation Trust | 1383     | 1427     | 49.2                    |
| Aintree University Hospitals NHS Foundation Trust | 1074     | 949      | 53.1                    |
| Buckinghamshire Hospitals NHS Trust               | 203      | 175      | 53.7                    |
| Portsmouth Hospitals NHS Trust                    | 588      | 490      | 54.5                    |
| North Bristol NHS Trust                           | 822      | 683      | 54.6                    |
| Chesterfield Royal Hospital NHS Foundation Trust  | 436      | 339      | 56.3                    |
| Derby Hospitals NHS Foundation Trust              | 510      | 377      | 57.5                    |
| Poole Hospital NHS Foundation Trust               | 455      | 302      | 60.1                    |

This broadly correlates with data from the NCRA in terms of regional variation in access to cardiac rehabilitation (see Figure 5).

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Figure 5 - Percentage of patients who received cardiac rehabilitation following discharge from hospital by SHA<sup>17</sup>



The range in participation is quite different however as, within the NCRA, participation ranges from 27% of patients in NHS London to 50% in NHS North East<sup>18</sup>. Data from our audit suggest that certain providers are performing much better in terms of ensuring that patients actually get access to cardiac rehabilitation than the NCRA. This could be for a number of reasons:

- The data in our audit are based on local provider practices and therefore do not take into account the variation in performance of providers across an SHA area
- It may be that providers that failed to provide data through HEART UK's FOI audit are those that are performing most poorly in relation to cardiac rehabilitation
- The fact that patients accepted an invitation to cardiac rehabilitation does not necessarily mean that they are appropriately referred or actually participate in the programme

### Explaining the variation in uptake

The NICE commissioning guide on cardiac rehabilitation identifies a number of reasons for the poor uptake of cardiac rehabilitation, including the following:

- Lack of engagement (people not being invited to attend cardiac rehabilitation)
- Low levels of referral
- Scarcity of service provision
- Poor uptake due to practical reasons (e.g. location and time of session)

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The most recent report from MINAP also suggests that the uptake of cardiac rehabilitation among patients who have had a heart attack is not as high as in other areas of cardiac care. The report noted that “It is extraordinary that nearly three times as many cardiac surgery patients participate in cardiac rehabilitation as do heart attack patients<sup>19</sup>”.

Our research suggests that patients are indeed being offered cardiac rehabilitation but the ‘offer’ is failing to impact on patients’ decisions on whether to actually participate. This may be a result of information that is made available to patients upon referral. Certainly, the level of information provided to a patient on cardiac rehabilitation upon discharge varies between trusts. For example:

- **St George’s Healthcare NHS Trust** has a number of checklists for patients that have been admitted for coronary complaint. As well as a reminder to discuss cardiac rehabilitation at the discharge meeting, there are also follow up actions that ensure that the provider sends through a referral request and also a box to see whether cardiac rehabilitation has been started<sup>20</sup>
- **Trafford Healthcare NHS Trust** has guidelines for secondary prevention post heart attacks. This includes reference to the need for patients to be referred for cardiac rehabilitation but does not include information on how this referral should take place. This document does however clearly set out the need for patients to be given advice on diet, exercise, smoking, alcohol and sexual activity<sup>21</sup>
- **Nottingham University Hospitals NHS Trust** stated that “All PPCI patients should be referred to the cardiac rehabilitation team. If the patient is out of area the NUH cardiac rehabilitation team will refer to the relevant hospital cardiac rehabilitation team”. No mention is made of steps to ensure that this is taken up by patients<sup>22</sup>

The way in which the offer of rehabilitation is made will have a significant impact on the likelihood of a patient accepting rehabilitation or indeed completing the course. Training should be provided to healthcare professionals so that they have the requisite skills to communicate a patient’s options with them after they have had a heart attack.

Written information has also been shown to improve patient awareness of the care pathway and the treatment options available to them<sup>23</sup>.

**Recommendation 2:** Healthcare professionals should receive communications skills training to support them in advising patients about recovery and the importance of cardiac rehabilitation following a heart attack.

Despite specific reference within the NICE commissioning guide that calls for “Reminders such as telephone calls, telephone calls in combination with contact from a healthcare professional, and motivational letters...to improve uptake of cardiac rehabilitation<sup>24</sup>”, none of the responders appeared to have any processes in place for actively following up to see whether patients wish to participate in cardiac rehabilitation. This kind of approach could help to ensure that patients do not fall through the net. In some instances, social care services which may be offering some kind

of support for patients after their heart attack could play a role in informing patients about the benefits of cardiac rehabilitation and ensuring that they are referred appropriately.

**Recommendation 3:** Patients should be provided with a personalised care plan to ensure continuity of care across providers and care settings and improve participation in cardiac rehabilitation. Written information leaflets on the benefits of cardiac rehabilitation and follow up phone calls should also be deployed without delay.

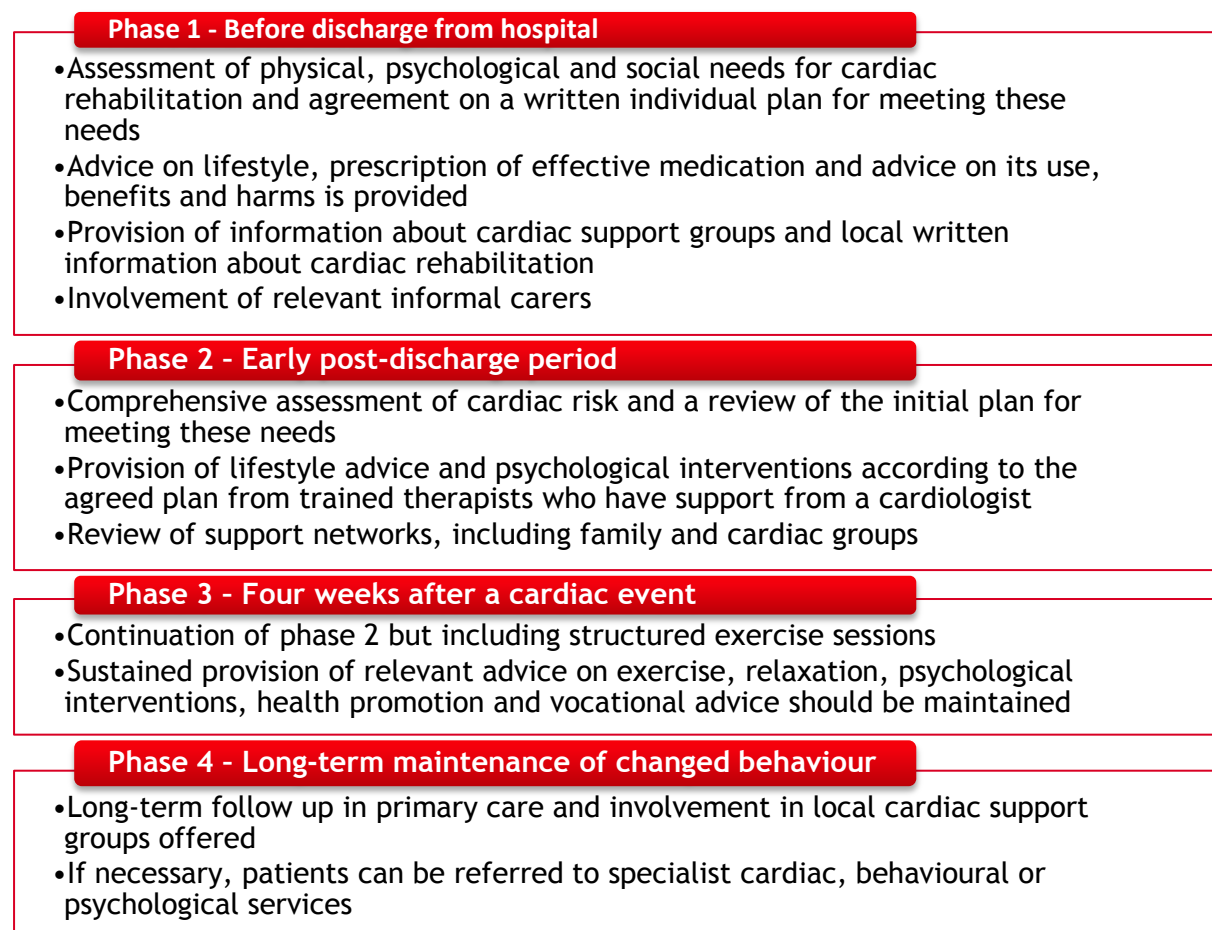
## Chapter 4: Ensuring high quality rehabilitation services

As we have set out above, the potential benefits of effective cardiac rehabilitation are significant. Rehabilitation programmes help to ensure that people with coronary heart disease have the best possible physical, psychological and social support to help them to preserve or resume their ability to function in society and it can reduce the long-term impact on NHS services<sup>25</sup>.

### The structure of cardiac rehabilitation services

The NSF for CHD set out clearly defined stages for cardiac rehabilitation for different phases of a patient's care. These phases were designed to ensure that patients were provided with appropriate and relevant information and support at the right time. The four phases are set out in Figure 6<sup>26</sup>.

Figure 6 - Structure of cardiac rehabilitation services



This phased system to cardiac rehabilitation represents a very structured approach to helping people to recover from their heart attack. Many providers who responded to our requests for information referred to the four phases of cardiac rehabilitation that they offered to patients. It is concerning that some providers do not offer all phases of cardiac rehabilitation. Kingston Hospital NHS Trust for example only offers phase one cardiac rehabilitation to patients - in their response, they do not mention referral to another provider for the stages two to four<sup>27</sup>.

### Choice in cardiac rehabilitation

Choice forms a major part of the health reforms and the Department of Health has stated that “giving people more choice and control is key to putting them at the heart of the NHS, giving them more say in making decisions about their care...it’s about giving them the opportunity and support to make the choices that will make a difference to them<sup>28</sup>”.

Providing patients with a choice of cardiac rehabilitation service is dependent on there being sufficient services to cater for the demand. Within the above framework, and according to what is clinically appropriate, choice should enable patients to participate in a cardiac rehabilitation service that fits into their lifestyle - whether it be community, home or hospital based. Introducing this flexibility will improve uptake of cardiac rehabilitation.

Although traditionally cardiac rehabilitation is offered in a hospital setting, some patients might benefit from a home or community-based model. This has been proven to produce similar gains to hospital patients and has been shown to be preferred by many patients. There are, however, patients whose needs are sufficiently complex to require supervision in a hospital setting<sup>29</sup>.

There are some examples of flexibility and choice in the provision of these services:

- **York Hospitals NHS Foundation Trust** stated that: “Cardiac rehab is offered as an inpatient and again on discharge and further offered in the community setting. The patients can choose one of 2 ways to receive rehab: as an outpatient with an exercise and education programme, or at home with community support and use of the Heart Manual. For those patients who can’t manage either, one-to-one sessions are offered<sup>30</sup>”
- **University Hospitals Coventry and Warwickshire NHS Trust** runs its cardiac rehabilitation service “using outpatient clinics. Depending on patient choice, the clinics are run at the patient’s home, Coventry Sports Centre or at the Trust<sup>31</sup>”

### Cardiac rehabilitation in the home

A good example of a home based system is that which has been developed by NHS Lothian but used across the UK. This manual is a home-based cardiac rehabilitation programme which is used by more than 350 NHS organisations across the UK. It can be used either as a stand-alone programme or as part of an integrated programme with hospital or primary care rehabilitation services<sup>32</sup>.

As well as providing cardiac rehabilitation in a home or hospital setting, certain providers have also developed community based programmes for patients to attend.

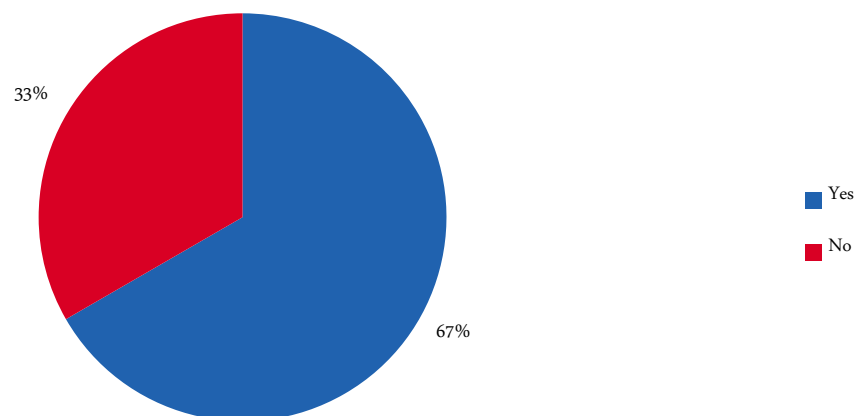
### Cardiac rehabilitation in the community

Wirral Community NHS Trust offers cardiac rehabilitation in the Community Cardiac Rehabilitation Centre which is managed by the Wirral Community NHS Trust. This service offers:

- Initial contact within two weeks of discharge
- Six weeks of education and exercise tailored to a patient's needs
- Twelve weeks of structured exercise which is individually prescribed
- The opportunity to exercise in the community after rehabilitation is finished<sup>33</sup>

In addition to choice in the type of cardiac rehabilitation that patients access, there should also be choice in what provider supplies this support. Figure 7 shows that around two thirds of providers have measures in place to refer patients to a different provider for cardiac rehabilitation.

**Figure 7 - Providers that have measures to refer patients to a different provider for cardiac rehabilitation**



This suggests that around two thirds of patients are able to access cardiac rehabilitation from another provider. It is concerning that around one third of patients are not offered this kind of choice. The providers that responded to our requests for information showed a variety of approaches to this type of choice.

A number of providers demonstrated a restrictive approach to referring patients to other areas:

- University Hospitals Coventry And Warwickshire NHS Trust makes it clear that “All Primary PCI (Percutaneous Coronary Intervention) patients are referred back to their local hospital - George Eliot Hospital, Nuneaton; Hospital of St Cross, Rugby; Warwick Hospital, Warwick”<sup>34</sup>

Royal Devon and Exeter NHS Foundation Trust also refers patients to a local service: “All post MI patients are referred on to their local cardiac rehab service, wherever the patient is from”<sup>35</sup>

- Where patients are offered choice, it tends to be location based:

West Suffolk NHS Trust states that “Patients have the choice of where they wish to undertake their Phase 3 Cardiac Rehabilitation - Addenbrookes, Norfolk and Norwich, Papworth, Ipswich Hospital, Community services, out of area referrals”<sup>36</sup>

University Hospital of South Manchester NHS Foundation Trust says that patients can choose to access cardiac rehabilitation at one of “23 other trusts and services listed in the North West”<sup>37</sup>

Peterborough and Stamford Hospitals NHS Foundation Trust says that the following providers can be referred to: “NHS Lincolnshire (phases 2 & 3); East Cambridgeshire and Fenland (phases 2 & 3); Cambridgeshire Community Services (phase 2 only)”<sup>38</sup>

- When patients are offered a choice, it can appear that this is not offered on a regular basis: Kettering General Hospital NHS Trust states that “Patients who come from different trusts after treatment for their myocardial infarction are referred to their local NHS Trust Rehabilitation service. Those who prefer to continue their rehabilitation program at Kettering General Hospital are allowed to do so”<sup>39</sup>

It is interesting to note that the majority of referrals tend to focus round the locality of service rather than service quality. This may be a result of the fact that patients prefer to be treated at their local hospital but it could also be a reflection of the approach to choice that a particular provider might take. The choice mandate that will be introduced under the health reforms should include reference to choice in cardiac rehabilitation so that it is not overlooked.

The provision of information to patients should be offered on a regular basis to ensure that patients are supported to make informed decisions. This information could include facts on the type of cardiac rehabilitation service on offer or data on the variety in the quality of services according to provider. In areas where patients are offered choice, it is unclear what information would be used to inform such decisions. This suggests that patients may not be offered an informed choice.

**Recommendation 4:** All providers should ensure that patients are offered every phase of cardiac rehabilitation with choice of where they access it in a format that suits them, whether it be in a hospital, community or home setting.

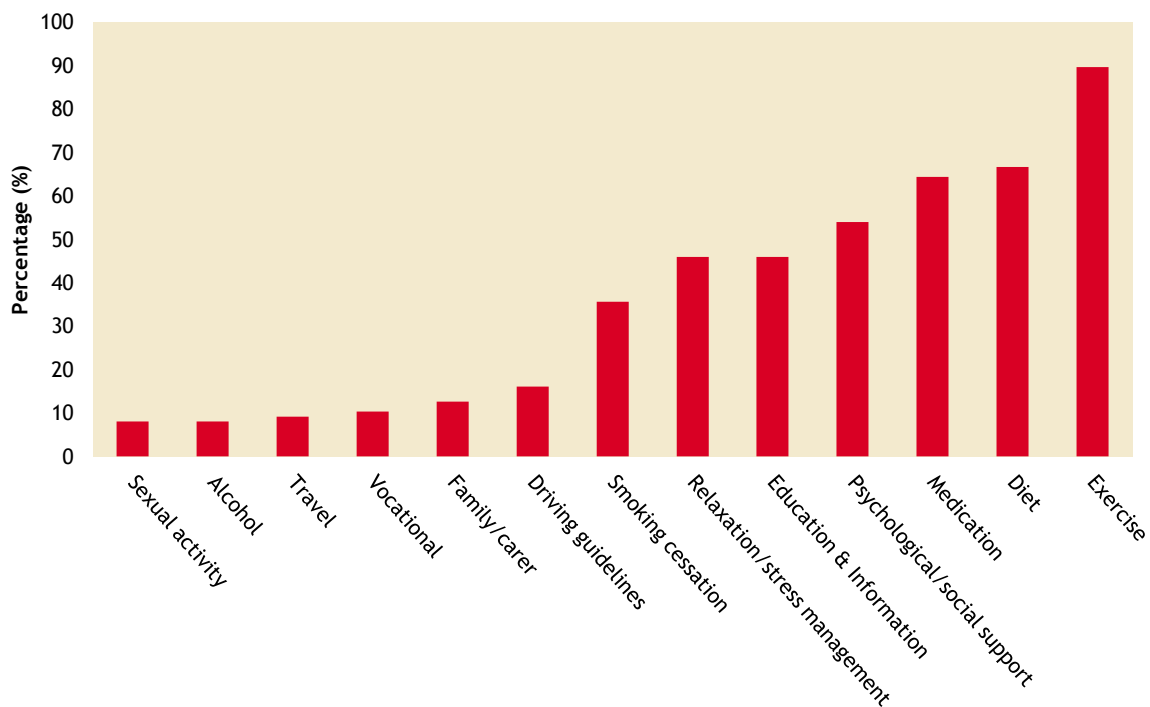
**Recommendation 5:** Providers should ensure that patients are provided real choice in cardiac rehabilitation and this should be incorporated into the national choice mandate with information for patients to support them in making an informed choice.

## The content of a cardiac rehabilitation service

Irrespective of the location of cardiac rehabilitation, it is important that the course covers consistent content to support full recovery following a heart attack. There is, however, evidence of local variation in the content of cardiac rehabilitation courses. This is despite clear guidance from NICE on the types of services that should be commissioned<sup>40</sup>.

In order to get an idea about the services that are provided on a local level, we asked providers what the key elements of cardiac rehabilitation services that were offered are. Figure 8 shows the broad range of support on offer, from diet and exercise to sexual activity and driving.

**Figure 8 - Cardiac rehabilitation services which are offered by providers**



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Encouragingly, for the most part, these correlate with the main categories within a cardiac rehabilitation service which were included in the NICE Guideline on secondary prevention. These categories were as follows<sup>41</sup>:

- Health, education and information
- Advice on lifestyle: diet and weight management, physical activity and exercise, smoking cessation and alcohol consumption
- Psychological and social support
- Cultural and vocational needs
- Family and carer needs

Given the direct link between lifestyle and coronary heart disease, there is no surprise that these feature heavily in the make-up of cardiac rehabilitation services. It is important that these are tailored to the needs of an individual. For example, if someone has a heart attack at a young age, it may not be most appropriate for them to attend a group exercise programme with other heart attack patients who are generally from an older age group. Instead, these patients could be given advice on the type of exercise that they could undertake in a gym and be monitored externally for such exercise. It is also important that patients are not excluded from an entire programme if they choose not to attend certain components<sup>42</sup>.

Notably, medication is the third most selected aspect of cardiac rehabilitation which is offered by providers. This does not formally fit into the NICE classification of a cardiac rehabilitation service (although it is likely they would include this under the education and information section). This is, however, a vital element of care in terms of secondary prevention and in preventing patients from having another heart attack. The latest MINAP audit showed that more than 90% of patients who are suitable for treatment are prescribed secondary prevention medication on discharge from hospital<sup>43</sup>. These treatments include ACE inhibitors, aspirin, beta blockers and statins. All these treatments are included in NICE guidelines<sup>44</sup> and it is encouraging that the NHS is currently exceeding targets set out in the NSF for CHD on prescribing these medicines.

Once patients have been prescribed medication, medicines adherence is the next challenge. NICE has developed a guideline on medicines adherence which recognises the challenges of ensuring that patients adhere to their treatment. This guideline states that:

“Non-adherence is a large problem but it should not be seen as the patient’s problem. Rather, it represents a limitation in the delivery of healthcare, often due to a failure to fully agree the prescription in the first place or to identify and provide the support that patients need later on. Addressing nonadherence is not about getting patients to take more medicines per se. It starts with an understanding of patients’ perspectives of medicines and the reasons why they may not want or are unable to use them. Practitioners have a duty to help patients make informed decisions about treatment and use appropriately prescribed medicines to best effect<sup>45</sup>”.

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Ensuring that patients are given appropriate support and advice about their medication will help to adhere to their programme of treatment.

It is important that the NHS remains flexible as to the treatments that they prescribe when patients are discharged from hospital so that new, cost-effective technologies can be introduced. This flexibility can have a positive benefit on patients' care.

**Recommendation 6:** Patients should be given information, support and advice about their medication to help them to concord with their treatment regime.

**Recommendation 7:** Providers should be flexible in the treatments that they offer to patients so that new treatments are made available to patients as soon as they have been deemed to be clinically and cost effective.

## Chapter 5: Improving the quality of cardiac rehabilitation services

As set out above, the reduction in mortality from heart disease in the past decade has been significant but to maintain this momentum, improvements are needed in post-event care. The reforms to the health service provide challenges but also a lot of opportunities to drive improvements in cardiac rehabilitation. It is vital that the reforms are capitalised on to ensure that all patients get access to the best services.

Many of the benefits of cardiac rehabilitation chime with the aims of the reforms. Notably:

- Improving survival for patients after they have had a heart attack will help to reduce preventable mortality
- Reducing unplanned hospital admissions will improve patient experience and support the NHS in delivering efficiency savings
- Improving clinical outcomes by enabling patients to become active self-managers of their condition<sup>46</sup> links with the ethos of putting patients at the heart of decisions about their care and enabling them to look after themselves<sup>47</sup>
- Providing efficient clinical management will help direct expertise to patients in the right format, at the right time
- Reducing inequalities is one of the key functions of the NHS Commissioning Board
- Securing better value for money through effective commissioning of cardiac rehabilitation will support the health service in delivering £20 billion savings between 2011-2014

There is a need for renewed leadership and a national strategy on cardiovascular disease to ensure that these elements are properly coordinated. This national direction should ensure seamless care for patients and a shared focus on improving outcomes of patients after they have had a heart attack. Although some of the activity can be taken at a local level through health and wellbeing boards, the NSF for CHD illustrated the outcomes benefit that can be brought by having national leadership and a clear strategy<sup>48</sup>. This new strategy could set out how the reforms should apply to CHD, identify areas where efficiency savings can be delivered and ensure coordination across public health, NHS and social care services. This strategy could also set out a role for cardiovascular networks in ensuring that commissioning decisions are supported by appropriate expertise.

**Recommendation 8:** The Department of Health should introduce a national outcomes strategy for cardiovascular disease to support improved outcomes for cardiovascular disease.

The reforms introduce a number of levers and incentives to drive improvements in services, with a focus on outcomes not targets. More information will be made available to commissioners, providers and patients and carers to support choice and benchmarking which should drive

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improvements in services and ensure quality cardiovascular disease services. These are explained in more detail below but are also set out in Figure 9.

**Figure 9 - Levers and incentives at heart of health reforms**



### **Putting outcomes at the heart of cardiac rehabilitation**

The NHS White Paper, Equity and excellence, put outcomes at the heart of the reforms, setting out that: “The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets<sup>49</sup>”. It set out that outcomes frameworks would be developed across public health, NHS and social care to support improvements in services and joint working across the three parts of the care pathway. The Department of Health has since published the NHS Outcomes Framework, Adult Social Care Outcomes Framework and a public health outcomes framework.

There is growing evidence that commissioners who prioritise an issue achieve a faster improvement in outcomes and are also more successful in containing costs<sup>50</sup>. It is encouraging therefore that all three frameworks include measures that should support improved access to better cardiac rehabilitation.

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These indicators should encourage a focus on cardiac rehabilitation and many of these are shared indicators which should encourage joined up working across the different parts of the health service. In particular:

- Domain one of the NHS Outcomes Framework and domain five of the public health outcomes framework have shared indicators on reducing mortality from cardiovascular disease. Participation in comprehensive cardiac rehabilitation is proven to lead to “greater survival for people with CHD<sup>51</sup>”
- Domain two of the NHS Outcomes Framework on ensuring people feel supported to manage their condition is relevant because one of the main aims of cardiac rehabilitation is to help patients to understand their condition and get back on their feet - self-management is key to a full recovery
- Domain three of the public health outcomes framework on helping people live healthy lifestyles and make healthy choices such as exercise, healthy eating and smoking is also relevant. Given the fact that lifestyle advice is a key component of cardiac rehabilitation, secondary prevention for people who have already had a heart attack should be prioritised through this
- Domain two of the Adult Social Care Outcomes Framework is particularly relevant as it specifically references the role of reablement and rehabilitation programmes in supporting patients over the age of 65 in staying at home after a period of hospitalisation. This should help to ensure that these patients are encouraged to participate in cardiac rehabilitation programmes

There are also indicators that could be strengthened to support the cardiovascular community, for example:

- Domain three in the NHS Outcomes Framework on helping people to recover from episodes of ill health or injury has a specific improvement area “Improving recovery from stroke<sup>52</sup>”. Were this indicator extended to cover improving recovery from cardiovascular disease, it would provide another incentive for the health service to ensure that patients who had a heart attack receive the necessary cardiac rehabilitation
- Given the extent of the burden of disease, measures on patient experience could include specific measures for patients with cardiovascular disease. This could follow the format of the national cancer patient experience survey

**Recommendation 9:** The Department of Health should consider introducing an improvement area on recovery from cardiovascular events and a national cardiovascular patient experience survey to support improvements in cardiovascular services within the NHS Outcomes Framework.

### Proxies for outcomes

In addition to overall outcome measures, it may also be necessary to identify proxies for outcomes for those outcomes where there will be a reporting lag - such as mortality from cardiovascular disease. This approach was one of the guiding principles of the MINAP audit which was founded on the principle that the audit standards of care should be chosen that have a “proven link to improved outcomes i.e. those aspects of care being audited, whilst capable of being expressed as measures of process, or performance, should link directly to better patient outcomes<sup>53</sup>”. The choice of this kind of measure should help to provide a guide to commissioners on what steps are needed for them to deliver on the outcomes frameworks and also provide an interim measure of performance before the overall outcomes data are available.

Proxies for outcomes for people who have had a heart attack could include: the percentage of patients who participate in a cardiac rehabilitation programme after a heart attack or the percentage of patients who are treated with secondary prevention medication after a heart attack.

**Recommendation 10:** The Department of Health should consider introducing proxies for outcomes in the NHS Outcomes Framework and Commissioning Outcomes Framework to support commissioners in taking steps to reduce mortality from heart disease.

### Incentivising quality

The NHS White Paper has set out that incentivisation will be focused on rewarding providers and commissioners on measures that have a direct link to improved outcomes. These include the Commissioning Outcomes Framework (COF), the Commissioning for Quality and Innovation Payment framework (CQUIN) and the Quality and Outcomes Framework (QOF).

### Commissioning Outcomes Framework (COF)

The COF provides a framework for clinical commissioning groups based on the NHS Outcomes Framework - this is designed “to create powerful incentives for effective commissioning<sup>54</sup>”. Responsibility for the development of the COF falls with NICE and they are in the process of developing measures on health outcomes and quality of care that will include patient reported outcome measures (PROMs) and patient experience.

The COF is designed to allow the NHS Commissioning Board to identify the contribution of clinical commissioning groups to the achievement of the priorities for health improvement in the NHS Outcomes Framework. This information will also ensure that clinical commissioning groups are

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accountable to the local communities and patients they serve and will allow for benchmarking between commissioners<sup>55</sup>. Commissioners will also be rewarded according to their performance against the framework.

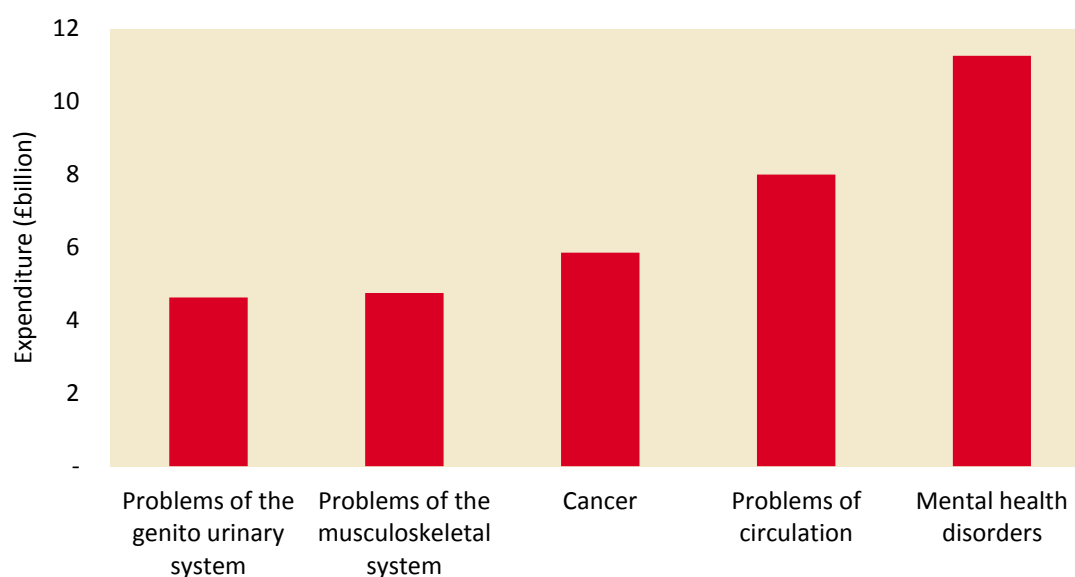
The development of the COF is welcome and as set out above, a number of measures are relevant to improving post-event care for patients. Clinical commissioning groups could play a major role in ensuring that patients access cardiac rehabilitation - this could include clauses in contracts which highlight the need for providers to not only offer, but also follow up on, appointments for cardiac rehabilitation. If this kind of approach is taken, commissioners should be rewarded accordingly. It will also be important that where relevant, proxies for outcomes are used in rewarding commissioners.

Clinical commissioning groups should ensure that they access appropriate clinical expertise in commissioning post-event care services. This kind of support could be provided by cardiovascular networks.

**Recommendation 11:** Cardiovascular networks should consolidate their ongoing role in supporting commissioning by helping clinical commissioning groups to make informed decisions about the care of patients after they have had a heart attack.

There should also be incentivisation for commissioning efficient services; this could support the delivery of £20 billion savings by 2013-2014<sup>56</sup>. Problems related to circulation are the second highest area of programme spend as can be seen in Figure 10. This means that the cardiovascular community will need to contribute £1.54 billion of savings to deliver on the Nicholson challenge<sup>57</sup>.

**Figure 10 - Programme budgeting spend in England<sup>58</sup>**



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Data from NICE suggests that there are opportunities for delivering efficiency savings through more effective commissioning and delivery of cardiac rehabilitation. The cost of cardiac rehabilitation ranges from £17 to £2186 per patient, despite it being highly cost effective at around £550 per patient<sup>59</sup>. This kind of variation is unacceptable, especially as higher spend does not always support better outcomes for patients. Clinical commissioning groups should therefore be rewarded, not just on delivering improved outcomes for patients, but also for identifying efficiency savings.

**Recommendation 12:** NICE should secure the support of clinical expertise in defining the Commissioning Outcomes Framework, which should include measures that both improve outcomes from cardiovascular disease and deliver efficiency savings.

### Commissioning for Quality and Innovation payments (CQUINs)

Equity and excellence set out that in the new world, providers will be paid according to their performance and that payment should reflect outcomes, not just activity, and provide an incentive for better quality<sup>60</sup>.

The scheme that is designed to support this is CQUINs - the objective of CQUINs is to make quality the organising principle of the NHS<sup>61</sup>. The CQUIN framework makes a proportion of provider income conditional on locally agreed quality and innovation goals. In 2009/10 this accounted for 0.5 per cent of a provider's contract value, rising to 1.5 per cent for 2010/11<sup>62</sup> and 2.5 for 2012/13<sup>63</sup>.

Local CQUIN schemes contain goals for quality and innovation that have been agreed between the provider and their commissioner. They specify quality indicators, the improvement or threshold expected, how achievement is measured and how payments are made. The only national requirement is that there should be at least one goal in each of four areas:

- Safety
- Effectiveness
- Patient experience
- Innovation

These indicators were introduced in 2008 but will be extended as part of the NHS reforms:

“The Department will extend the scope and value of the Commissioning for Quality and Innovation (CQUIN) payment framework, to support local quality improvement goals. The CQUIN framework will be important for the implementation of NICE quality standards and improving patient experience and patient-reported outcomes. And in future, if providers deliver poor quality care, the commissioner will also be able to impose a contractual penalty. In particular, we will proceed with work to impose fines for an extended list of “never events”, such as wrong site surgery, from October 2010<sup>64</sup>.”

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It is encouraging that indicators of relevance to effective cardiac rehabilitation have been selected by providers. Table 3 sets out the relevant CQUINs that have been selected by providers.

It is encouraging that indicators of relevance to effective cardiac rehabilitation have been selected by providers. Table 3 sets out the relevant CQUINs that have been selected by providers.

**Table 3 - Relevant CQUIN indicators that have been selected**

| CQUINs  | Indicator          |
|---|--------------------|
| Barnsley Hospital NHS Foundation Trust<br>Ealing Hospital NHS Trust<br>Hull and East Yorkshire Hospitals NHS Trust<br>Liverpool Women's NHS Foundation Trust<br>Medway NHS Foundation Trust<br>Papworth Hospital NHS Foundation Trust<br>University Hospital of North Staffordshire NHS Trust   | Heart attacks      |
| Guy's and St Thomas' NHS Foundation Trust<br>Harrogate and District NHS Foundation Trust<br>Homerton University Hospital NHS Foundation Trust<br>North West London Hospitals NHS Trust*<br>Tameside Hospital NHS Foundation Trust<br>The Rotherham NHS Foundation Trust<br>The Walton Centre NHS Foundation Trust<br>Yeovil District Hospital NHS Foundation Trust  | Readmissions       |
| Mid Yorkshire Hospitals NHS Trust<br>Norfolk and Norwich University Hospitals NHS Foundation Trust<br>North West London Hospitals NHS Trust*<br>Northern Lincolnshire And Goole Hospitals NHS Foundation Trust<br>Royal Cornwall Hospitals NHS Trust<br>Royal Free Hampstead NHS Trust<br>Royal United Hospital Bath NHS Trust<br>St George's Healthcare NHS Trust<br>The Hillingdon Hospital NHS Trust<br>The Newcastle Upon Tyne Hospitals NHS Foundation Trust<br>University College London Hospitals NHS Foundation Trust | Discharge planning |

\* North West London Hospitals NHS Trust has selected an indicator for both readmissions and discharge planning

Only one provider that has selected a CQUIN of relevance was able to respond to our Freedom of Information requests, which prevents us from being able to undertake a detailed assessment of whether providers that prioritise these issues offer better cardiac rehabilitation services.

Research has shown that some CQUINs appear to be rewarding the achievement of minimum standards rather than high quality care - if providers are to be incentivised for their performance, it must be for achieving high quality care<sup>65</sup>. This means that if a provider has selected effective discharge planning as a CQUIN indicator, it should promote the highest quality care and support for

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patients. This would mean that patients who have had a heart attack would be supported to leave hospital in a timely manner but only when a cardiac rehabilitation programme has been identified for them.

There should also be a focus on rewarding providers which manage to deliver significant efficiency savings while also delivering high quality care. As set out above, there is a wide range in the cost of cardiac rehabilitation services - and high cost does not always equate with the best services. Providers should be encouraged to make efficiency savings and should be rewarded for delivering high-quality services within this framework.

**Recommendation 13:** CQUIN payments should reward efficiency on the part of providers, when this is combined with delivering high-quality care such as the provision of cardiac rehabilitation within discharge planning.

### Quality and Outcomes Framework (QOF)

The QOF is the annual reward and incentive programme for GP practice results, the QOF rewards practices financially for the provision of quality care and helps to fund further improvements in the delivery of care<sup>66</sup>. The role of the QOF in driving improvements in primary care has been proven, specifically in the areas of diabetes and chronic obstructive pulmonary disease<sup>67,68</sup>. The Department of Health has made it clear that the QOF will continue, although there will be a greater focus on outcomes rather than process targets. There are a number of secondary prevention measures in the guidance on the QOF on CHD as can be seen in table 4.

Table 4 - QOF indicators on secondary prevention of CHD<sup>69</sup>

| Indicator   | Points |
|---|--------|
| <b>Records</b>  |        |
| CHD 1: The practice can produce a register of patients with coronary heart disease  | 4      |
| <b>Diagnosis and initial management</b>   |        |
| CHD 13: For patients with newly diagnosed angina (diagnosed after 1 April 2011), the percentage who are referred for specialist assessment<br>NICE menu ID: NM08  | 7      |
| <b>Ongoing management</b>   |        |
| CHD 6: The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less   | 17     |
| CHD 8: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less  | 17     |
| CHD 9: The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken (unless a contraindication or side effects are recorded) | 7      |
| CHD 10: The percentage of patients with coronary heart disease who are currently treated with a beta-blocker (unless a contraindication or side effects are recorded)   | 7      |

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|   |    |
|---|----|
| CHD 14: The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin, or an alternative anti-platelet therapy, beta-blocker and statin (unless a contraindication or side effects are recorded NICE menu ID: NM07 | 10 |
|---|----|

|   |   |
|---|---|
| CHD 12: The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March | 7 |
|---|---|

These indicators illustrate that there is a focus in primary care on supporting people after they have had a heart attack to ensure that they are being given the right treatment and that their blood pressure and cholesterol are at healthy levels. All these indicators could be supported by effective cardiac rehabilitation as patients will be supported to live healthier lifestyles and should have a better understanding of the benefits of the various treatments that they are prescribed which will support concordance.

The British Medical Association (BMA) and NHS Employers should therefore consider including a section on recommending that patients attend cardiac rehabilitation courses in the supporting notes within the QOF guidance. This would ensure that general practice managers understand the role that GPs could play in improving performance against measures within the QOF and support increased participation in cardiac rehabilitation programmes.

**Recommendation 14:** The BMA and NHS Employers should consider revising the General Medical Contract guidance so that it includes reference to the role of GPs in increasing participation in cardiac rehabilitation programmes.

It is important that the QOF is flexible in order that new developments in treatment and support are taken on board and that GPs are supported to adopt new innovations.

**Recommendation 15:** NICE should ensure that indicators on treatments are flexible in order that new treatments can be included in the QOF process in a timely manner.

## Accounting for quality to patients and commissioners

As well as incentivising improved outcomes, the NHS reforms set out a number of measures that are designed to improve reporting on the quality services. By improving the reporting of specific areas of care, it will support patient choice and allow benchmarking of commissioners to encourage improvements in services.

## Quality Accounts

Quality Accounts were developed alongside the CQUIN framework. They are annual reports for the public from providers of NHS healthcare about the quality of services they deliver. They are

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designed to support the leadership within NHS organisations to assess quality across all the services they offer and allow “leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence-based quality improvement, and to explain their progress to the public”<sup>70</sup>.

The latest guidance from the Department of Health sets out that Quality Accounts will be maintained under the new NHS structures and will allow NHS organisations to:

- Demonstrate that a relentless focus on improving service quality is being maintained
- Demonstrate their commitment to continuous, evidence-based quality improvement across all services
- Set out to patients where they need to improve
- Receive challenge and support from local scrutinisers on what they are trying to achieve
- Be held to account by the public and local stakeholders for delivering quality improvements<sup>71</sup>

There will be a greater focus on Quality Accounts delivering improvements and ensuring that Quality Account reports set out a clear picture for the local public on the progress made in improving services and addressing challenges on a local level<sup>72</sup>. A number of providers have identified priorities relevant to heart attacks and post-event care within their Quality Accounts as can be seen in Table 5.

**Table 5 - Relevant Quality Accounts that have been selected**

| Quality Accounts   | Priority areas     |
|--|--------------------|
| Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust<br>County Durham and Darlington NHS Foundation Trust<br>Liverpool Heart and Chest NHS Foundation Trust<br>Mid Cheshire Hospitals NHS Foundation Trust<br>Stockport NHS Foundation Trust<br>The Dudley Group of Hospitals NHS Foundation Trust<br>Warrington and Halton Hospitals NHS Foundation Trust<br>West Hertfordshire Hospitals NHS Trust | Heart attacks      |
| Great Western Hospitals NHS Foundation Trust<br>Leeds Teaching Hospitals NHS Trust<br>North Cumbria University Hospitals NHS Trust<br>Oxford Radcliffe Hospitals NHS Trust<br>The Rotherham NHS Foundation Trust   | Readmissions       |
| Northern Devon Healthcare NHS Trust<br>Queen Elizabeth Hospital NHS Trust<br>Royal Brompton and Harefield NHS Trust<br>Royal Bolton Hospital NHS Foundation Trust<br>Royal Cornwall Hospitals NHS Trust<br>Royal Devon and Exeter NHS Foundation Trust<br>South Warwickshire NHS Foundation Trust<br>Southend University Hospital NHS Foundation Trust<br>The Walton Centre NHS Foundation Trust         | Discharge planning |

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Despite the fact that providers can decide to link their Quality Accounts to measures set out in the CQUIN framework - whether they are aligned or complementary to each other<sup>73</sup>, when comparing those providers that have prioritised relevant indicators in CQUIN and Quality Accounts, it can be seen that there is only limited crossover between the two. Royal Cornwall Hospitals NHS Trust has selected a CQUIN and Quality Account on discharge planning however there is not further overlap.

In reporting on Quality Accounts, providers should give a clear breakdown on what steps they are taking to support improved outcomes across the patient pathway. For example, if a provider has selected heart attacks as a priority, they should set out the ways in which they have addressed urgent and follow-up care in their annual reports.

### Information revolution

A major theme within the reforms is an information revolution whereby data on service outcomes, patient outcomes and patient experience will be made publicly available in order that patients can choose services according to the quality of the services offered by a provider and providers can benchmark their performance against others to drive improvements in services. Within this framework, the provision of support so that patients and their families are able to navigate the information and make informed decisions will be important<sup>74</sup>.

There are two main tiers to the information revolution: providing information on the care pathway, such as information on treatment options; and providing data on the performance of providers or commissioners.

We have already underlined the importance of written and verbal information in supporting patients to make informed decisions about their care, such as taking up invitations to cardiac rehabilitation. This section will look more closely at data and how this can support high quality cardiac rehabilitation.

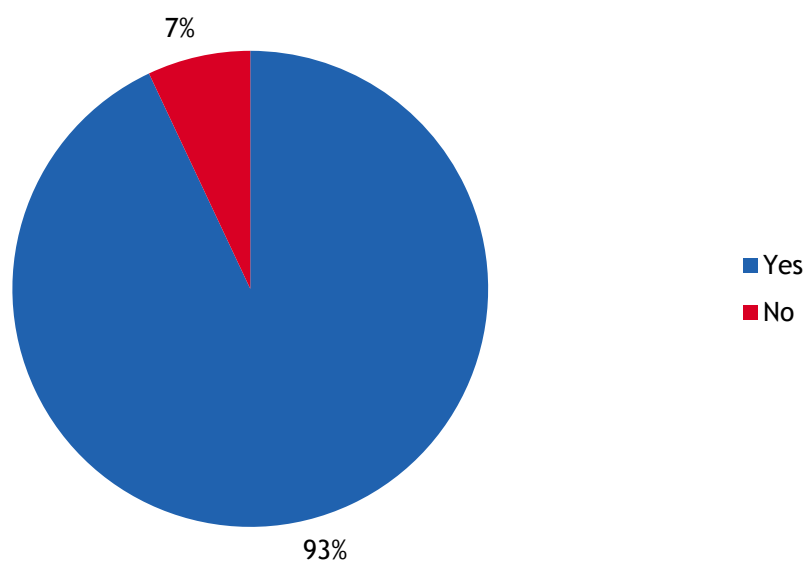
The information revolution is not necessarily about collecting additional data (although in many instances, more data collection is needed) but rather ensuring that relevant clinical outcome indicators are used to support and inform existing levers and those proposed in the NHS reforms. It is vital that these focus on the right data if we are to use them to improve outcomes for patients who have had a heart attack.

There are a number of data sources that should be made available. The data from the MINAP audit have shown the benefits that audit data can have on performance in cardiovascular disease<sup>75</sup>. Not all data in the MINAP audit however are made publicly available. The MINAP audit includes questions on whether patients are seen by a cardiologist after a heart attack and whether a cardiac

rehabilitation appointment has been made for patients after discharge from hospital<sup>76</sup>. Publishing these kind of data would allow providers to benchmark their performance against others which would in turn, drive improvements in performance. Encouragingly, the Government announced its intention to ensure these data are publishing in future MINAP reports in response to a recent parliamentary question<sup>77</sup>. In the interim, MINAP should publish the data that have already been collected to inform local knowledge on cardiac rehabilitation.

Data on readmissions to hospital within 28 days of a heart attack should also be published to allow an assessment of the effectiveness of discharge planning, and the support provided to patients when they are sent home after a heart attack. Although the majority of providers were able to provide these data (see Figure 11), the Department of Health was not able to provide this information to reflect the national picture and regional variation. Given the quality and cost implications of readmissions following a heart attack, we would ask the Secretary of State to review this without delay.

**Figure 11 - Providers that were able to provide data on readmissions following a heart attack**



**Recommendation 16:** Data on readmissions within 28 days of discharge following a heart attack should be collected and published on an annual basis.

**Recommendation 17:** MINAP should publish data on post-event care without delay to support patients, commissioners and providers in benchmarking performance between providers.

Data that are published through the information revolution should support measures in the outcomes frameworks. Where possible, this should also include data on proxies for outcomes such as participation in cardiac rehabilitation. By making these data available, patients, commissioners

and providers will be able to access data in a timely way - this will ensure that these groups are basing decisions on close to real-time data rather than waiting for mortality data to come through.

**Recommendation 18:** Providers should ensure that patients are provided with sufficient support to understand data and information so that they make informed decisions about their care.

## Quality standards

NICE quality standards are a set of specific, concise statements and associated measures that “set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions”<sup>78</sup>. These standards are based on evidence from NICE guidance and other evidence sources which have been accredited by NHS Evidence - they will be central to supporting the health reforms. They will be reflected in the COF, CQUINs and QOF and are designed to ensure that the health service is delivering the best outcomes for patients.

A quality standard on secondary prevention of myocardial infarction and cardiac rehabilitation is in the National Quality Board’s proposed library of topics that will be prioritised for development<sup>79</sup>. This is welcome although it is not in the first tranche of indicators that will be developed, which may delay improvements to post-event care. As has been seen in NICE Improving Outcomes Guidance for cancer, head and neck cancer reconfiguration lags slightly behind that for the other four cancer areas, largely because it was published at a later date<sup>80</sup>.

This time lag in improvement, coupled with the lack of focus on cardiac rehabilitation in health policy prioritisation in recent years suggests that it may be beneficial for some kind of interim standard to be developed so that commissioners have a guide to support them in purchasing the right services. This could take the form of a draft standard, based on the expertise of clinicians, patients and carers.

**Recommendation 19:** The quality standard on secondary prevention of myocardial infarction and cardiac rehabilitation should be published without delay to ensure a framework is in place for commissioners to ensure that people can access the necessary care and support after they have had a heart attack.

## Patient and public involvement

Shared decision-making will be at the heart of the health reforms and Andrew Lansley has coined the phrase “no decision about me without me”<sup>81</sup>. The involvement of patients and the public in their healthcare will help to ensure that services are delivered to a high standard.

This involvement could include patients exercising choice after they have had a heart attack on issues such as:

- What type of cardiac rehabilitation - whether it be hospital-, community- or home-based
- Which provider they go to - a local hospital or centre of excellence
- Which elements of cardiac rehabilitation they receive

Local HealthWatch is designed to provide the necessary advocacy and support to help patients to make these decisions<sup>82</sup>. Given the inequalities in access to cardiac rehabilitation that already exist<sup>83</sup>, any support from Local HealthWatch should be targeted to equality groups so that they have the same opportunities as other patients.

**Recommendation 20:** Local HealthWatch should target resources so that patients from equality groups are supported in making informed decisions about their care.

Patient and public involvement should also be a major part of commissioning. Local HealthWatch's role in ensuring that views and feedback from patients feed into commissioning decisions will help to drive improvements on a local level. This kind of local accountability should work effectively, however, some key principles should be followed:

- There should be clear mechanisms for patients and carers to feed their views into Local HealthWatch
- Local HealthWatch should be required to report back to patients on the steps they have taken upon the receipt of these figures
- Serious complaints should be transferred to HealthWatch England so that they can inform the Care Quality Commission (CQC)

There should also be mechanisms to ensure that patients are involved with health and wellbeing boards. This is particularly relevant for patients who have had a heart attack as their care will span public health, NHS and social care so coordination on a local level between local authorities, NHS bodies and social care providers will be critical in making sure patients receive seamless care.

## Annex 1

### NHS providers that supplied a response to the Freedom of Information requests

Aintree University Hospitals NHS Foundation Trust  
 Ashford And St Peter's Hospitals NHS Trust  
 Barking, Havering And Redbridge University Hospitals NHS Trust  
 Barnet And Chase Farm Hospitals NHS Trust  
 Barnsley Hospital NHS Foundation Trust  
 Basingstoke And North Hampshire NHS Foundation Trust  
 Bedford Hospital NHS Trust  
 Birmingham Children's Hospital NHS Foundation Trust  
 Birmingham Women's NHS Foundation Trust  
 Blackpool, Fylde And Wyre Hospitals NHS Foundation Trust  
 Brighton And Sussex University Hospitals NHS Trust  
 Buckinghamshire Hospitals NHS Trust  
 Burton Hospitals NHS Foundation Trust  
 Cambridge University Hospitals NHS Foundation Trust  
 Chelsea And Westminster Hospital NHS Foundation Trust  
 Chesterfield Royal Hospital NHS Foundation Trust  
 City Hospitals Sunderland NHS Foundation Trust  
 Colchester Hospital University NHS Foundation Trust  
 Countess Of Chester Hospital NHS Foundation Trust  
 County Durham And Darlington NHS Foundation Trust  
 Croydon Health Services NHS Trust  
 Cumbria Partnership NHS Foundation Trust  
 Dartford And Gravesham NHS Trust  
 Derby Hospitals NHS Foundation Trust  
 Dorset County Hospital NHS Foundation Trust  
 Ealing Hospital NHS Trust  
 East And North Hertfordshire NHS Trust  
 East Cheshire NHS Trust  
 East Lancashire Hospitals NHS Trust  
 East Sussex Hospitals NHS Trust  
 Epsom And St Helier University Hospitals NHS Trust  
 Frimley Park Hospital NHS Foundation Trust  
 George Eliot Hospital NHS Trust  
 Great Ormond Street Hospital For Children NHS Trust  
 Great Western Hospitals NHS Foundation Trust  
 Guy's and St Thomas' NHS Foundation Trust  
 Heatherwood And Wexham Park Hospitals NHS Foundation Trust  
 Hinchingsbrooke Health Care NHS Trust  
 Homerton University Hospital NHS Foundation Trust  
 Hull And East Yorkshire Hospitals NHS Trust  
 Imperial College Healthcare NHS Trust  
 James Paget University Hospitals NHS Foundation Trust  
 Kettering General Hospital NHS Foundation Trust

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### NHS providers that supplied a response to the Freedom of Information requests

King's College Hospital NHS Foundation Trust  
 Kingston Hospital NHS Trust  
 Lancashire Teaching Hospitals NHS Foundation Trust  
 Leeds Community Healthcare NHS Trust  
 Leeds Teaching Hospitals NHS Trust  
 Liverpool Heart and Chest NHS Foundation Trust  
 Luton And Dunstable Hospital NHS Foundation Trust  
 Medway NHS Foundation Trust  
 Mid Cheshire Hospitals NHS Foundation Trust  
 Mid Essex Hospital Services NHS Trust  
 Mid Staffordshire NHS Foundation Trust  
 Milton Keynes Hospital NHS Foundation Trust  
 North Bristol NHS Trust  
 North Middlesex University Hospital NHS Trust  
 North West London Hospitals NHS Trust  
 Northampton General Hospital NHS Trust  
 Northumbria Healthcare NHS Foundation Trust  
 Nottingham University Hospitals NHS Trust  
 Oxford Radcliffe Hospitals NHS Trust  
 Oxleas NHS Foundation Trust  
 Papworth Hospital NHS Foundation Trust  
 Pennine Acute Hospitals NHS Trust  
 Peterborough And Stamford Hospitals NHS Foundation Trust  
 Plymouth Hospitals NHS Trust  
 Poole Hospital NHS Foundation Trust  
 Portsmouth Hospitals NHS Trust  
 Royal Berkshire NHS Foundation Trust  
 Royal Bolton Hospital NHS Foundation Trust  
 Royal Brompton And Harefield NHS Trust  
 Royal Devon And Exeter NHS Foundation Trust  
 Royal Free Hampstead NHS Trust  
 Royal Liverpool And Broadgreen University Hospitals NHS Trust  
 Royal United Hospital Bath NHS Trust  
 Salford Royal NHS Foundation Trust  
 Salisbury NHS Foundation Trust  
 Sandwell And West Birmingham Hospitals NHS Trust  
 Scarborough And North East Yorkshire Health Care NHS Trust  
 Sheffield Teaching Hospitals NHS Foundation Trust  
 Shrewsbury And Telford Hospital NHS Trust  
 South Tees Hospitals NHS Trust  
 South Warwickshire NHS Foundation Trust  
 Southampton University Hospitals NHS Trust  
 Southend University Hospital NHS Foundation Trust  
 St George's Healthcare NHS Trust  
 St Helens And Knowsley Hospitals NHS Trust  
 Stockport NHS Foundation Trust

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Surrey And Sussex Healthcare NHS Trust  
 Tameside Hospital NHS Foundation Trust  
 Taunton And Somerset NHS Foundation Trust  
 The Christie NHS Foundation Trust  
 The Dudley Group Of Hospitals NHS Foundation Trust  
 The Hillingdon Hospital NHS Trust  
 The Rotherham NHS Foundation Trust  
 The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust  
 The Royal Marsden NHS Foundation Trust  
 The Royal Wolverhampton Hospitals NHS Trust  
 The Walton Centre NHS Foundation Trust  
 The Whittington Hospital NHS Trust  
 Trafford Healthcare NHS Trust  
 University College London Hospitals NHS Foundation Trust  
 University Hospital Of North Staffordshire NHS Trust  
 University Hospital Of South Manchester NHS Foundation Trust  
 University Hospitals Bristol NHS Foundation Trust  
 University Hospitals Coventry And Warwickshire NHS Trust  
 University Hospitals Of Morecambe Bay NHS Trust  
 Walsall Hospitals NHS Trust  
 Warrington And Halton Hospitals NHS Foundation Trust  
 West Hertfordshire Hospitals NHS Trust  
 West Middlesex University Hospital NHS Trust  
 West Suffolk Hospitals NHS Trust  
 Western Sussex Hospitals NHS Trust  
 Winchester And Eastleigh Healthcare NHS Trust  
 Wirral Community NHS Trust  
 Wirral University Teaching Hospital NHS Foundation Trust  
 Wrightington, Wigan And Leigh NHS Foundation Trust  
 Wye Valley NHS Trust  
 Yeovil District Hospital NHS Foundation Trust  
 York Hospitals NHS Foundation Trust

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### NHS providers that did not supply a response to the Freedom of Information requests

Airedale NHS Trust  
 Alder Hey Children's NHS Foundation Trust  
 Barts And The London NHS Trust  
 Basildon And Thurrock University Hospitals NHS Foundation Trust  
 Bradford Teaching Hospitals NHS Foundation Trust  
 Calderdale And Huddersfield NHS Foundation Trust  
 Cambridgeshire Community Services NHS Trust  
 Central Manchester University Hospitals NHS Foundation Trust  
 Derbyshire Community Health Services NHS Trust  
 Doncaster And Bassetlaw Hospitals NHS Foundation Trust  
 East Kent Hospitals University NHS Trust  
 Gateshead Health NHS Foundation Trust  
 Gloucestershire Hospitals NHS Foundation Trust  
 Harrogate And District NHS Foundation Trust  
 Heart Of England NHS Foundation Trust  
 Ipswich Hospital NHS Trust  
 Lincolnshire Community Health Services NHS Trust  
 Liverpool Women's NHS Foundation Trust  
 Maidstone And Tunbridge Wells NHS Trust  
 Mayday Healthcare NHS Trust  
 Mid Yorkshire Hospitals NHS Trust  
 Newham University Hospital NHS Trust  
 Norfolk And Norwich University Hospitals NHS Foundation Trust  
 North Cumbria University Hospitals NHS Trust  
 North Tees And Hartlepool NHS Foundation Trust  
 Northern Devon Healthcare NHS Trust  
 Northern Lincolnshire And Goole Hospitals NHS Foundation Trust  
 Nuffield Orthopaedic Centre NHS Trust  
 Queen Elizabeth Hospital NHS Trust  
 Queen Victoria Hospital NHS Foundation Trust  
 Royal Cornwall Hospitals NHS Trust  
 Royal Surrey County Hospital NHS Trust  
 Sherwood Forest Hospitals NHS Foundation Trust  
 South Devon Healthcare NHS Foundation Trust  
 South London Healthcare NHS Trust  
 South Tyneside NHS Foundation Trust  
 Southport And Ormskirk Hospital NHS Trust  
 The Lewisham Hospital NHS Trust  
 The Newcastle Upon Tyne Hospitals NHS Foundation Trust  
 The Princess Alexandra Hospital NHS Trust  
 The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust  
 University Hospital of Birmingham NHS Foundation Trust  
 University Hospitals Of Leicester NHS Trust  
 Weston Area Health NHS Trust  
 Whipps Cross University Hospital NHS Trust  
 Worcestershire Acute Hospitals NHS Trust

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**NHS providers that did not supply a response to the Freedom of Information requests**

Worthing And Southlands Hospitals NHS Trust

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