Cardiac rehabilitation: we should all be doing it

Anitha Varghese, Jane Flint

Authors

Anitha Varghese
Specialist Registrar in Cardiology

University Hospital Birmingham NHS Foundation Trust, Edgbaston, Birmingham, B15 2TH

Jane Flint
Consultant Cardiologist, Medical Director, Action Heart, and National Clinical Advisor for Cardiac Rehabilitation

The Dudley Group of Hospitals NHS Foundation Trust, Dudley, West Midlands, DY1 2HQ

Correspondence to:
Dr J Flint
(Jane.Flint@dgoh.nhs.uk)

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"Cardiac rehabilitation (CR) is the process by which patients with cardiac disease, in partnership with a multi-disciplinary team of health professionals, are encouraged and supported to achieve and maintain optimal physical and psychosocial health."[1] The fundamental interventions required for CR should provide the cornerstone of lifelong management in cardiovascular disease – for those who present with the numerous manifestations, those identified as being at increased risk, and, indeed, all of us.

A reminder

The article by Pollard and Sutherland (pages 247–49) reminds us of the importance of such effective treatments as smoking cessation, regular exercise, a balanced diet enriched by fresh fruit but deficient in *trans*-fats, and a suitable body mass index.[2] The author presents findings from a survey conducted on patients offered CR in the light of Department of Health guidelines outlined in the National Service Framework (NSF) for Coronary Heart Disease (2000), and raises several points.[3] First, CR has once again been shown to achieve its intended goals. Additionally, it is an extremely popular intervention among patients, with nearly 90% reporting that they were at least moderately satisfied with the CR programme. So why are less than half of those offered this useful and successful treatment not utilising the services?

Within the UK, provision of CR has been shown to be patchy and poor. The first audit cycle of the National Audit of Cardiac Rehabilitation (NACR) between 2005/2006 and 2006/2007 showed only 40% uptake of CR by patients standing to benefit, with individuals directed towards percutaneous coronary intervention (PCI) particularly poorly served at 28%.[4] Views of patients and carers following primary PCI were disappointing regarding their arrangements and access to rehabilitation.[5] In order to redress this deficiency, a national campaign was launched by the British Heart Foundation (BHF), the British Association for Cardiac Rehabilitation, and the BHF Care and Education

Research Group at the University of York to support CR patients and providers, in conjunction with guidelines outlined within the NSF and by the National Institute for Health and Clinical Excellence (NICE), both post-myocardial infarction (post-MI), and commissioning.

The current state

Cardiac and Cardiovascular Networks are ideally placed to co-ordinate improvement across their health communities, and we recently evaluated the state of development of CR across the English Cardiac Networks and their commitment to NACR.[6] A 16-part questionnaire was developed and distributed jointly by the Black Country Cardiac Network and the Heart Improvement Programme. Twenty-nine of the 30 Cardiac Networks, sent this questionnaire by electronic mail in July 2007, completed responses for provisional analysis by September 2007 to inform the 'Shaping the Future of Cardiology' perspective in October 2007. Within these, 93% had a specific clinical subgroup for CR and there was a designated Lead CR Cardiologist in 69% of the networks. It is encouraging to see this trend also supported by Pollard and Sutherland's paper. Assigning a lead clinician is of key importance in improving uptake of CR, as will

undoubtedly be shown at repeat audit from St George's Hospital. Of much less benefit appears to be home-based CR. This option was only provided by 21% of the networks anyway, and is not the way forward according to Pollard and Sutherland.

Entry of data into the NACR was performed by about one in five of the networks across their patch, with the vast majority (90%) expressing the intention to do so in the near future. Eighty-three per cent followed defined standards of service provision, and most of these audited themselves to inform commissioning. Only 34% reported a robust commissioning link, 41% access to Choice Revascularisation Pathway monies, but 10% were revisiting this pathway approach with introduction of primary PCI. We anticipate improvement in the post-primary PCI arrangements from this year's impending data analysis, although a major challenge remains to counter the Sheffield University patient/carer evidence in the National Infarct Angioplasty Project (NIAP).[5] Beneficial patient involvement in Cardiac Networks was 79% (45% of Cardiac Networks being specifically encouraged towards improving CR by their public and patient involvement approach).

Conclusion

Our operational survey has supported Cardiac Networks in developing their CR work plans by sharing practice experience, finding majority commitment to the NACR longer term, identifying commissioning challenges, and demonstrating the tremendous patient appreciation of valuable CR services. We know the evidence base, we continue building the infrastructure, and we must deliver!

Conflict of interest

None declared.

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