Heart Failure Rehabilitation Closer to Home: *A Community Hub*

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Comisiwn Bevan Commission

Team Members: Linda Edmunds - Nurse Consultant, Emma Davies – Cardiac Rehabilitation CNS, Hayley Rose- Heart Failure CNS, Nadine Eckford – Physiotherapist, Mark Harris – Exercise Specialist, Rachael Prosser – Cardiac Rehab Nurse, Maria Davies - Occupational Therapist ABUHB

Project Background:

ABUHB were successful in securing funding for a fixed term project to test a community model for rehabilitation and review of heart failure patients in the Caerphilly Borough.

Why Caerphilly?

- High prevalence of Heart Failure
- Readmission to secondary care in 30 days = 25% (11% across ABUHB)
- Only 4% of patients accessed Cardiac Rehabilitation

Project Aims/Objectives:

- To test a different Model to reduce readmissions, increase cardiac rehab uptake and improve outcomes related to quality of life and health outcomes
- To place a greater emphasis on rehabilitation for delivering evidence-based programme of care and optimizing HF patients on their medications
- To free up specialist capacity for the more complex patients

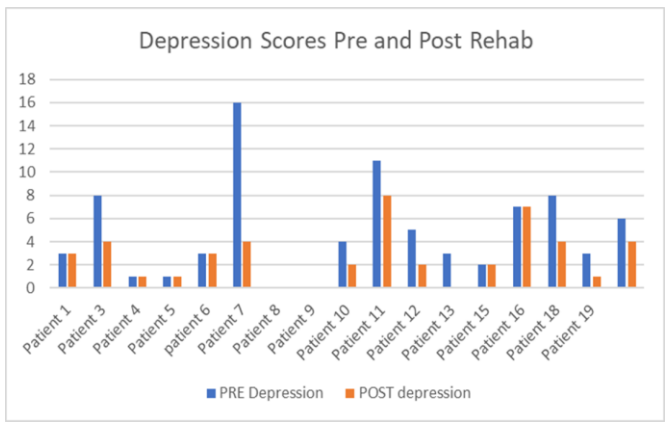
Project Outcome Measures:

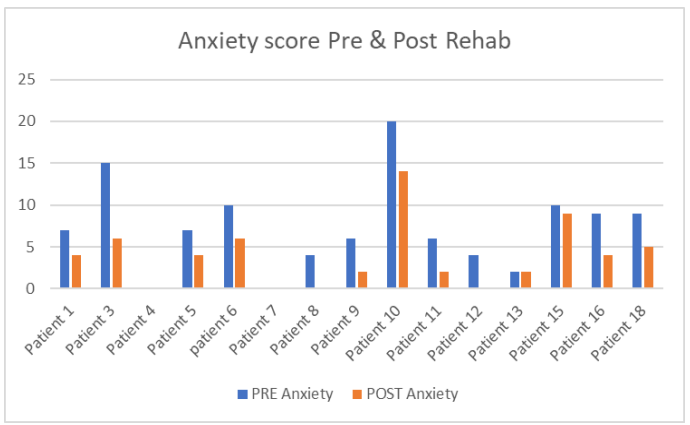
- Use of PROMS to monitor symptoms
- Improvement in patients to self manage – LIKERT
- Decrease in optimization time – 4 pillars therapy
- Decrease in readmission in 30 days
- Improved QOL by end of programme
- Increased no. of patients optimized on therapy during CR

Project Approach:

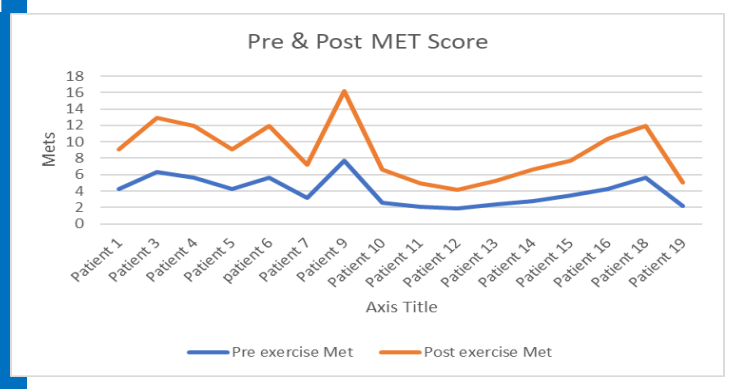
- Delays due to COVID/Sickness
- 3 sites – Trethomas ,Rhymney and YMCA Bargoed – care closer to home offered
- Usual care arm = secondary care
- Greater emphasis on self management
- Shorter appointment times
- Use of PROMS/HAD scores symptoms real time
- 8 weeks CR and OT input +/- optimization alongside
- Good example of MDT working

Project Impact:

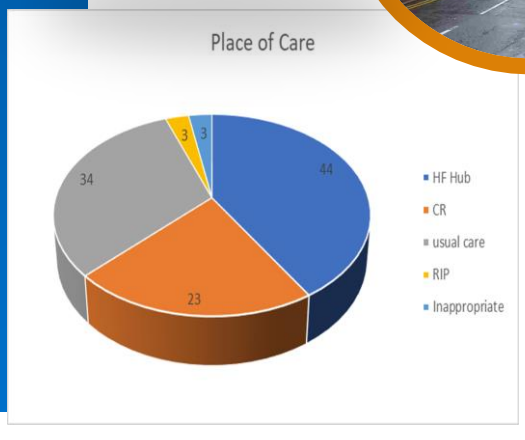




- Improvements in exercise, QOL - reporting reduction in anxiety and depression score
- Optimisation of medication was achieved on average 15 weeks compared to 28 weeks in usual care
- Readmission rate 1.5% ~ usual readmission rate 25%
- 335 appointments were freed in secondary care for more complex patients
- Co-Production Meetings x 3 held



Patient Benefits:



Next Steps:

It is recommended that:

- Funding secured to spread and scale the Model throughout ABUHB
- Continued Co-production
- Initiate Patient support group
- Cardiac Rehab nurses to attend independent prescribing module
- Possibility of developing Dual HF and CR Nurse Role

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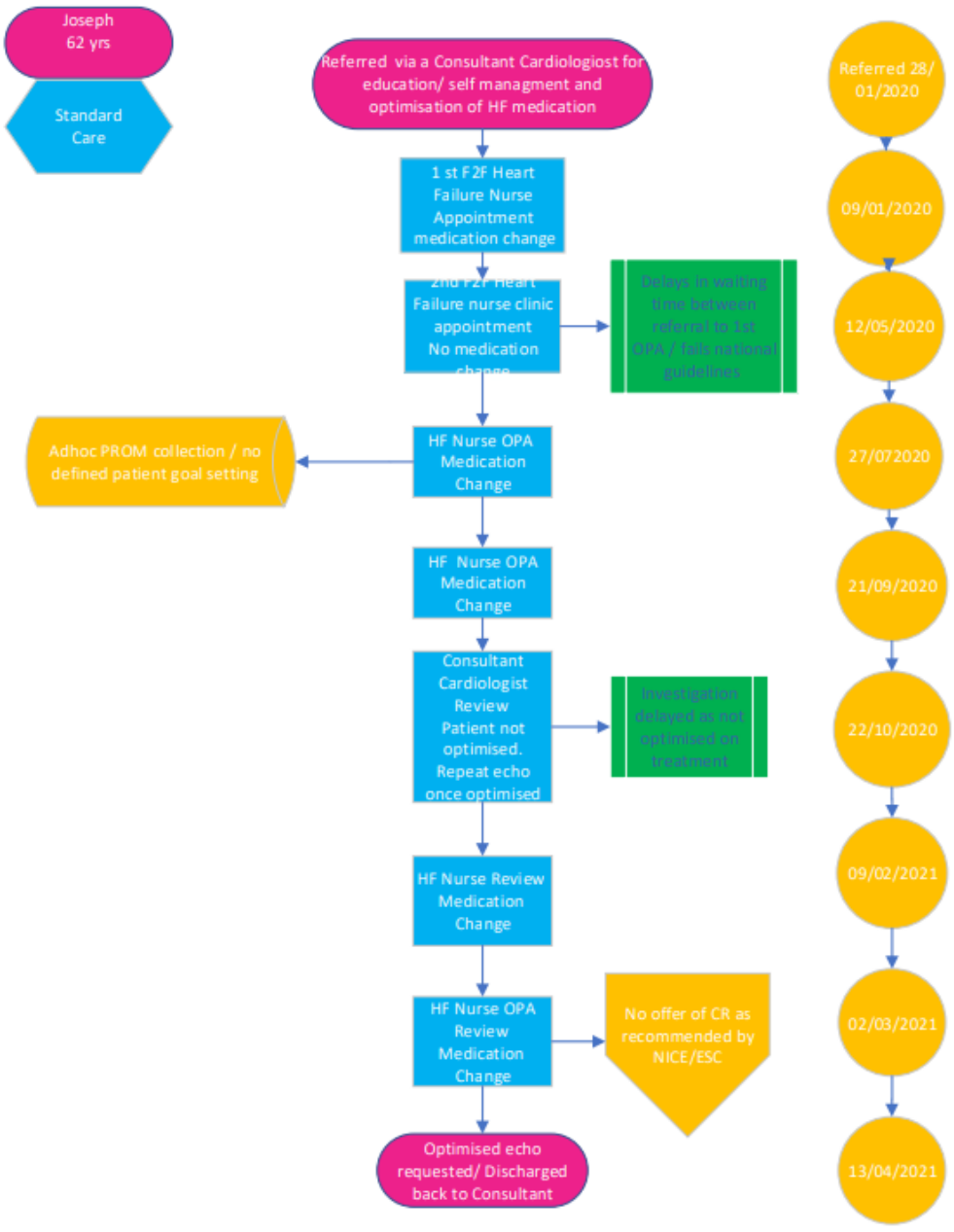
Joseph's pathway reflects timely delays and numerous secondary care appointments. Lacked patient engagement



Jack was seen timely, as per NICE/NICOR guidelines was optimised on treatment with 3 months. He was engaged in his care and his goal was achieved through attending Cardiac Rehabilitation