Assessment Workshop

BACPR Conference October 2019

There are often questions around what is a 'valid' assessment, and what should be assessed pre and post CR. Expectations of what should be recorded, not necessarily in an ideal world but practically, where many programmes have limitations on space, staff, time etc. Is there a 'minimum', and should this focus on all the BACPR standards or the measures relevant to the patient? With limited resources what should the priorities be? This workshop aimed to collect some feedback from clinicians as to what is being recorded on the ground, and what the barriers may be for outcomes measure that are not being recorded as much. Attendees worked in groups to respond to workshop questions posed by the NACR team. The responses from those groups have been collected and are presented/summarised below. The accompanying spreadsheet breaks down the feedback in more detail. Information will be shared with the BACPR to feed in to the current work on developing the new BACPR Standards.

What are you Assessing?

Regarding the results, it's not clear if this is what is assessed generally, or what is put on NACR (as this may not be the same thing); also, need to consider how representative these figures are in comparison to the data we have - although initial comparisons seem to show similar patterns and looking at NACR data, the completion rate per outcome measure is comparable with the trends identified in the workshop.

It was noted that, within the workshop, ISWT is less completed than 6MWT and other FCT (Fitness Level/METS) however, the NACR data shows that for each measure (ISWT/6MWT/Other METS) the completion rate is similar, at around 20% , with approximately one third of all patients in total having an FCT at baseline.

Those highlighted in blue on the spreadsheet have a percentage response of over 90% (maximum number of responses for this was 39).

Drugs are well recorded, both according to the workshop and looking at NACR data. Currently, usage of this information has been limited primarily to audit-related research, but we are hoping to refine the data fields and increase use of this information going forward.

The two least completed, according to the workshop, are: i) Canadian Angina Scale – many clinicians were not aware what this is (and it is condition specific); and ii) Mediterranean Diet Score – which needs a dietician to complete with patients, and many programmes do not have access to this support. There are also cultural/demographic limitations to the score (eg. Areas of high deprivation; areas with high numbers of ethnic diversity), and it may be worth investigating if it is possible to audit diet differently.

What are you not Assessing?

The responses here are more or less showing the reverse of the above information, particularly around the Canadian Angina Scale and Mediterranean Diet Score. In addition, GAD7/PHQ9 (alternative to HADS) and Minnesota (HF specific) have low numbers. We know GAD7/PHQ9 is increasing in use, but the default is still usually HADS as this is included in the NACR questionnaires.

Why are you not Assessing?

There is some interesting feedback in the comments, and some areas that are worth noting for NACR and possibly also BACPR.

For NACR, there were comments around the Questionnaires (length, patients struggling with them generally and with specific questions) and this has already led to some work to address this within the team – the team will be getting some feedback from clinicians before sending out updated versions.

It also flagged up that NACR may need to be more specific around 'duplicated' tests eg HADs + GAD7/PHQ9; Dartmouth + Minnesota and clarify that only one of these would be completed for a patient, not both/all.

A number of clinicians, both at the conference and generally in feedback to the team, have asked about recording Non-HDL for cholesterol (although we can obtain this figure from Total-HDL if both are already recorded).

For BACPR perhaps the main issue is the Mediterranean Diet/Diet measure, as the vast majority of teams are not using this in practice. Generally, thoughts around alternative FCT, particularly for less mobile patients (eg. Chair based) may also be welcomed.