

10<sup>th</sup> March, 2017

**BACPR / BSH Position Statement on:**

The access of patients with “heart failure” to exercise-based cardiovascular rehabilitation services.

According to the most recent National Audit of Cardiac rehabilitation (NACR) report 2015, of the total number of patients accessing CR services in England & Wales, less than 5% have a primary diagnosis of “heart failure”. In Northern Ireland, the figure is less than 1% (no data available for Scotland at present). There will be a variety of reasons that underpin this, yet the evidence for CR in this patient group is robust and is supported by explicit quality standards published by NICE:

“Adults with stable, chronic heart failure are offered an exercise-based programme of cardiac rehabilitation. Offering an exercise-based programme of cardiac rehabilitation to ALL adults with chronic heart failure when their condition is stable will help to prevent the person’s heart failure from worsening, reduce their risk of future heart problems and improve their quality of life.” **Chronic Heart Failure in Adults, Quality Standard (February 2016): [nice.org.uk/guidance/qs9](http://nice.org.uk/guidance/qs9) (Quality Statement 6)**

For many patients who have been hospitalised with heart failure, there may be a reluctance to offer early access to CR due to uncertainty about “stability” of the condition and/or lack of clarity concerning aetiology and additional investigations or procedures (such as invasive angiography, complex device implantation). It is the view of both BACPR and BSH, that if patients are deemed sufficiently “stable” to be discharged from an acute care setting, then onward referral to a CR programme should take place just as it would for patients post MI or revascularisation. The benefits of many of the CR core components can be realised by this patient group (including self-management) even if plans for additional tests / procedures have been initiated. During “initial assessment”, if there are concerns regarding a patient’s “risk stratification” (because additional tests have been planned) then it is reasonable to delay a formalised assessment of exercise capacity and begin an exercise programme at the lowest intensity level. Once an appropriate risk tool can be completed, this component should be reviewed. Attempts should be made to improve local awareness of the importance of early access to CR for patients with heart failure, develop electronic referral processes and, where practical, involve specialist heart failure nurses (community & hospital-based).



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