**Impact of the Continuing Covid Pandemic on Cardiac Rehabilitation services**

A joint position statement from :
British Association for Cardiovascular Prevention and Rehabilitation (BACPR)
British Cardiovascular Society (BCS)
British Heart Foundation (BHF)
Cardiovascular Care Partnership UK (CCP UK)

**BACPR strongly recommend that during the continued covid pandemic cardiac rehabilitation services, including undertaking both a full initial assessment and delivering an individualised programme, should be offered to eligible patients.**

Cardiac rehabilitation is an evidence-based essential intervention which has been demonstrated to be highly effective in reducing morbidity and mortality in people with existing CVD.

Understandably, hospitals have again postponed non-critical services so that healthcare professionals can be deployed to support staffing shortages and areas dealing with patients who have the COVID-19 virus. However, there remains an ongoing need to assess, support and rehabilitate those who have CVD or are newly diagnosed with it to prevent the considerable risk of unintended, yet significant consequences in the long-term. The consequence of withdrawing or offering only minimal cardiac rehabilitation services is that there is likely to be an increase of 30% of unplanned hospital admissions of CVD patients for those eligible resulting in substantially reduced health-related quality of life, compromised mental health, and decreased daily activity / functional ability.

The Covid pandemic has led to many services across the UK being fast to respond in terms of initiating delivery of online/virtual and home-based options. In the future, as the risk of covid decreases further, cardiac rehabilitation teams will need to determine when face – to face assessment can safely resume to complement these digital / home- based options along with offering the option of group face to face sessions. There is growing evidence that these online/virtual and home-based options are effective when delivered by appropriately qualified health and exercise professionals with regular reviews. Increasing the range of different modes of delivery that are offered by programmes is a positive step to continue in the future which will lead ultimately to increasing uptake and patient choice, particularly among those groups that are currently poorly represented.

Cardiac rehabilitation services should also ensure that there is a clear effective pathway for patients into community services and long-term maintenance exercise sessions. In addition, we would encourage that statutory and third sector services prioritise reinstating previous support for long term provision for people with CVD .

This position statement therefore sets out what cardiac rehabilitation services should be prioritised during the ongoing covid pandemic (See Appendix 1). It should be stressed that all efforts to adhere to the BACPR Standards and Core Components of cardiovascular prevention and rehabilitation provision should be made. Most certainly, comprehensive cardiac rehabilitation should be reinstituted as soon as practicably possible and the goal being consistent effective quality delivery of services across cardiac networks/health boards.

Support for cardiac rehabilitation programmes is available on the BACPR (www.bacpr.org) and BHF website (www.bhf.org.uk).

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British Cardiovascular Society

C C P UK
Cardiovascular Care Partnership (UK)

British Heart Foundation

**Appendix 1**
**Recommended minimum provision in relation to BACPR Standards during the ongoing covid pandemic**

| **BACPR Standards** | |
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| Standard One | Cardiac rehabilitation should be provided by appropriately qualified healthcare and / or exercise professionals |
| Standard Two | *Eligible patients:*<br>As a minimum the following priority patient groups should be offered cardiac rehabilitation:<br>• Acute coronary syndrome<br>• Coronary revascularisation<br>• Heart failure<br><br>*Referral:*<br>Referral methods for cardiac rehabilitation should continue in the normal manner if possible and ideally within 24-hours after patient discharge from hospital.<br><br>*Recruitment:*<br>Cardiac rehabilitation professionals should contact priority patients by telephone within 3 working days. |
| Standard Three | Initial assessment of patients' rehabilitation needs and personalised goal setting should be completed within 10 working days after receipt of referral. Consideration should be given to conducting the initial assessment by telephone / video consultation.<br><br>Initial assessment should consist of:<br>• Medical history<br>• Assessment of lifestyle risk factors<br>• Assessment of psychosocial health<br>• Medical risk management (including medication concordance and symptoms management education and advice)<br><br>Formal assessment of functional capacity should be prioritized for face to face appointments as they resume. Until that time telephone assessment, knowledge of previous history and investigations and patient self-reported functional capacity (e.g. left ventricular ejection fraction, history of arrhythmia / symptoms) can assist with risk stratification for exercise and physical activity.<br><br>The written cardiac rehabilitation care plan should define the pathway of care while meeting the individual patient needs, participation preferences and choices. |
| Standard Four | Using a menu-based approach consideration should be given to home-based, manual-based or web-based cardiac rehabilitation dependent on patient choice and availability.<br>The duration should last a minimum of 8 weeks. |
| Standard Five | On completion of cardiac rehabilitation a final assessment of individual patient needs should be conducted by face to face / telephone / video |

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| | consultation<br><br>Maintain referral / signposting to community-based support services, such as online / virtual classes and support with home-based activities for long-term maintenance. |
| Standard Six | Where relevant and possible, data to the National Audit for Cardiac Rehabilitation (NACR) should be submitted. |