key points

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Cardiac rehabilitation (CR) is, in effect, a chronic disease management programme with a very strong evidence base. Exercise-based CR results in a 20% reduction in all cause mortality and a 25% reduction in total cardiac mortality. Other benefits of CR have also been clearly demonstrated. These include: reduction in symptoms in those with angina; increase in exercise capacity and general fitness; reduction in blood pressure; improvement in lipid profile (mainly by raising HDL); reduction in arrhythmias; improved coronary blood flow; and improvement in psychological measures.

CR programmes can be carried out in hospital or the community. The traditional hospital-based programme is divided into four phases. The other widely used model outside hospital is a six-week, home-based programme using written and audiotape materials.

CR programmes should have strong links with the primary care team. GPs already have their own effective initiatives to improve lifestyle and reduce risk factors, such as smoking cessation strategies and nurse-run secondary prevention clinics. The GP and other members of the primary healthcare team play vital roles in reinforcing healthy lifestyle change, optimising medical risk factor management and ensuring long-term continuation of appropriate cardioprotective medication.

GPs can refer CHD patients to an appropriately qualified instructor for Phase IV community-based exercise sessions, using the British Association for Cardiac Rehabilitation's (BACR) protocol for GP referral. The BACR exercise referral pathway recommends annual review of the patient by their GP or other designated health professional.

The following patient groups benefit from CR programmes: post-MI; post-revascularisation (either surgical or PCI); stable angina; heart failure; post-valve surgery; and cardiac transplantation or ICD insertion.

The BACR Standards and Core Components for Cardiac Rehabilitation set out the minimum standard for CR programmes. The core components reflect that cardiac rehabilitation services are moving away from the traditional model with its focus on exercise, psychological support and education to a more comprehensive approach which includes optimising secondary prevention measures. The optimal model of cardiac rehabilitation is one that provides these core components but also takes into account the fact that the needs and beliefs of individual patients vary considerably. Programmes are becoming increasingly patient-centred and moving towards a menu-based approach where the patients choose the components most relevant to them.