National Audit

NHS

National Audit of Cardiac Rehabilitation

Quality and Outcomes Report 2026



Executive Summary

The National Audit of Cardiac Rehabilitation (NACR) Annual Quality and Outcomes Report 2026 highlights continued improvements in the provision of cardiac rehabilitation (CR) across the UK, despite ongoing workforce, funding and service pressures. CR programmes continue to demonstrate progress in service quality and patient outcomes.

The number of patients accessing CR has increased over the past year, which is positive news. However, the number of eligible patients has also risen, resulting in only a modest improvement in uptake, which now stands at approximately 47.4% for ACS across England and Wales, as reported this year.

NACR's staffing survey continues to highlight the widespread nature of the multi-disciplinary teams (MDT) delivering CR. The majority of services reported an MDT (98%), comprising three or more professional groups, the minimum required in the National Certification Programme for Cardiac Rehabilitation (NCP_CR). Reported recruitment activity suggests most programmes are maintaining workforce provision, while just over a quarter are attempting to expand their workforce (28.9%).

Optimal management of cardiovascular risk factors remains a central component of CR services. Most programmes reported access to prescribing professionals, making it possible for medication review and optimisation to be delivered directly within CR services and reducing reliance on external referrals, such as GPs and Pharmacists.

The summary of this year's quarterly reports shows encouraging alignment with the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) Standards and Core Components (2023), including strong provision for priority patient groups, widespread use of multi-mode delivery, improving pre- and post-CR assessment rates, and median waits of under four weeks across the main patient groups. However, variation between services and gaps in data quality remain, particularly for mode of delivery, assessments and wait times.

Our analysis of patient outcomes in relation to mode of delivery revealed several significant findings. Notably, patients starting Home-based/Self-managed CR alone have lower levels of physical activity (Chief Medical Officer recommendation: at least 150 mins per week), and higher levels of smoking, total cholesterol and BMI. Home-based/Self-managed alone also results in the least proportional patient benefit following CR across all measures of physical fitness and depression, and has a greater proportion of smokers who are still smoking at the end of CR.

The Group-based and Hybrid (a mixture of Group- and Home-based) modes have comparable patient characteristics at the start of CR and both are associated with a higher level of patient benefit across the range of measured outcomes.

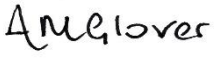
A notable positive finding across the data is a significant increase in the percentage of physical fitness assessments being recorded pre- and post-CR enabling evaluation of fitness outcomes in relation to mode of delivery.

A key achievement during this reporting period has been a further improvement in service quality as shown in the NCP_CR report. This year, 59.1% of CR programmes achieved Green certified status, representing a 6% increase compared with the previous year. The number of programmes classified as Fail status reduced from four to one.

NACR would like to thank all CR teams for their continued commitment to submitting audit data, responding to workforce surveys and supporting national quality improvement. Through collaboration with NHS England, the BACPR, the British Heart Foundation (BHF), the Cardiovascular Care Partnership UK (CCP UK), the All Wales Cardiac Rehabilitation Group and colleagues across the UK, NACR will continue to support services in improving access, quality and outcomes for patients with cardiovascular disease.



Professor Patrick Doherty, Clinical Lead -
National Audit of Cardiac Rehabilitation



Maria Glover, President -
British Association for Cardiovascular Prevention and Rehabilitation



Diane Saunders, Head of CVD-R Programme
Prevention & Long-Term Conditions -
NHS England



Roland Malkin, President -
Cardiovascular Care Partnership UK



Kasia Pisarska, Senior Programme Manager –
Cardiac and Stroke, Medical Directorate -
NHS England

Contents

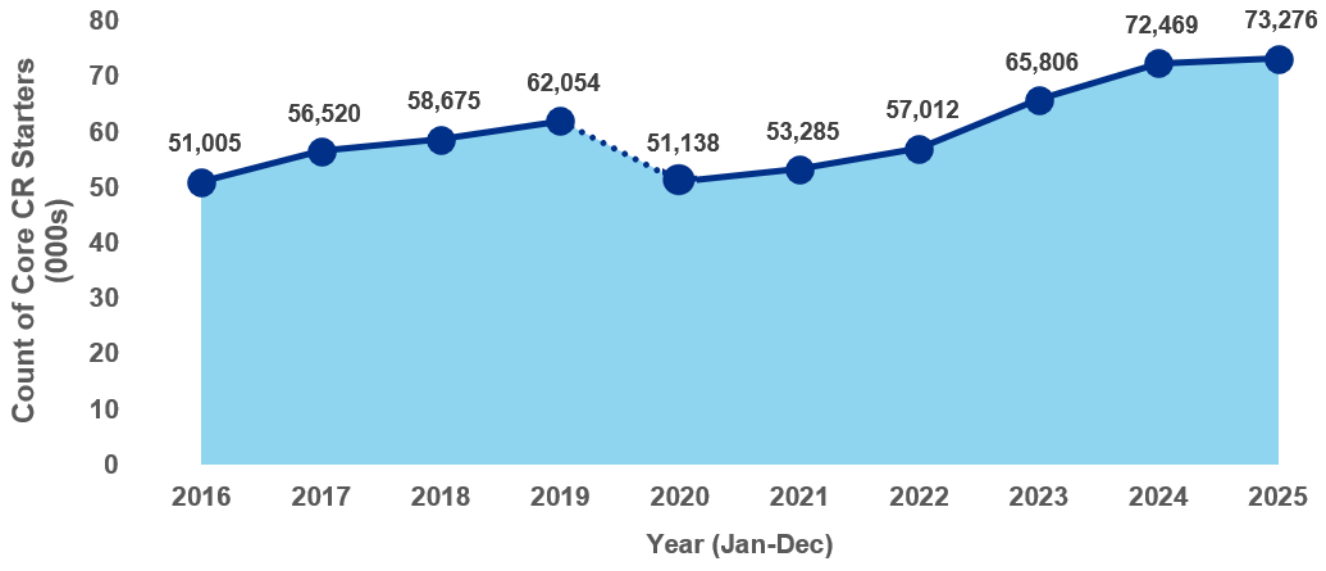
Executive Summary 2
SECTION 1 - Uptake to Cardiac Rehabilitation by Country 5
SECTION 2 - Staffing 7
Staff Composition 7
Staff Loss 8
Staff Recruitment in 2025 11
Staff Prescribers 12
Patient Groups Actively Prescribed to 14
Where are Patients Medically Managed External to CR Programmes 14
SECTION 3 - Summary of NACR Quarterly Reports 16
Quarterly Reports in 2025 16
Diagnosis/Treatment 16
Mode of Delivery 17
Completion 19
Wait Times 20
SECTION 4 - Patient Outcomes in Relation to Cardiac Rehabilitation Mode of Delivery 22
Cardiovascular Risk Factor Outcomes 22
Psychosocial Wellbeing Outcomes 24
Physical Fitness Outcomes 25
Physical Fitness Assessment Over the Last Five Years 27
SECTION 5 - National Certification Programme for Cardiac Rehabilitation (NCP_CR) 29
NCP_CR Summary 29
SECTION 6 - Recommendations and Actions 31
Acknowledgements 32
List of Tables and Figures 33
Tables 33
Figures 33
List of Supplements 35
NACR Methodology Document 35
References 36

SECTION 1 - Uptake to Cardiac Rehabilitation by Country

Although the number of patients accessing cardiac rehabilitation has increased significantly over the last five years, this has been accompanied by an increase in the number of eligible patients, resulting in only a modest change in uptake which currently stands at around 47% across the nations for acute coronary syndrome.

The positive trend in the number of patients starting Core* cardiac rehabilitation (CR) prior to the COVID pandemic (2019) dropped from 62,054 to 51,138 in 2020 (Figure 1). This was due primarily to services temporarily shutting during lock down and redeployment of CR staff to acute front-line services. In the 2026 reporting period (January-December 2025 data) we see that 73,276 patients started CR, indicating that services have now overtaken the pre-Covid peak patient numbers for the last three years. This trend has been developing since 2021 with the total number of patients starting CR increasing year-on-year. Although this represents a substantial recovery of service provision since COVID, the percentage of eligible patients receiving CR is, on average, still less than half. The year-on-year increase in the uptake metric remains small, at around 2%. Improvement is made more challenging by a rise in cardiovascular disease (CVD) admissions over the last five years. Data from the British Heart Foundation (BHF) in 2026 highlights the scale of CVD prevention by showing that around 8 million people are now living with CVD in the UK and this trend remains on the increase (BHF 2026). As this cohort have an increased likelihood of becoming eligible for CR, with admission of acute coronary syndrome (ACS) or heart failure (HF) for example, it showcases the potential increase in demand for CR services in the future. In order to achieve equitable access for the large number of eligible patients missing out on CR and to keep pace with the increasing incidence of CVD, service providers will need to continue to adapt and innovate.

Figure 1. The number of all patients starting CR, as entered into NACR, over 10 years



* Core refers to core or phase 3 throughout the document

England

This year patients with both ACS and HF have shown an increase in overall numbers starting Core CR as well as an increase in the percentage uptake. The ACS patient group saw an increase of 199 patients and HF an extra 700. The uptake rate increased by 1.4% (from 44.5% to 45.9%) and 2.8% (from 16.4% to 19.2%) for ACS and HF respectively, compared to last year's report.

The uptake metric for England is reported annually within this report but can also be accessed in more detail, for CR teams and commissioners, at Integrated Care Board (ICB), Network and Regional levels on the Model Health System dashboard.

Northern Ireland

NACR are unable to report Northern Ireland uptake this year due to a delay in receiving the eligible cohort from Health and Social Care Northern Ireland. Uptake data will be shared for Northern Ireland as soon as it is available.

Wales

The number of patients starting CR has increased this year, however, uptake percentage in Wales has decreased. This change is due to a higher number of eligible patients which informs the denominator of the uptake metric. Compared to last year, services across Wales saw an extra 133 ACS patients and 44 HF patients. What this data shows is that despite higher levels of activity in Wales, service provision still needs to increase in volume to maintain the proportion seen in the 2024 data period and meet the demand of a greater number of eligible patients.

Table 1. CR uptake split by country and main diagnosis/treatment group

Country	Diagnosis/Treatment Type	Eligible Number	Number Starting CR	Uptake %
England* / **	ACS (MI w/o Revascularisation)	64,581	29,673	45.9
	HF	54,077	10,368	19.2
Northern Ireland	ACS (MI w/o Revascularisation)	Not reported		
	HF			
Wales	ACS (MI w/o Revascularisation)	4,955	3,313	66.9
	HF	3,841	1,009	26.3

*Due to method of processing, a small number of outliers in both denominator and numerator have been removed
CR – cardiac rehabilitation, ACS – acute coronary syndrome, MI – myocardial infarction, HF – heart failure, w/o – without

** Due to data accessibility for the final quarter of 2025, the data for uptake for England uses the period of October 2024-September 2025

SECTION 2 - Staffing

Staff Composition

Survey responses show 98% of teams have an MDT with three or more professions, however, workforce variation between nations highlights areas for shared learning to meet patient needs.

There were 200 responses to staffing this year across all CR services (94.3% return rate). The total column in Table 2 shows that four staff types - nurse, exercise practitioner, physiotherapist and secretarial/all - were the most frequently reported across all three nations.

Table 2. Proportion of staff type by programme split by country

Staff Types	Programmes in England (n=181)		Programmes in Northern Ireland (n=5)		Programmes in Wales (n=12)		Total**** (n=200)	
	Count	%	Count	%	Count	%	Count	%
Advanced Clinical Practitioner	10	5.5	0	0	3	25.0	13	6.5
Assistant Practitioner	12	6.6	0	0	2	16.7	14	7.0
Counsellor	12	6.6	0	0	1	8.3	13	6.5
Dietitian	70	38.7	3	60.0	4	33.3	77	38.5
Doctor*	61	33.7	2	40.0	2	16.7	66	33.0
Any Exercise Staff	137	75.7	0	0	8	66.7	146	73.0
Health Care Assistant	32	17.7	3	60	2	16.7	38	19.0
Nurse	180	99.4	5	100.0	12	100	199	99.5
Nursing Associate (under Band 4)	5	2.8	0	0	0	0	5	2.5
Occupational Therapist	27	14.9	2	40.0	8	66.7	38	19.0
Pharmacist	43	23.8	4	80.0	3	25.0	51	25.5
Physiotherapist	104	57.5	5	100.0	8	66.7	119	59.5
Physiotherapy Assistant	40	22.1	1	20.0	3	25.0	46	23.0
Psychologist	48	26.5	1	20.0	2	16.7	52	26.0
Secretarial All**	144	79.6	4	80.0	12	100	160	80.0
Social Prescriber	4	2.2	0	0	0	0	4	2.0
Other***	20	11.0	1	20.0	0	0	21	10.5
Patient Volunteer	34	18.8	0	0	0	0	35	17.5
MDT	177	97.8	5	100	12	100	196	98.0

*Includes Registrar/Consultant, ** Includes Admin and Admin Manager, *** Includes Volunteer and CR Assistant, **** Total includes programmes from Channel Islands

England

Programmes in England show the widest mix of professional roles across all 18 staffing categories, including nursing associates, patient volunteers and social prescribers. None of these were reported in Northern Ireland or Wales. The presence of social prescribers (2.2%) and patient volunteers (18.8%) exclusively within England suggests a growing focus on supporting the wider needs of patients beyond their cardiac condition. The inclusion of social prescribers may help to address social, practical and wellbeing issues, while patient volunteers provide peer support and lived experience that may improve engagement with CR services.

Northern Ireland

Northern Ireland has moved to reporting fully at Health and Social Care Trust (HSCT) level, with their responses now representing five HSCT programmes, as opposed to seven programmes last year. Northern Ireland reported 11 staff types with a particularly high representation of physiotherapists (100%), pharmacists (80%), healthcare assistants (60%), dietitians (60%) and doctors (40%), indicating a workforce model built around a smaller number of professional types within their multi-disciplinary services.

Wales

Wales reported a diverse workforce comprising 14 different staff types, with occupational therapists and staff in exercise-related roles particularly well represented (66.7% each), alongside advanced clinical practitioners (ACP) (25%) and assistant practitioners (16.7%). Occupational therapy was notably more prominent in Wales, reported by two-thirds of programmes compared with 14.9% in England. These findings demonstrate the variation in workforce composition and skill mix across CR teams.

Multi-disciplinary team

Overall, 98% of services reported an MDT (three or more staff types) in this year's survey, which is 2% higher than last year and shows more services are meeting the staffing Key Performance Indicator (KPI) of the National Certification Programme of Cardiac Rehabilitation (NCP_CR). However, there remains a small group of services not meeting the MDT staff requirement for comprehensive CR. The NACR staffing supplement gives further detail on MDT at a programme level.

The wider composition of a CR team varies considerably reflecting differences in local staffing resources and potentially the tailoring of staff provision around the complexity and need of the specific patient cohort accessing the service. This approach follows the guidelines and competencies outlined in the BACPR Standards and Core Components (2023) and aligns with the NHS Cardiovascular Disease Modern Service Framework (2026).

Staff Loss

Permanent staff loss

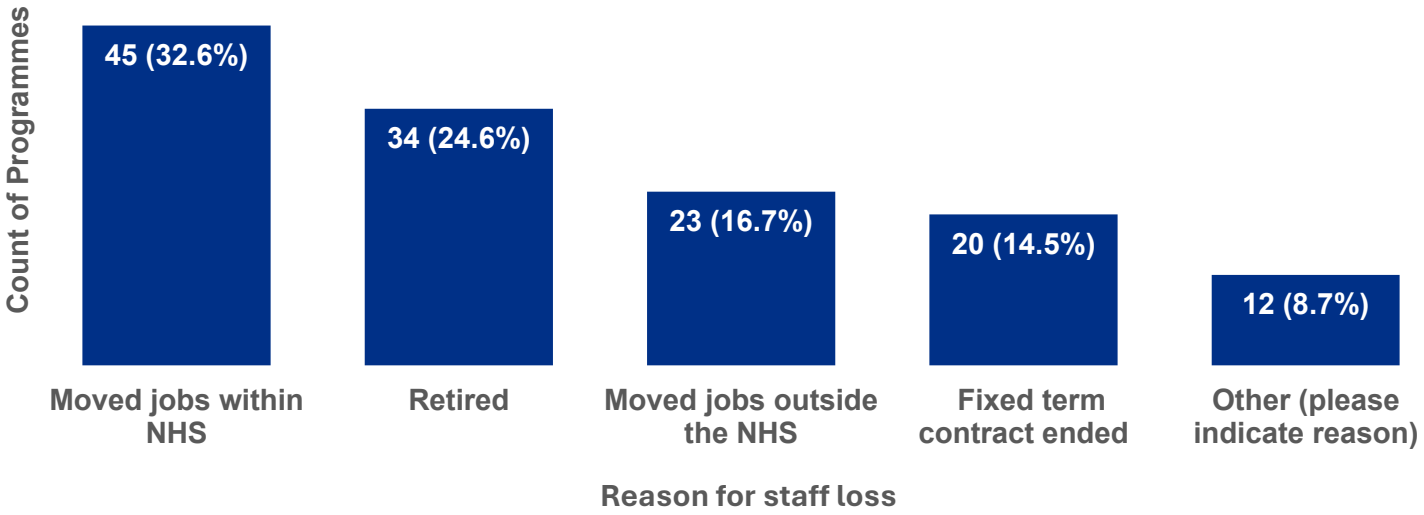
Retention measures are required to avoid the impact of rising retirement rates, career changes and the end of fixed-term funding.

Figure 2 shows the extent of services reporting permanent staff loss and the reasons why they left their posts. This year shows nine fewer services reporting permanent staff loss, with a decrease to 46.5% from 50.2% last year.

The proportion reporting staff moving to another job within the NHS remains the most common reason for workforce loss with comparable levels to last year: 31.7% to 32.6% this year. This is followed by retirement (24.6%), increasing by 9.5% points from last year; staff moving to jobs outside the NHS (16.7%); and end of a fixed-term contract (14.5%) which has doubled. Other reasons for staff leaving were reported by 8.7% of programmes (n=12) and include studying, travel

and career breaks. These findings highlight the range of workforce challenges facing CR teams in retaining staff especially when recruitment and replacement may take time.

Figure 2. In 2025, have any of your staff permanently left the CR team?' (n=200)



Note – Programmes may report more than one reason for staff loss, so totals may exceed the number of programmes who responded to the survey

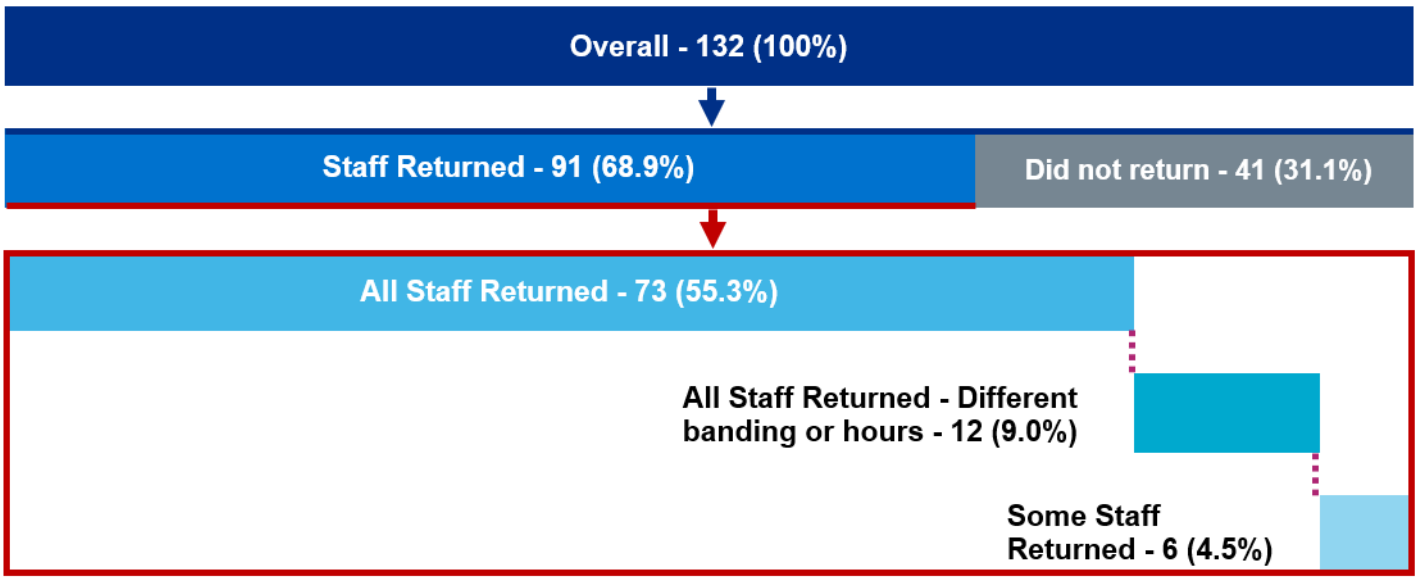
Replacement following permanent staff loss

Despite many services replacing permanent staff lost almost half of services had a decrease in staff resource.

Services who reported permanent staff departure, were asked if the position was fully replaced, replaced at different band/hours, partially replaced or not replaced. This information was collected at an individual staff type level.

Figure 3 shows that across all staff types, of the 91 services that report permanent staff loss, 68.9% were replaced. However, while 73 programmes replaced staff fully, 12 services reported different band and/or hours, and six programmes reported some replacements. Overall, 59 services were unable to fully restore staffing levels following staff departures.

Figure 3. Of your staff that permanently left the CR team how many were replaced? (n=132)



Nurses accounted for the most reported staff losses, with around three-quarters of posts being replaced. Replacement was generally successful for nursing, administrative and exercise physiology roles, but was less consistent for specialist clinical posts such as psychology, medical and dietetic roles. This suggests services have largely replaced core team roles, but recruitment challenges remain for some specialist disciplines.

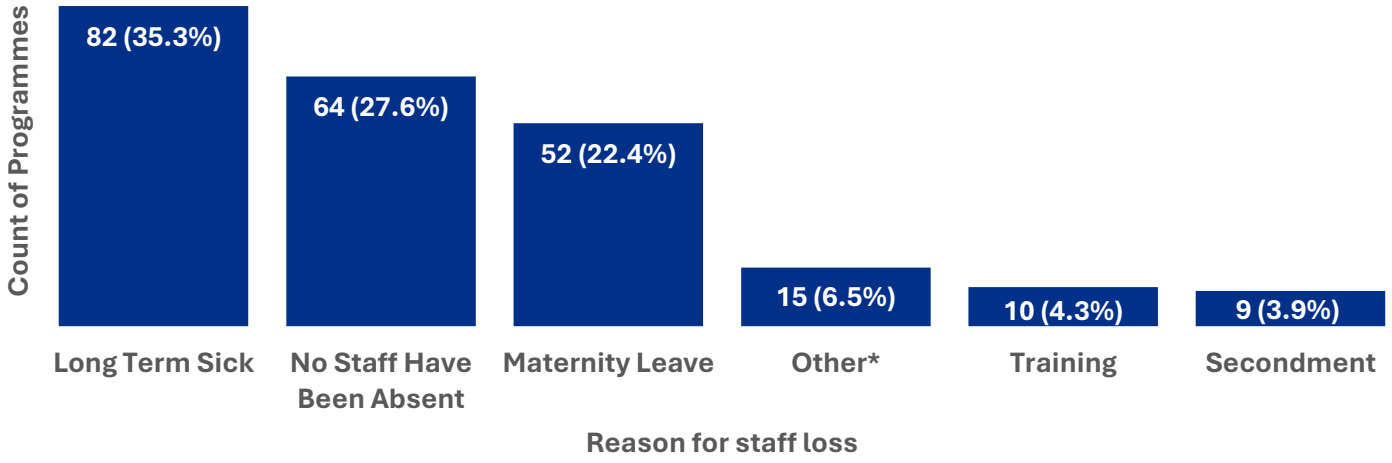
Temporary staff loss

Two thirds of services reported staff temporarily leaving the team with over 40% not fully returning.

Temporary staff absence was a substantial workforce issue during 2025. Of the 189 services responding, there was 125 (66.1%) that reported at least one temporary absence. Within Figure 4, reported reasons for temporary staff loss are presented, due to services being able select more than one reason services may be represented in more than one bar. Long-term sickness was the most common reason, reported by 82 services, followed by maternity leave in 52 services. Smaller numbers reported absence associated with training, secondment or other reasons.

At the time of the survey, 67.1% of the 82 services reporting long-term sickness indicated that staff had returned (Table 3). Return levels were lower for maternity leave and secondment (40.4% and 33.3% respectively). These findings suggest that temporary absence continues to be a workforce pressure for many services, particularly where maternity leave, secondment or ongoing long-term sickness is the reason for absence.

Figure 4. In 2025, have any of your staff temporarily left the CR team?' (n=189)



* Other included family and compassionate leave, long-term leave, training and development and workforce and organisational factors

Table 3. Of all services reporting temporary staff departure, how many returned (n=125)

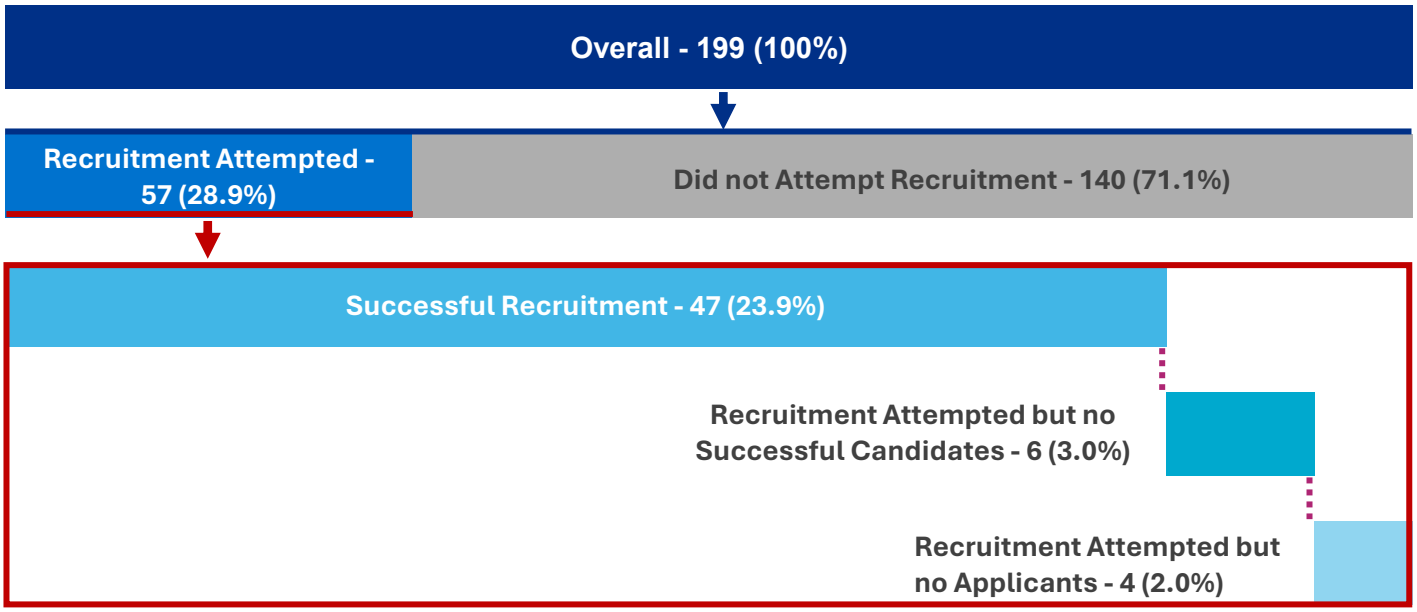
Absence Type	Fully Returned	Did not Return	Partial Return	Total
Long-term sickness	55 (67.1%)	25 (30.5%)	2 (2.4%)	82
Maternity leave	21 (40.4%)	29 (55.8%)	2 (3.8%)	52
Secondment	3 (33.3%)	6 (66.7%)	0	9
Training	8 (80.0%)	2 (20.0%)	0	10
Other absence	10 (66.7%)	4 (26.7%)	1 (6.7%)	15

Staff Recruitment in 2025

During the reporting period, services continued to face significant pressures in delivering high-quality CR, while responding to increasing patient numbers and meeting the complex needs of patients with multiple long-term health conditions.

Figure 5 shows that in the 2025 period, 57 services (28.9%) reported attempting to recruit additional staff to their workforce. Of these, 47 were successful. As some services recruited to more than one position, there were 74 new staff in total appointed to services in the year. However, there were also signs that recruitment remained challenging, with 10 services reporting no successful appointments. Due to some services attempting to recruit to more than one post, this equated to a total of 18 individual positions advertised but not appointed to.

Figure 5. Did you try to recruit to new positions within the team and was the recruitment successful? (n=199)



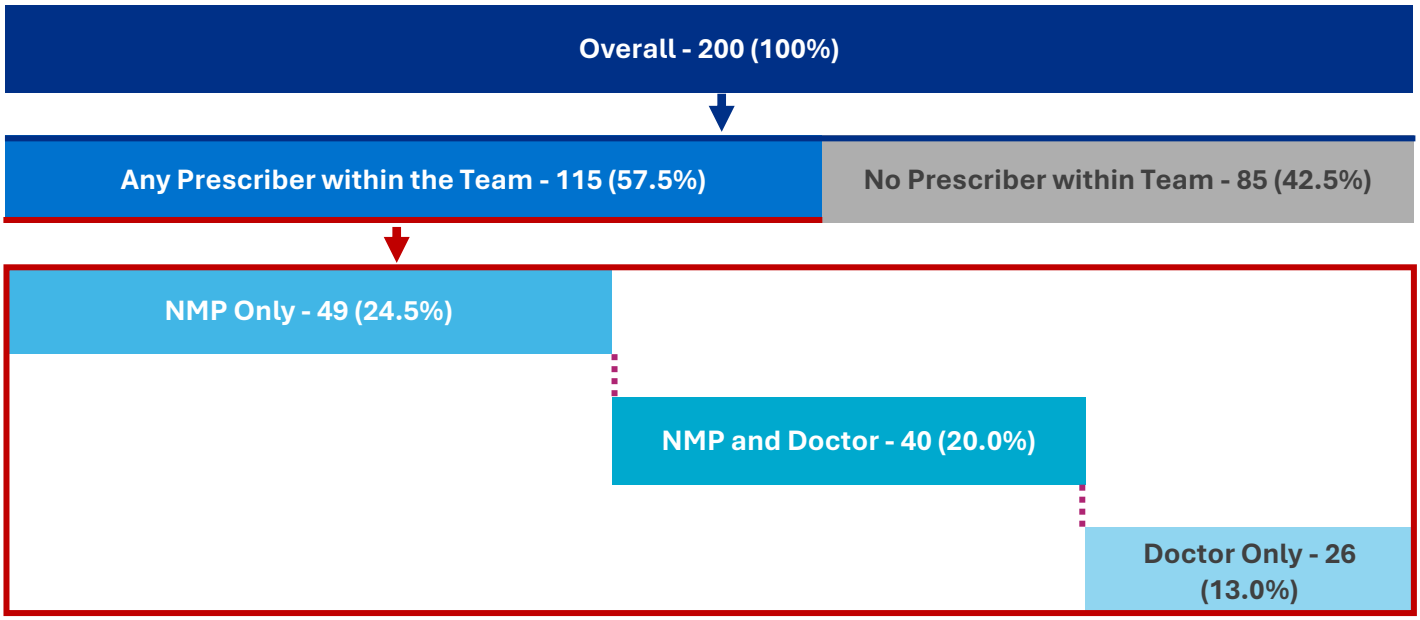
Staff Prescribers

The majority of services have prescribers within the team; however, a large proportion still rely on external prescription, adding pressure to primary care and pharmacies.

Medication optimisation is an important element of patient-centred care within Core CR, as outlined in the BACPR Standards and Core Components (2023). For the last two years, NACR has reported on Non-Medical Prescribers (NMPs) within services to show how CR teams are meeting this requirement.

The findings from the staffing survey show (Figure 6) that in 2025, 57.5% of services had NMPs or doctors within the CR team, which is similar to the results from last year (59%). The breakdown of services with prescribers was: 49 with only NMPs in the team (24.5%), 40 with NMPs alongside doctors (20%) and 26 with doctors only (13%).

Figure 6. Were there prescribers within the team and how many of the staff were NMPs or doctors? (n=200)



The survey also asked which specific staff types were prescribing within the team and to what extent they prescribe either CVD medications or other medications. Table 3a shows that the majority of prescribers were nurses, across 39.2% of all services with nurses. The next largest by staff number were pharmacists (17) with 33.3% NMPs. This was followed by ACPs (11), with 84.6% NMPs. Other staff types were physiotherapists and psychologists from six and two services respectively.

Table 3a. Staff types of prescribers within the team (n=89)

	Total Staff as NMPs	% of Total Staff Type
Nurse	78	39.2
Pharmacist	17	33.3
Advanced Clinical Practitioner	11	84.6
Physiotherapist	6	5.0
Psychologist	2	3.8

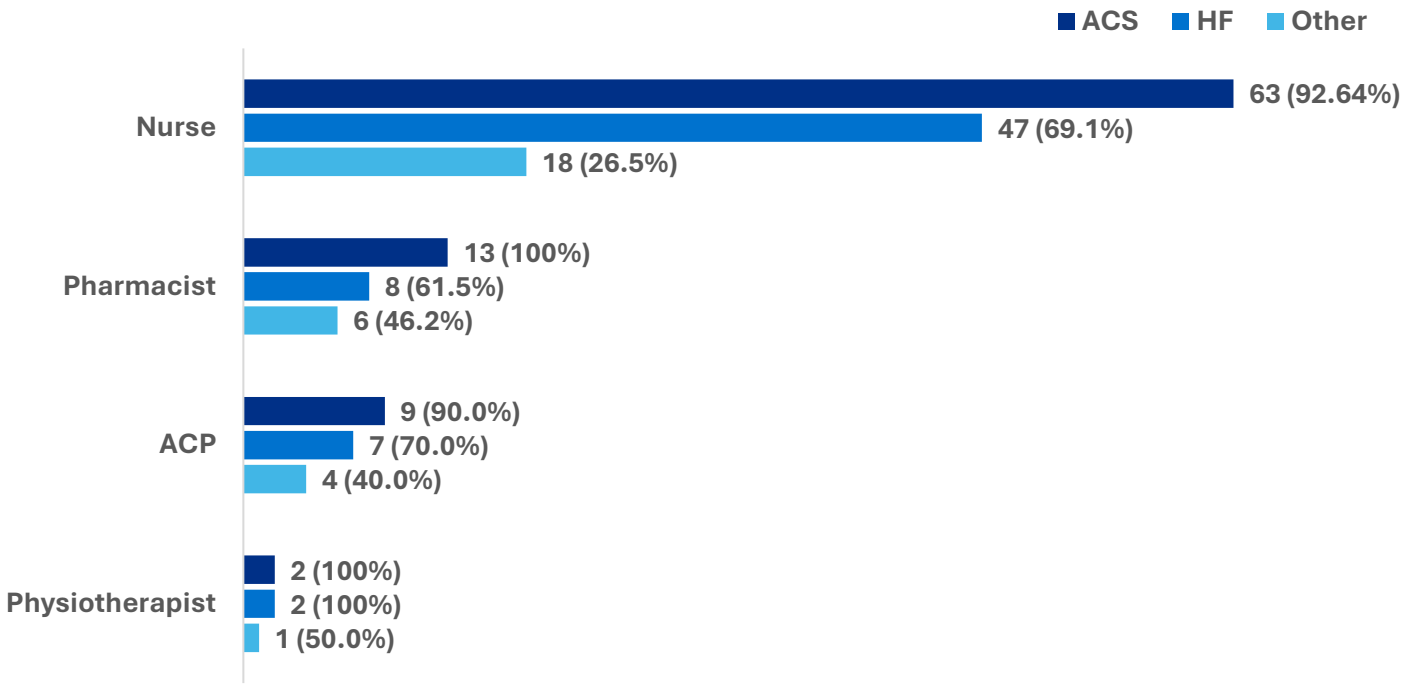
When prescribing status was examined by staff type, most NMPs were prescribing CVD medications with or without additional medications (Table 3b). Only a small proportion were not actively prescribing, and where this was the case, there was usually another staff band or type providing this. Consequently, only six of the 49 services with NMPs alone having no active prescriber.

Table 3b. Are the staff actively prescribing (n=89)				
	CVD Medications Only	CVD and Other Medications	Other Medications Only	No/None
Nurse	57 (73.1%)	9 (11.5%)	0 (0%)	12 (15.4%)
Pharmacist	11 (64.7%)	2 (11.8%)	0 (0%)	4 (23.5%)
Advanced Clinical Practitioner	9 (81.8%)	1 (9.1%)	0 (0%)	1 (9.1%)
Physiotherapist	2 (33.3%)	0 (0%)	1 (16.7%)	3 (50.0%)
Psychologist	0 (0%)	0 (0%)	0 (0%)	2 (100%)

Patient Groups Actively Prescribed to

The survey asked which patient groups each NMP prescribe to (Figure 7). Responses showed consistently high levels of prescribing for patients with ACS (90.0-100%), however there was greater variation in patients with HF (61.5%-100%). Nurses accounted for the largest number of responses, with most prescribing across both ACS and HF patients. ACPs, physiotherapists and pharmacists also primarily prescribed to ACS and HF patients, although several services reported extending this to patients with arrhythmia, valve disease, peripheral arterial disease (PAD), congenital heart disease and those undergoing other types of cardiac surgery. These specialist groups were relatively uncommon compared with ACS and HF, suggesting that secondary prevention remains mainly focused on the latter.

Figure 7. Which patient groups did staff prescribers actively prescribe to? (n=92)



ACS – Acute coronary syndrome, HF – Heart Failure, ACP – Advanced Clinical Practitioner

Where are Patients Medically Managed External to CR Programmes

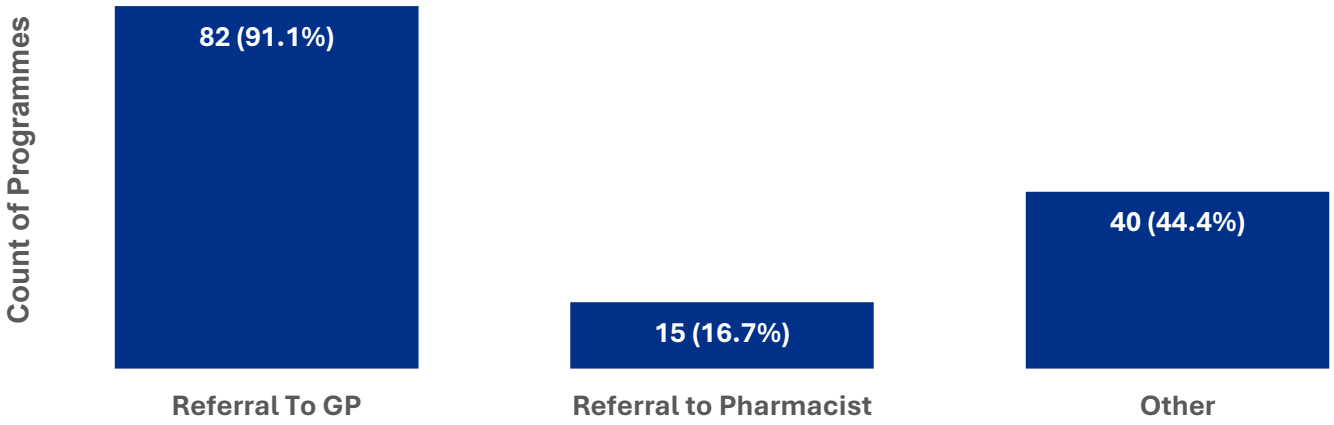
Of the 49 services (24.5%) with an NMP only within the CR team, seven reported that no NMP was actively prescribing. These services, together with 85 services reporting no NMP or doctor

within the team, were asked where patients received prescribing and medication titration to support medication optimisation (total services asked 92).

Figure 8 shows that the majority of patients were referred to primary care/their GP for medication optimisation (91.1%). A small proportion were referred to a pharmacist outside the team (16.7%), but many of these were also alongside a GP referral. Some services indicated that referral to pharmacists was for prescription more general medication such as antibiotics, whereas the GPs prescribed CVD medications.

There was a large number of services reporting Other for medication titration (40 services, 44.4%). Of the free-text responses describing referral pathways, the most common approach was referral to a cardiologist or consultant-led service (n=19). Services also reported referral to HF specialist nurses (n=7) and involvement of primary care for medication titration (n=7). Several programmes described access to advanced nurse practitioners, ACPs or other NMPs (n=6), while a smaller number used MDT review (n=2), a formal shared-care/advisory arrangement with cardiology teams (n=4), or referral to other specialist services such as ACS or cardiac pain clinics (n=2).

Figure 8. If no medical titration or management happens within the service, where are patients referred? (n=90)



Counts are not mutually exclusive as some services described multiple referral routes.
Note – Two of the 92 services supported by NMPs prescribing or had doctors did not respond to this question
Other includes cardiologist involvement (n=19), specialist nurse involvement (n=7),

SECTION 3 - Summary of NACR Quarterly Reports

Quarterly Reports in 2025

The quarterly reports, published throughout the year, each cover a three-month period. This report presents data for the full 12-month period of January-December 2025, providing further insight into the findings to support and inform CR services. This year's quarterly reports focus on specific areas of service provision which are:

- Diagnosis/Treatment
- Mode of Delivery
- Completion
- Wait times

Diagnosis/Treatment

CR provision remains focused on delivering to ACS, revascularisation and HF patients, who together account for 84% of the cohort. Local variation exists in the provision of CR from other eligible groups.

The delivery of CR is informed by the BACPR Standards and Core Components (2023), which identify the patient groups recommended for CR including ACS, revascularisation and HF. The BACPR also recognises that other patient groups may benefit, including atrial fibrillation and PAD. As part of the NCP_CR, NACR reports annually on the proportion of programmes providing CR to the five priority groups (myocardial infarction (MI), MI+ percutaneous coronary intervention (PCI), PCI, coronary artery bypass graft (CABG) and HF).

There is increasing discussion around other patient groups that may or should be receiving CR. This report therefore looks at the number and proportion of patients from different diagnosis and treatment groups receiving CR as part of routine care. It also examines how widely these patient groups are represented across the 177 services included in the 12-month analysis.

In terms of the five priority groups, these represented 84.3% of the entire patient cohort in 2025. Of the remaining 15.7%, they were mainly patients undergoing cardiac surgery (7.3%) and the other four groups presented in Table 4 made up around 2% of the overall patient cohort each.

At service level, the five priority patient groups were represented across the vast majority of CR services, with over 90% seeing patients from each group. Although the additional patient groups accounted for a relatively small proportion of all patients receiving CR, they were included across a substantial proportion of services. More than 90% of services provided CR to patients following cardiac surgery, 87.8% included patients following other treatments, such as a CVD device or transplant, and 77.9% of services included patients with angina without revascularisation.

Provision was less widespread across CR services for patient groups who were undergoing transcatheter aortic valve implantation (TAVI), 65.7% of services, or were included in other diagnosis groups such as arrythmia, cardiac arrest or PAD (44.8%).

In light of growing pressure to accommodate increasing patient numbers, particularly those with ACS and HF, the profile of patients receiving CR may continue to evolve in the next five to ten

years. The 2025/26 findings therefore provide an important baseline against which future changes in the CR population can be compared.

Table 4. Patients attending from diagnosis and treatment groups at a UK level and presence within services

Condition	Count of Patients who Started Core CR with Diagnosis/Treatment	% of all Patients by Diagnosis/Treatment (n=73,276)	% of Programmes that Included Patients with Diagnosis/Treatment (n = 177)
MI with Heart Failure	2,732	3.7	91.3
Heart Failure/Cardiomyopathy	9,446	12.9	98.8
MI and CABG	2,464	3.4	97.7
MI with PPCI/PCI	23,494	32.1	99.4
MI Alone	7,713	10.5	98.8
CABG	5,894	8.0	98.8
PCI	9,994	13.7	98.8
Angina Without Revascularisation	1,494	2.0	77.9
TAVI	1,567	2.1	65.7
Cardiac Surgery (Including Mitral, Aortic and Tricuspid)	5,368	7.3	94.2
Other Treatment (e.g. CVD Device, Transplant, Medical or Other)	1,757	2.4	87.8
Other Event (Including High Risk, Arrhythmia/Cardiac Arrest, PAD)	1,353	1.9	44.8

Mode of Delivery

Despite nationally diverse modes of delivery being utilised at a programme level some services still only provide one mode for all patients.

A menu-based approach to CR mode of delivery is clearly outlined in the BACPR Standards and Core Components (2023). The audit has routinely reported on the number of patients receiving Group-based, Home-based/Self-managed and Hybrid CR since 2020. Prior to 2020, Group-based CR was the dominant mode of delivery, accounting for 80% with Home-based/Self-managed and Hybrid making up the other 20%. Since 2020, there has been a marked shift with Home-based/Self-managed and Hybrid becoming more integrated in standard delivery. By 2024, delivery was more evenly distributed with each of the three modes accounting for around one third.

Reporting of mode of delivery at a patient level is high in 2025, with 84.4% who commenced CR having mode recorded. However, this still means that over 10,000 patients do not have this information recorded. This year, of the patients with known mode of delivery, the percentage was higher within Group-based CR than Home-based/Self-managed and Hybrid. However, the split was still relatively even (26.5-39.2%).

There were 2.2% of patients recorded as receiving Patient-led (reduced staff support) CR in isolation of any other modes which, although not a mode supported by robust evidence, is reported by NACR to indicate the variation in types of delivery and offer across CR programmes.

Digital rehabilitation, which includes App- and Web-based delivery, was incorporated within both Home-based/Self-managed and Hybrid provision. This accounted for 7.5% of the total provision among patients with a recorded mode of delivery, representing a small increase of 6% reported in the quarterly report. As digital offers become more widely adopted, this aspect of CR provision will be monitored during 2026/27. Next year's annual report will provide greater detail on digital delivery, supported by data collected through the recently updated mode of delivery list.

In July 2026, the NACR mode of delivery list was updated to include three aspects of digital delivery. First, all seven NICE EVA recommended technologies were included as named options. Second, the BHF Cardiac Rehab at Home online programme was added as a specific delivery option after last year's Quality and Outcomes report found that 60% of services responding to the survey used it as part of their CR provision. Lastly, the updated list recognises the growing use of wearable technology as part of the provision of healthcare, with its ability to track risk factors such as physical activity, heart rate and blood pressure, as well as estimate metabolic equivalents of task (METs) during periods of exercise. To help monitor the use of this technology within CR more effectively, two options were added: wearables provided by the team and wearables already owned by the patient.

As data on these new modes of delivery are collected, NACR will incorporate them into reporting. This will allow the audit to track usage trends across patient, service and regional areas and explore if adherence to CR and outcomes are different when they are part of the intervention.

Table 5 also shows the rate of services utilising multi-mode delivery (both Group-based and Home-based/Self-managed or Hybrid), a single mode (only Group-based or Home-based/Self-managed) or no mode recorded. The data shows that 90.7% of services are adhering to the menu-based approach with a multi-mode delivery, however, 6.2% were only using Group-based or Home-based/Self-managed and 3.1% of services had no mode of delivery recorded for any patient.

Table 5. Mode of delivery at the patient and CR programme level		
	Count	**%**
Total Patients Starting	73,276	
Patients with Mode Recorded	61,571	84.0
Patients with no Mode Recorded	11,705	16.0
Patients Receiving Group-based	24,136	39.2
Patients Receiving Home-based/Self-managed	19,773	32.11
Patients Receiving Hybrid*	16,307	26.5
Patients Receiving Other – Patient Led Reduced Staff Support	1,355	2.2
Patients Receiving Any Digital	4,612	7.5
Services Utilising Multi**/Hybrid Mode	176	90.7
Services Utilising Single Mode	12	6.2
Services with No Mode Recorded	6	3.1

*Hybrid is the use, at the patient level, of Group-based and Home-based/Self-managed together. ** Multi-mode is the use of, at a programme level, both Group-based and Home-based delivered in isolation of each other for different patients.

Completion

Assessment rates for patients completing CR have increased, but one in ten still do not have both assessments 1 and 2 recorded.

Assessment 1 (pre-CR) informs the setting of goals and targets and assessment 2 (post-CR) is used to evaluate progress against these goals, and to modify or set new targets to support long-term lifestyle change. NACR and the BACPR published a definition of completion in 2026 outlining the need for patients to have reached their set targets and goals and have had a follow up assessment 2 to be deemed ‘complete’.

For NACR to be able to evaluate provision of routine care, such as the new emerging NICE EVA recommended digital modes of delivery, comprehensive assessments need to be done pre- and post-Core CR, and the data entered onto the audit. The completion quarterly report provides an insight into the number of patients completing CR that had had either a recorded assessment 1 and/or an assessment 2, and who had both assessments. The latter is essential to measure improvement in outcomes following the intervention.

Full 12-month data shows that, of those patients completing CR, 97.1% had an assessment 1 recorded (Table 6). This is encouraging as it shows assessment 1 rates have increased from 87.4% in 2016, helped by the inclusion of assessments as two of the NCP_CR KPIs. However, this report also highlights that 1,564 patients were completing CR without assessment 1. A similar improvement was seen for assessment 2, with percentages increasing from 74.8% (in 2016) to 90.4%. Despite this progress 5,247 patients were completing CR without assessment 2 being submitted to NACR.

The final measure examined the proportion of patients with both assessment 1 and 2, showing that overall, 89.2% of patients completing CR have both assessments recorded. This high

percentage allows for detailed analysis of different modes of delivery and outcomes but also highlights that nearly 6,000 patients are missing from this analysis with 10.8% who do not have both assessments. Furthermore, missing assessments 1 and 2 were more prevalent in some programmes, which may limit the robustness of programme level analysis.

Table 6. Rate of patients completing CR with assessment 1, assessment 2 and both assessment 1 and assessment 2 recorded

	Count	% of Completers
Total Patients Completing CR	54,757	
Patients Completing CR with Assessment 1 Recorded	53,193	97.1
Patients Completing CR with Assessment 2 Recorded	49,510	90.4
Patients Completing CR with both Assessment 1 and 2 Recorded	48,817	89.2

Wait Times

Patient groups have on average less than four weeks wait time from referral to start of Core CR, but wide programme variation means there is a lack of equity.

Wait time from post-discharge referral to the start of Core CR forms two of the seven NCP_CR KPIs, looking at patients with MI and/or PCI and patients with CABG. In the 2026 certification report, wait times remained the least achieved KPI nationally, with performance particularly challenging for patients with MI and/or PCI. To support local quality improvement, the quarterly report looked at wait times across all major patient groups, enabling programmes to benchmark performance and explore variation in pathways and service delivery.

Nationally, the median wait time from post-discharge referral to start of CR was 20 days across all patients. Patients following MI and/or PCI had the shortest median wait time (18 days), followed by patients with HF (21 days) and other diagnosis/treatments (24 days). Patients following CABG experienced the longest wait, with a median wait time of 26 days (Table 7).

Table 7. Wait time by patient groups

	Total Starting Count	Count with Wait time	Median Wait time (days)
All Patients	73,276	65,622	20
Patients with MI and or PCI	41,269	37,053	18
Patients with CABG	5,897	5,276	26
Patients with HF	12,078	10,720	21
All Other Patients	14,032	12,573	24

Reducing wait times remains important because shorter delays to starting CR are associated with improved patient outcomes and higher programme completion rates (Fell et al 2016). Consequently, reductions in wait times have the potential to deliver both patient and service benefits.

Programme-level analysis demonstrated substantial variation in wait times, both between providers and between patient groups. This variation was particularly notable for CABG patients. Traditionally, patients who have undergone CABG have been advised to return for CR six weeks

after surgery (Ngaage et al 2019). However, some programmes reported median post-referral waits of fewer than 10 days. Additional review of these services and their typical patient journey suggests that many are adopting innovative pathway models in which patients commence core components of CR earlier. An initial assessment and tailored intervention which may include education, dietary change, supported self-management or graded walking programmes is being delivered before progressing to other more formal components, such as exercise-based sessions. This approach enables patients to start their programme in a way that remains clinically appropriate for their stage of recovery.

These findings suggest that some programmes are adapting traditional CABG pathways, often using hybrid and flexible modes of delivery, to engage patients sooner. Given the established relationship between earlier CR engagement, completion and outcomes, these models may offer important opportunities to improve patient experience and maximise programme outcomes.

Further work is required to understand how these pathways operate in practice, identify barriers to wider implementation, and determine whether successful approaches can be adopted more consistently across services. NACR will continue to monitor variation in wait times and highlight emerging examples of effective practice throughout 2026/27.

SECTION 4 - Patient Outcomes in Relation to Cardiac Rehabilitation Mode of Delivery

Patient outcomes differ across modes of delivery, with Home-based/Self-managed often having the least proportional patient benefit

In the NACR reports from 2007 through to 2019, the audit routinely reported patient outcomes at an aggregate level pre- and post-CR and during that time, Group-based CR was by far the dominant mode of delivery with around 80% of patients. Home-based/Self-managed represented less than 10% of the patient population and web-based was around 1%. The COVID pandemic changed the status quo, leading to a huge shift in delivery by CR teams. This has resulted in a more proportional redistribution in the mode of delivery in the form of Group-based, Home-based/Self-managed and Hybrid, as shown in the mode of delivery quarterly report section (Table 6). Since 2021 the quality of CR mode of delivery data has steadily improved, alongside increased levels of assessment, enabling the audit to carry out a comprehensive analysis of patient outcomes in relation to mode of CR delivery using routine practice data.

Our analyses focus on three important outcome domains namely:

- Cardiovascular risk factors
- Psychosocial wellbeing
- Physical fitness

Cardiovascular Risk Factor Outcomes

Figures 9 and 10 show the proportion of patients meeting clinical targets pre- and post-CR and the extent of change following CR for CVD risk factors. This data highlights the differences in patient outcomes split by mode of delivery.

Physical activity status

Physical activity status is assessed against the Chief Medical Officer (CMO) guidelines of achieving the recommended 150 minutes minimum physical activity per week target. The blue bars in Figure 9a show physical activity levels at the start of CR and highlight a 12.9% to 14.4% lower level of physical activity status for patients commencing a Home-based/Self-managed programme compared to Group-based and Hybrid programmes.

The grey bars in Figure 9a show the percentage point change in patients meeting the 150-minute target following CR. Similar levels of change for patients on Home-based/Self-managed and Group-based programmes were observed (29.2-29.3%). A greater percentage of patients (34.5%) on Hybrid programmes met the physical activity target.

Smoking status

The blue bars in Figure 9b show the extent to which patients were not smoking or had stopped smoking at the point they started CR. Home-based/Self-managed CR had the lowest proportion at 89.5% meaning that around 10% were smokers. Those not smoking was higher for both Hybrid (94.2%) and Group-based (95.8%).

The change in smoking status following CR was relatively small (at or under 1%) in all three groups, however, the most notable difference is that Home-based/Self-managed patients start with twice as many patients smoking, by proportion, than the other two groups. On completion there is a similar percentage point change across all three groups, however this means nearly 10% of Home-based/Self-managed patients continue to smoke upon completion, twice as many as Group-based and Hybrid.

Body mass index (BMI)

In Figure 9c the blue bars show slight differences in the percentage of patients meeting a BMI of less than 30 at the start of CR, slightly in favour of Hybrid followed by Group-based and then Home-based/Self-managed CR. The change in BMI (grey bars) is small but positive, being between 0.7% to 1.6% across all modes of CR.

Figure 9. Proportion of patients achieving targets for physical activity, smoking status and BMI pre-CR, post-CR and the change

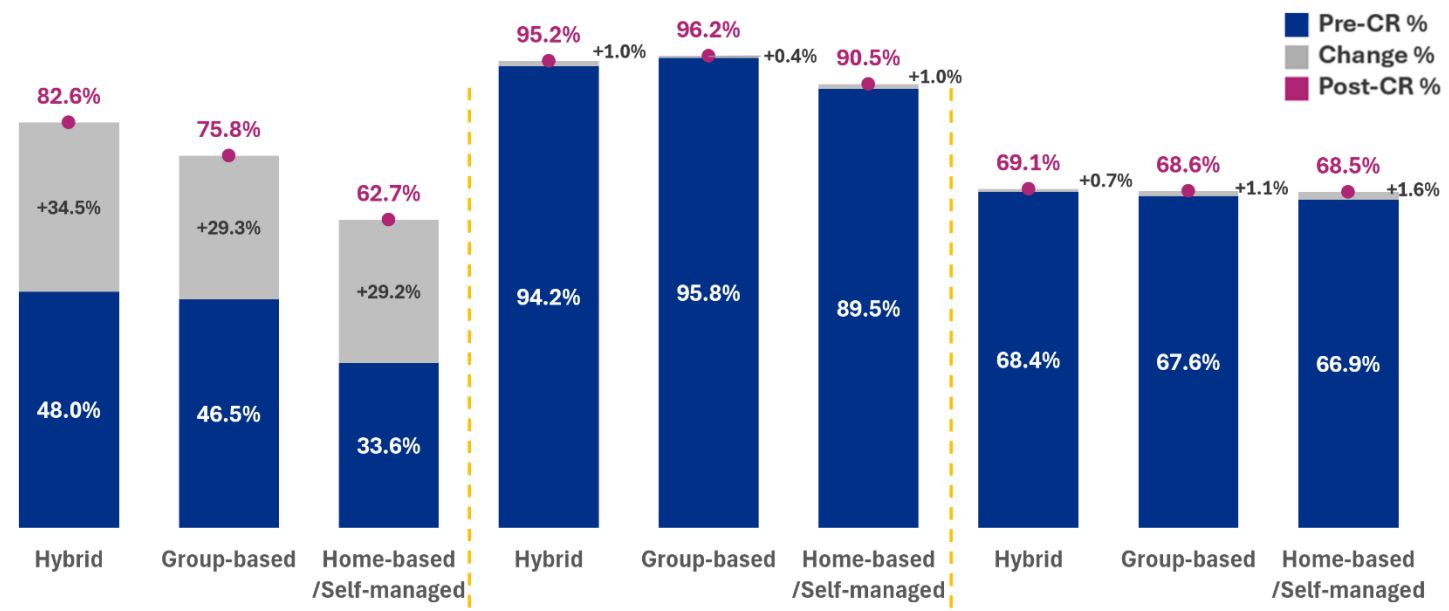


Fig. 9a Physical Activity (150 mins moderate activity per week)

Fig. 9b Smoking Status (Not Smoking/Stopped Smoking)

Fig. 9c BMI <30

Blood pressure

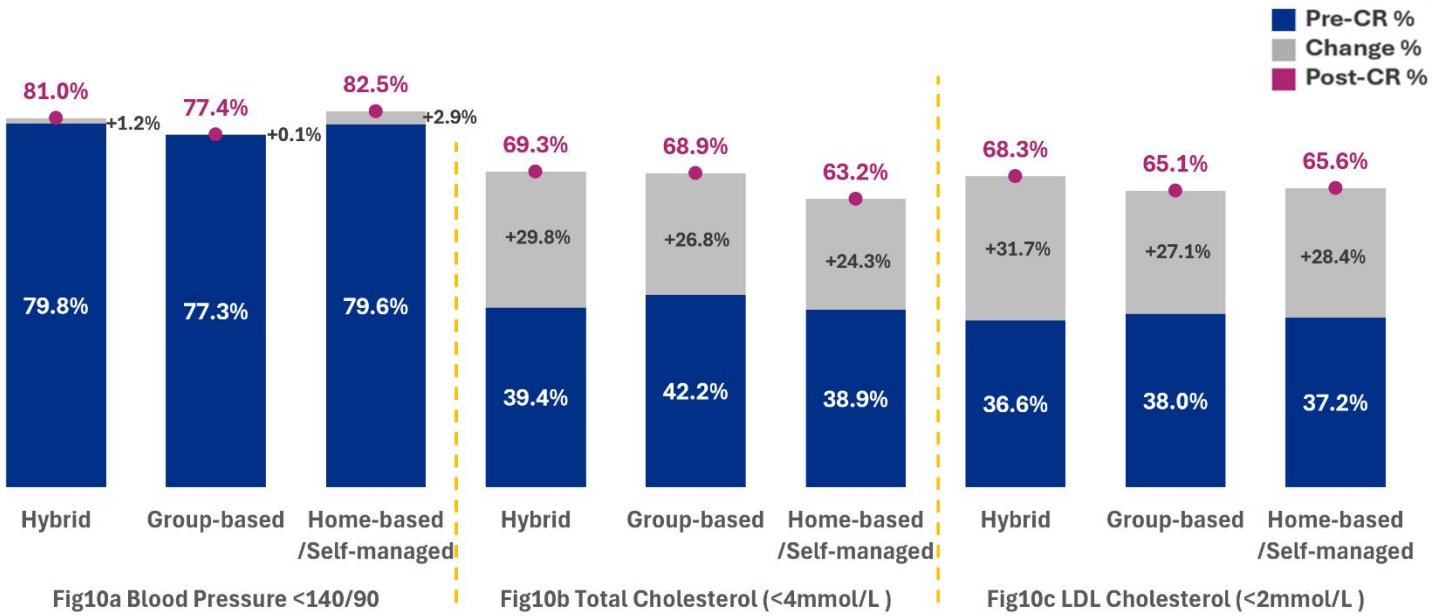
The blue bars in Figure 10a show the percentage of patients meeting the blood pressure target (<140/90) pre-CR with between 79.6-79.8%% of patients on the Home-based/Self-managed and Hybrid programmes followed by Group-based at 77.3%. The grey bars show small improvements in all modes of delivery post-CR with the greatest change observed for Home-based/Self-managed (2.9%) followed by Hybrid 1.2% and then Group-based 0.1%.

Cholesterol

For total cholesterol (Fig 10b), 38.9% of patients on the Home-based/Self-managed programme met the target of <4mmol/L at the start of CR, compared with Hybrid (39.4%) and Group-based (42.2%). Following CR, improvements were observed across all modes of delivery, although the increase was smallest in Home-based/Self-managed (24.3%) followed by Group-based (26.8%) with Hybrid leading the way with almost 30% more patients meeting the total cholesterol target

post-CR. Hybrid CR also demonstrated the greatest percentage benefit in meeting the Low-Density Lipoprotein (LDL) cholesterol target following CR (Figure 10c).

Figure 10. Proportion of patients achieving targets for blood pressure and cholesterol pre-CR, post-CR and the change



Psychosocial Wellbeing Outcomes

The evaluation of psychosocial wellbeing of patients in this section will focus on the Hospital Anxiety and Depression Scale (HADS), which is the most frequent measure reported in the NACR database. Although the use of other measures such as GAD7, PHQ9, and the Minnesota HF questionnaires has increased in recent years, they are yet to meet data threshold requirements for a comprehensive analysis by CR mode of delivery. The Dartmouth COOP questionnaire is less used than HADS and, as a more complex, multi domain outcome measure, will be explored separately in future analyses.

HADS depression

In Figure 11a baseline depression (blue bars) showed that the percentage of patients with scores <= 8 (within normal range) pre-CR exceeded 80% and there was variation of just 1.9% across all three modes of delivery. Of those patients with elevated HADS depression, there was a positive percentage point change post-CR (grey bars) across all three modes with the greatest benefit seen in Hybrid (5.7%) then Group-based (5.6%) and finally Home-based/Self-managed (4.8%).

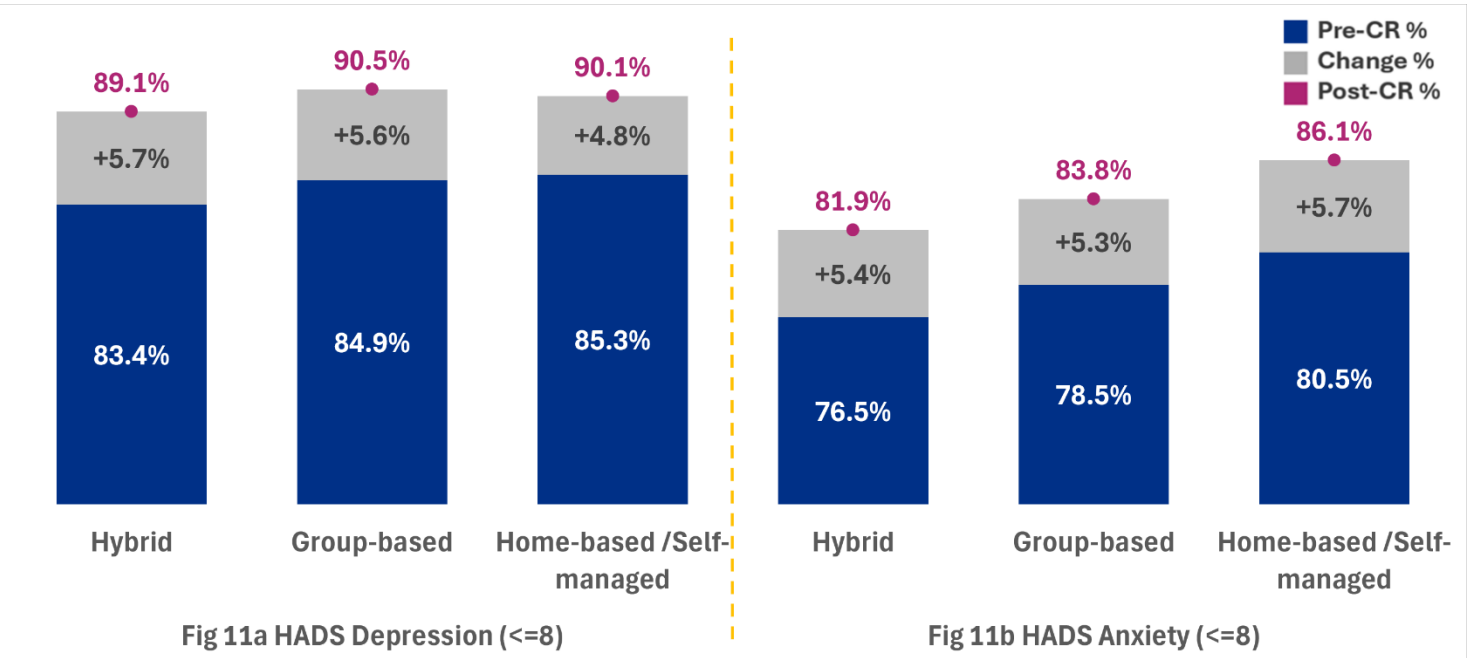
HADS anxiety

The same analysis for patients in the normal range of anxiety (Fig.11b) pre-CR (blue bars) ranged from 76.5% to 80.5% and differed by 4% across all three modes of delivery.

A comparable positive percentage point change in anxiety was observed post-CR (grey bars) across all three modes of delivery. The greatest improvement was seen in Home-based/Self-managed (5.7%), followed by Hybrid (5.4%) and Group-based (5.3%).

In respect of both anxiety and depression more patients starting Home-based/Self-managed CR were in the normal HADS range, compared to the other two modes of CR.

Figure 11: Proportion of patients scoring at or below the stated HADS threshold for anxiety and depression pre-CR, post-CR and the change



Physical Fitness Outcomes

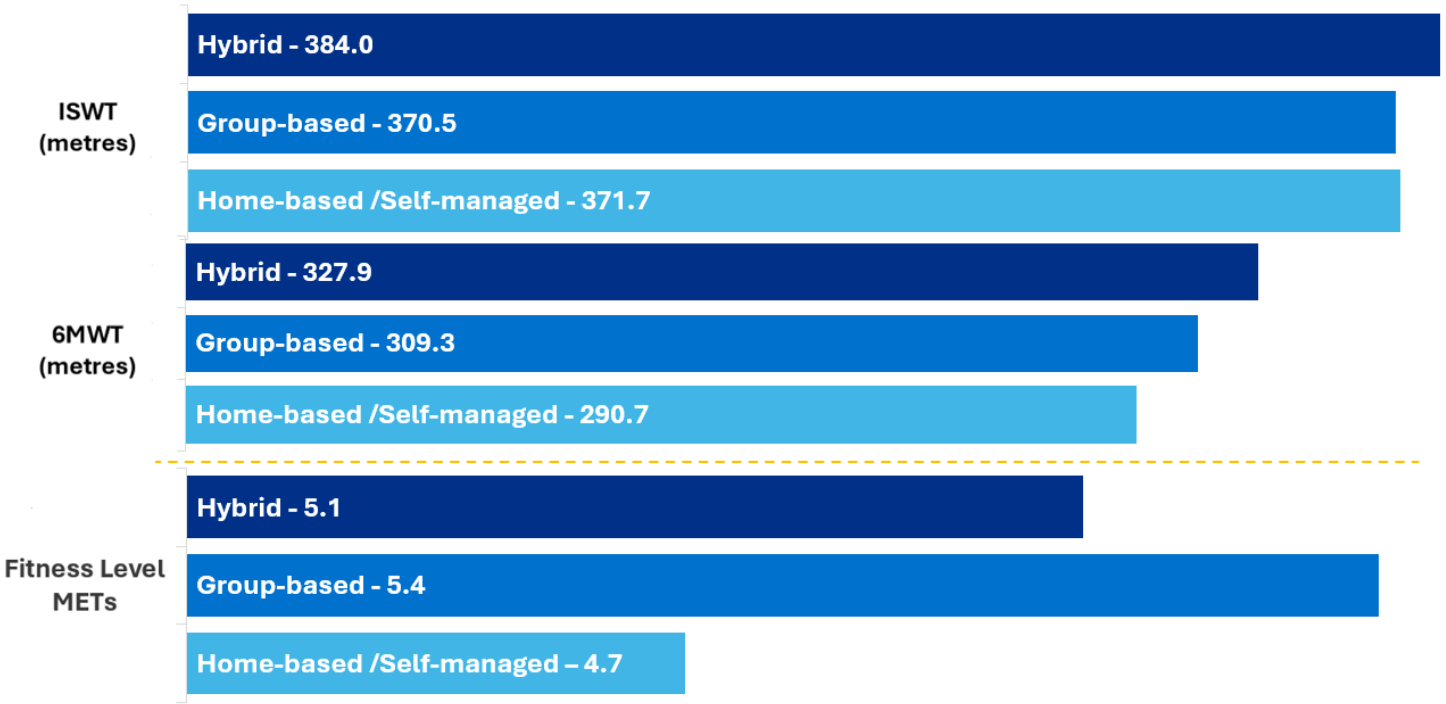
NACR records physical fitness through the use of the six-minute walk test (6MWT), incremental shuttle walk test (ISWT) plus a combination of other tests under the banner of Fitness Level METs (such as step test, static bikes or treadmills) that yield an outcome quantified as metabolic equivalents of task (METs).

Table 8 shows the pre-CR baseline and post-CR physical fitness scores split by mode of delivery across the three measures used by CR teams. ISWT and 6MWT physical fitness scores are expressed in metres walked. Although metres walked is common to both tests they should not be compared like-for-like as the ISWT has 12 incremental stages with the speed increasing each minute whereas the 6MWT uses a patient's natural cadence at a relatively constant walking speed. Fitness Level METs reports the level of fitness achieved using a shared outcome measure of METs.

Table 8: Physical fitness outcomes pre-CR, post-CR and the change split by mode of delivery					
Measure	**Mode of Delivery**	**Count of Patients Recorded Pre- and Post-CR**	**Pre-CR (mean)**	**Post-CR (mean)**	**Change (mean)**
6MWT (metres)	Group-based	3,021	309.3	373.1	63.8
	Hybrid	1,570	327.9	388.4	60.4
	Home-based /Self-managed	500	290.7	329.0	38.4
ISWT (metres)	Group-based	3,527	370.5	465.1	94.6
	Hybrid	3080	384.0	488.2	104.2
	Home-based /Self-managed	516	371.7	457.0	85.2
Fitness Level METs	Group-based	7,190	5.4	6.5	1.0
	Hybrid	5,255	5.1	6.1	1.0
	Home-based /Self-managed	3,162	4.7	5.4	0.7

Figure 12a shows the pre-CR physical fitness for each test split by mode of delivery. This analysis reveals that patients starting Home-based/Self-managed CR tend to be less physically fit than those in the other two modes of delivery, particularly in terms of Fitness Level METs and 6MWT. This is important to note prior to evaluating change in fitness after CR.

Figure 12a: Baseline scores for physical fitness measures split by mode of delivery

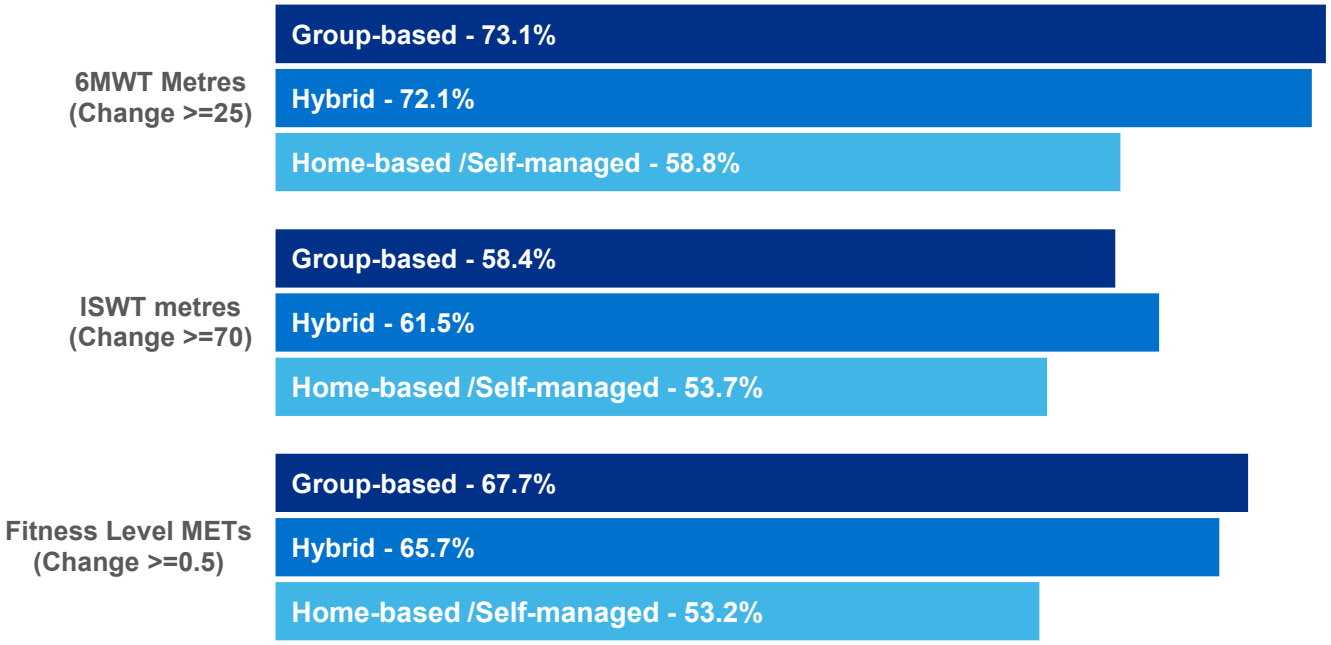


Note – Hashed line inserted to indicate the difference in units. 6MWT and ISWT are presented using metres, whereas Fitness Level is presented via METs

Figure 12b shows the proportion of patients meeting a minimum clinically important difference (MCID) on completion of CR. The MCID is a value of change in a patient's level of fitness that is deemed as meaningful and beneficial to them. Across all three measures, Home-based/Self-managed had the lowest proportion of patients meeting the MCID at 55.2% compared to 66.4% for patients achieving the MCID on Hybrid and Group-based CR.

The extent of variation in change was between 7.8-14.5%. Group-based had higher change for Fitness Level METs and 6MWT, whereas Hybrid was greater for ISWT.

Figure 12b. Proportion of patients meeting MCID for the measures of physical fitness upon completion of CR split by mode

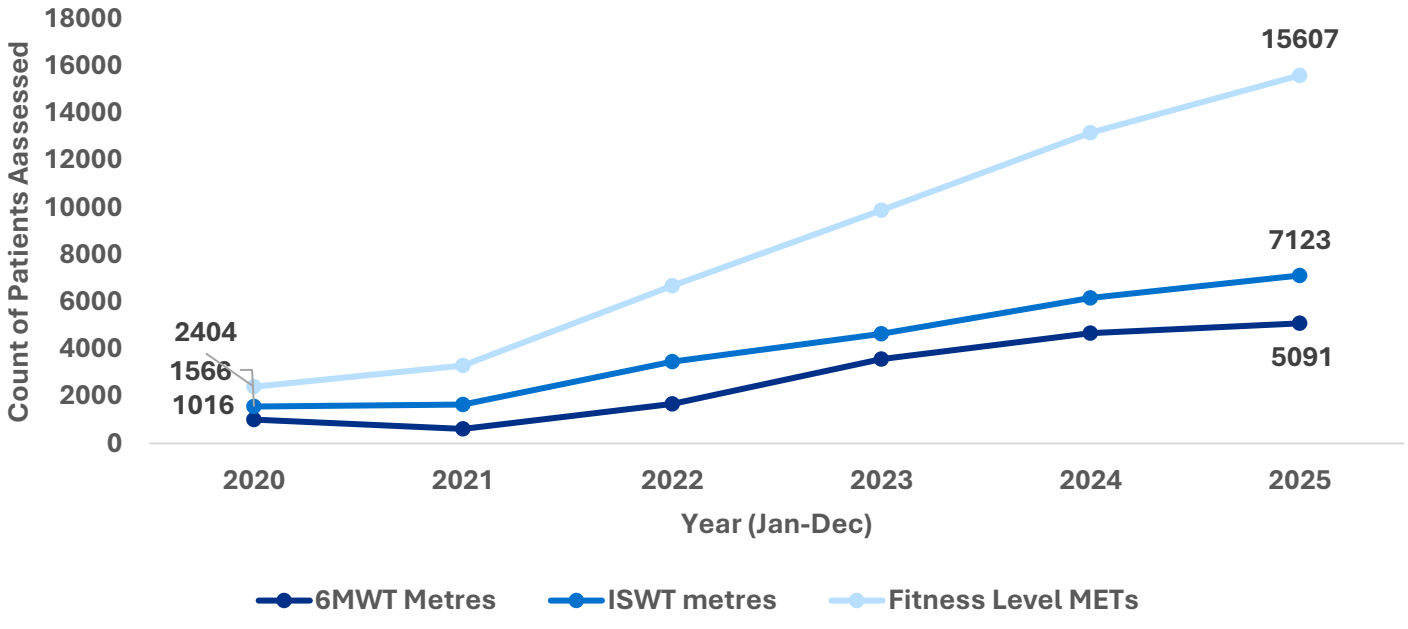


Physical Fitness Assessment Over the Last Five Years

Over the last five years NACR annual and quarterly reports alongside training, information and support from the NACR team, and BACPR conferences and educational courses has placed increasing emphasis on the completion of assessments. The data available for this report has shown a huge improvement in data entry by CR teams, making better analysis of CR outcomes a reality. The NACR team would like to thank the CR teams for their support in improving data quality.

Figure 13 shows a significant increase in the number of physical fitness tests recorded for all three test types and particularly in the Fitness Level METs category. The Fitness Level METs data field on NACR covers a set of tests that coalesce around the use of METs as a unit of measurement. This is either derived through ergometers such as static bikes, treadmills, cross trainers or rowers that have an automatic algorithm that calculates METs or field tests like the Chester Step Test which uses the work done on the test to estimate METs. The exponential rise in the frequency of Fitness Level METs type testing combined with the ISWT and 6MWT enables CR teams to offer a more patient tailored approach to physical fitness assessment. No one test is ever likely to address the complexity of patients attending CR hence an increased menu of available testing options that can be recorded is important.

Figure 13. The count of patients with physical fitness measures recorded pre- and post-CR in the years 2020-2025



SECTION 5 - National Certification Programme for Cardiac Rehabilitation (NCP_CR)

Certification continues to show increasing performance, however, wait times - specifically MI/PCI - remain the largest barrier.

NCP_CR Summary

As published in this year's NCP_CR report, overall performance has improved, with 59.1% of services achieving Green certified status, up 6% from last year, while programmes in Fail status fell from four to one. Thirty-six programmes improved their certification status, including 22 newly Green certified programmes.

More than 70% of programmes maintained their status, with 95 remaining Green certified despite ongoing workforce and resource pressures. However, some services declined, with 14 losing Green certified status and four moving down a category – this is largely due to incomplete audit data, longer waiting times, and low post-CR assessment rates.

Findings at a national level highlight specific challenges. Within England, there continues to be Red and Fail services – while the number is decreasing this remains a concern. Red and Fail status is predominantly due to low or no data and an improved focus on timely and complete submission of data will lead to more KPIs being met. Northern Ireland and Wales contain no Red or Fail (Table 9). Northern Ireland has demonstrated encouraging performance, with all services achieving Amber status, following the recent implementation of a new reporting system which has represented a significant change in data collection and reporting processes. Further work is underway to enhance data quality and analytical functionality and as these developments are embedded, it is anticipated that any anomalies related to data extraction or reporting will be resolved, providing a more accurate reflection of service performance and supporting continued progress towards meeting all KPI requirements.

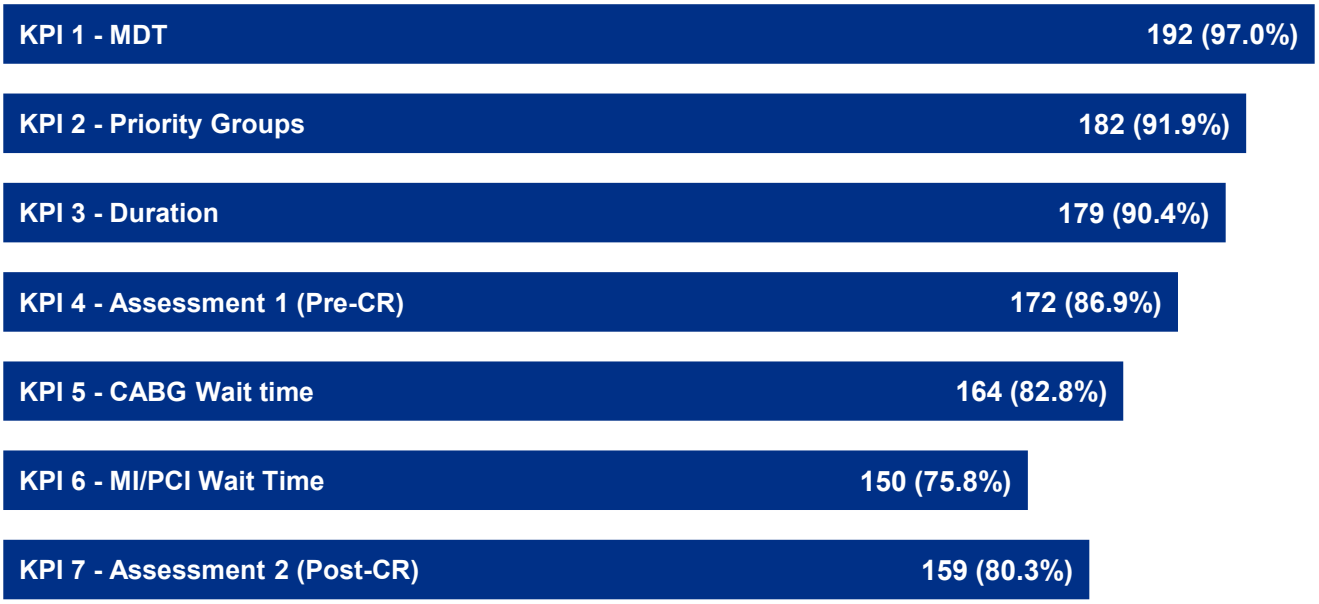
Table 9. NCP_CR certification status for CR programmes across England, Northern Ireland and Wales

	England Total programmes =181	Northern Ireland Total programmes =5	Wales Total programmes =12	UK Total programmes =198
Green certified	108 (59.7%)	0 (0%)	9 (75.0%)	117 (59.1%)
Amber	57 (31.5%) (A=49, Aw7 =8)	5 (100%)	3 (25.0%)	65 (32.8%)
Red	15 (8.3%)	0 (0%)	0 (0%)	15 (7.6%)
Fail	1 (0.6%)	0 (0%)	0 (0%)	1 (0.5%)

Green certified (7 KPIs met), Amber (A) (4 to 6 KPIs met and Amber with 7* (Aw7)), Red (1 to 3 KPIs met) and Fail (0 KPIs met). Due to rounding, percentages may not add up to 100%.
*Amber with 7 is where a programme meets all seven KPIs, but due to incomplete data in the period cannot be Green certified.

Within the NCP_CR report, and as shown in Figure 14, despite the very high number of services meeting MDT, Priority Groups and Duration (97-90.4%), there is still a considerable proportion not meeting the Assessment and Wait times KPIs. Of these the least met was MI/PCI Wait time which was only met by 75.8% of services.

Figure 14. Of the 198 services included in the NCP_CR report, how many were meeting each of the seven KPIs?



This year's NCP_CR report shows a strong positive trend of services meeting Green certified and Amber status. However, the presence of 18 services moving down a status shows that maintaining service quality is not guaranteed. The recommendations for 2026/27 are:

1. Programmes that achieve the minimum standard (Green certified status) should agree a goal to maintain it the following year.

2. Wait time KPIs (Referral to start of Core CR), specifically for MI/PCI patients, are the least met at a UK level - and represent a key area for improvement across all nations.

3. Ensuring that full and complete NACR data submission occurs, throughout the year, encompassing all patients and all months across the entire pathway, notably final discharge and assessment.

Further detail and potential actions for meeting the recommendations can be found in the NCP_CR report.

SECTION 6 - Recommendations and Actions

Based on the data from this year's report the NACR Steering Committee proposes the following recommendations and actions for service provision of CR:

Recommendation 1 - Increase uptake of CR, ensuring provision meets the demand

- Ensure that all eligible patients are consistently identified and managed through inclusive referral processes.
- CR programmes should engage with and support emerging CR modes to increase uptake.

Recommendation 2 - Ensure that staff delivering CR can meet the patient need

- Upskilling staff within the team to meet patient needs, such as Non-Medical Prescribers (NMPs) and the inclusion of psychological components.
- Focus on efforts to retain staff, avoiding loss of skilled staff to the wider NHS or through other departure mechanisms. Where staff are lost, replacing them with the commensurate banding/skill set.

Recommendation 3 - Deliver and record CR in line with the BACPR Standards and Core Components (2023), using NACR data to identify and reduce unwarranted variation in access, delivery and outcomes

- Ensure timely data submission to NACR, focusing on completeness, particularly for mode, assessments and wait times.
- Reduce wait times, prioritising MI/PCI while monitoring CABG, HF and other patient groups for variation.
- Review CR delivery against BACPR Standards and Core Components (2023), using NACR data to identify and address variation.

Recommendation 4 - Optimise patient outcomes across all modes of delivery

- Review the content of programmes to help optimise outcomes.
- Identify strategies to improve outcomes in physical fitness, depression and smoking status, particularly in Home-based /Self-managed CR.
- Ensure that patients are assessed for physical fitness pre- and post-CR, especially in Home-based /Self-managed CR.

Recommendation 5 - Achieve and maintain Green certified status

- Develop an action plan to retain Green certified status year-on-year.
- Ensure that NACR data submission occurs regularly throughout the year for all patients covering the complete CR patient journey.

Acknowledgements

Thank you to NHS England for their ongoing commitment to CR and NACR. Specifically, our thanks go to Diane Saunders and Kasia Pisarska.

Thanks also to BACPR, particularly Sally Hinton and Maria Glover for their support as well as the wider NCP_CR Steering Group.

The optimal functionality of NACR relies on good quality data which is only possible through the willingness of clinical teams to audit their service and to work with us to improve CR quality. A major aspect of their work involves entering comprehensive patient data which is done alongside completing clinical assessments and questionnaires specific to our audit reporting. We would like to thank all clinical teams and staff for their continued support.

As the patient voice for CR in the UK, the Cardiovascular Care Partnership UK (CCP UK) continues to support NACR enabling the audit and its findings to become more meaningful for patients and carers. Thanks to Roland Malkin.

Thank you also to the NACR Steering Group for their continued support, expertise and critical friend role which is one of the main reasons NACR is fit for purpose.

Ashley Bolton (Head of Clinical Registries and Audits, NHS England)
Dr Hayes Dalal (Professor (Associate) – University of Exeter Medical School)
Claire Dobson (Health and Care Lead, BHF)
Sara Drew (All Wales Group Representative)
Denise Duggan (Northern Ireland Representative)
Jennifer Hannay (England Cardiac Network Representative)
Sally Hinton (Executive Director, BACPR)
Sarah Howard (All Wales Group Representative)
Dr Mike Lawless (Cardiologist Registrar, Newcastle Hospital/Newcastle University)
Roland Malkin (CCP UK President)
Gillian Moore (Northern Ireland Representative)
Dominic Povey (NHS England)
Maria Glover (BACPR President)
Janine O'Rourke (England Cardiac Network Representative)
Kelly Read (North London Cardiac Delivery Network)
Professor Lars Tang (International NACR Representative)

Writing group:
Professor Patrick Doherty, Clinical Lead of NACR
Dr Alex Harrison, NACR Lead Analyst
Corinna Petre, NACR Project Manager
Nerina Onion, NACR Programme Manager
Professor Lars Tang, International NACR Representative
Jonathon Gregory, NHS England

List of Tables and Figures

Tables

Table 1	**CR uptake split by country and main diagnosis/treatment group**	6
Table 2	**Proportion of staff type by programme split by country**	7
Table 3	**Of all services reporting temporary staff departure, how many returned (n=125)**	11
Table 3a	**Staff types of prescribers within the team (n=89)**	13
Table 3b	**Are the staff actively prescribing (n=89)**	14
Table 4	**Patients attending from diagnosis and treatment groups at a UK level and presence within services**	17
Table 5	**Mode of delivery at the patient and CR programme level**	19
Table 6	**Rate of patients completing CR with assessment 1, assessment 2 and both assessment 1 and assessment 2 recorded**	20
Table 7	**Wait time by patient groups**	20
Table 8	**Physical fitness outcomes pre-CR, post-CR and the change split by mode of delivery**	26
Table 9	**NCP_CR certification status for CR programmes across England, Northern Ireland and Wales**	29

Figures

Figure 1	**The number of all patients starting CR, as entered into NACR, over 10 years**	5
Figure 2	**In 2025, have any of your staff permanently left the CR team?' (n=200)**	9
Figure 3	**Of your staff that permanently left the CR team how many were replaced?' (n=132)**	10
Figure 4	**In 2025, have any of your staff temporarily left the CR team?' (n=189)**	11
Figure 5	**Did you try to recruit to new positions within the team and was the recruitment successful? (n=199)**	12
Figure 6	**Were there prescribers within the team and how many of the staff were NMPs or doctors? (n=200)**	13

Figure 7	**Which patient groups did staff prescribers actively prescribe to? (n=92)**	14
Figure 8	**If no medical titration or management happens within the service, where are patients referred? (n=90)**	15
Figure 9	**Proportion of patients achieving targets for physical activity, smoking status and BMI pre-CR, post-CR and the change**	23
Figure 10	**Proportion of patients achieving targets for blood pressure and cholesterol pre-CR, post-CR and the change**	24
Figure 11	**Proportion of patients scoring at or below the stated HADS threshold for anxiety and depression pre-CR, post-CR and the change**	**25**
Figure 12a	**Baseline scores for physical fitness measures split by mode of delivery**	26
Figure 12b	**Proportion of patients meeting MCID for the measures of physical fitness upon completion of CR split by mode**	27
Figure 13	**The count of patients with physical fitness measures recorded pre- and post-CR in the years 2020-2025**	28
Figure 14	**Of the 198 services included in the NCP_CR report, how many were meeting each of the seven KPIs?**	30

List of Supplements

In addition to the data and figures within this report, NACR provides local and regional reports online. These supplements can be used to inform services and drive improvement. The full list of available supplements is below and they can be accessed from the following - Annual Report Supplements.

- Inclusion
- Staffing
- Staff Prescribers (Doctors/NMPs) and Medication Prescription
- Physical Fitness Tests
- Early

Further information on the programme level data within Quarterly reports can be accessed from the following - Quarterly Reports.

NACR Methodology Document

NACR has produced a document that describes the methodology underpinning routine patient-level data collection the annual staffing survey and national reporting. It explains how data are processed, quality-assured and checked and how reporting cohorts and measures are defined. It also sets out each of the routine mechanisms for reporting including the NCP_CR, Quarterly Reports and the Quality and Outcomes report.

The document can be found here: NACR Methodology

References

• American College of Sports Medicine. *ACSM's Guidelines for Exercise Testing and Prescription*. 11th Edition (2021) Philadelphia Lippincott, Williams & Wilkins.

• British Heart Foundation, UK Cardiovascular Disease Factsheet 2026 https://www.bhf.org.uk/what-we-do/our-research/heart-statistics/heart-statistics-publications

• British Association for Cardiovascular Prevention and Rehabilitation. *BACPR Standards and Core Components 2023 Edition*. https://www.bacpr.org/news/bacpr-standards-and-core-components-2023-edition.

•Brown TM, Pack QR, Aberegg, E, et al. Core components of cardiac rehabilitation programs: 2024 update: A scientific statement from the American Heart Association and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Circulation* 2024;, 150, (18). https://doi.org/10.1161/CIR.0000000000001289.

• Cowie A, Buckley J, Doherty P on behalf of the British Association for Cardiovascular Prevention and Rehabilitation (BACPR), et al. Standards and core components for cardiovascular disease prevention and rehabilitation. *Heart* 2019; 105: 510-515. https://doi.org/10.1136/heartjnl-2018-314206.

• Dalal H, Doherty P, Taylor R. Clinical review: Cardiac rehabilitation. *British Medical Journal* 2015; 351: h5000. https://doi.org/10.1136/bmj.h5000.

• Dalal HM, Evans PH, Campbell JL, Taylor RS, Watt A, Read KL, Mourant AJ, Wingham J, Thompson DR, Pereira Gray DJ. Home-based versus hospital-based rehabilitation after myocardial infarction: A randomized trial with preference arms--Cornwall Heart Attack Rehabilitation Management Study (CHARMS). *International Journal of Cardiology* 2007 Jul 10; 119(2): 202-11. https://doi.org/10.1016/j.ijcard.2006.11.018 Epub 2006 Dec 28. PMID: 17196274.

• Department of Health and Social Care & NHS England. (2026). *Cardiovascular Disease (CVD) Modern Service Framework (MSF): A Cardiovascular-kidney-metabolic Approach* 2026. https://www.gov.uk/government/publications/cardiovascular-disease-modern-service-framework

• Dibben G, de Vries FBG, Faulkner J, Oldridge N, Rees K, Stens NA, Thijssen D, Thompson DR, Zwisler AD, Taylor RS. Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews 2026, Issue 9. Art. No.: CD001800. DOI: 10.1002/14651858.CD001800.pub5. Accessed 20 October 2026.

• Doherty P and Lewin B. The RAMIT trial, a pragmatic RCT of cardiac rehabilitation versus usual care: what does it tell us? *BMJ Heart* 2012; 98: 605-6. https://doi.org/10.1136/heartjnl-2012-301728.

• ESC 2024 – https://www.escardio.org/Congresses-Events/ESC-Congress/Congress-news/2024-esc-clinical-practice-guidelines-for-the-management-of-elevated-blood-press#:~:text=After20320months20of20lifestyle,mmHg20to20reduce20CVD20risk.

• Fell J, Dale V, Doherty P. Does the timing of cardiac rehabilitation impact fitness outcomes? An observational analysis. *Open Heart* 2016 Feb 8; 3 (1): e000369. https://openheart.bmj.com/content/3/1/e000369.

• Furze G, Doherty P, Grant-Pearce C. Development of a UK National Certification Programme for Cardiac Rehabilitation (NCP_CR). *British Journal of Cardiology* 2016; 23 (2). https://doi.org/10.5837/bjc.2016.024.

• Hinde S, Harrison A, Bojke L, et al. Quantifying the impact of delayed delivery of cardiac rehabilitation on patients' health. *European Journal of Preventive Cardiology* 2020. https://doi.org/10.1177/2047487320912625.

• Jallow H, Chacin-Suarez A, Medina-Inojosa J, et al. Major adverse cardiovascular events in heart failure patients with multimorbidity undergoing cardiac rehabilitation: a community cohort. *Journal of the American College of Cardiology* 2022 Mar, 79 (9_Supplement): 1590. https://doi.org/10.1016/S0735-1097(22)02581-5.

• Mafham MM, Spata E, Goldacre R, et al COVID-19 pandemic and admission rates for and management of acute coronary syndromes in England. *Lancet* 2020; 396 (10248), 381-9. https://doi.org/10.1016/S0140-6736(20)31356-8.

• Molloy CD, Lon, L, Mordi IR, Bridges C, Sagar VA, Davie, EJ, Coats AJS, Dalal H, Rees K, Singh SJ and Taylor RS Exercise-based cardiac rehabilitation for adults with heart failure – 2023 Cochrane systematic review and meta-analysis. *European Journal of Heart Failure* 2023. https://onlinelibrary.wiley.com/doi/10.1002/ejhf.3046

• Ngaage, D.L., Gooseman, M.R., Bulliment, K.L., Jarvis, M.A., Chaudhry, M.A., Cale, A.R. and Cowen, M.E. (2019) 'Is six weeks too long for the first outpatient review after cardiac surgery? FORCAST6', *British Journal of* Cardiology, **26**, p. 34. https://doi.org/10.5837/bjc.2019.008

• NHS England 2022 https://www.nhs.uk/conditions/high-cholesterol/cholesterol-levels/.

• NICE *Unstable Angina and NSTEMI: Early Management. NICE Clinical Guideline 94*. 2010. https://www.nice.org.uk/guidance/CG94.

• NICE *MI-Secondary Prevention in Primary and Secondary Care for Patients Following a Myocardial Infarction. NICE Clinical Guideline 172*. 2013. https://www.nice.org.uk/Guidance/CG172.

• NICE *Chronic Heart Failure in Adults: Diagnosis and Management. NICE Guideline 106*. 2018. https://www.nice.org.uk/guidance/ng106.

• NICE *Hypertension in Adults: Diagnosis and Management. NICE Guideline 136*. 2023. https://www.nice.org.uk/guidance/ng136.

• NHS England *Cholesterol Levels*. 2022. https://www.nhs.uk/conditions/high-cholesterol/cholesterol-levels/.

• NICE *Cardiovascular Disease: Risk Assessment and Reduction, Including Lipid Modification. NICE Guideline 238*. 2023. https://www.nice.org.uk/guidance/ng238/.

• Pelliccia A, Sharma S, Gati S, et al. ESC Scientific Document Group, 2020 ESC Guidelines on sports cardiology and exercise in patients with cardiovascular disease: The Task Force on sports cardiology and exercise in patients with cardiovascular disease of the European Society of Cardiology (ESC), *European Heart Journal*. 2021; 42 (1): 17–96. https://doi.org/10.1093/eurheartj/ehaa605.

• Rauch B, Davos C H, Doherty, P, et al. The prognostic effect of cardiac rehabilitation in the era of acute revascularisation and statin therapy: A systematic review and meta-analysis of randomized and non-randomized studies – The Cardiac Rehabilitation Outcome Study (CROS). *European Journal of Preventative Cardiology*. 2016; 23 (18): 1914-39. https://dx.doi.org/10.11772F2047487316671181.

• Salzwedel A, Jensen K, Rauch B, et al. Effectiveness of comprehensive cardiac rehabilitation in coronary artery disease patients treated according to contemporary evidence based medicine: Update of the Cardiac Rehabilitation Outcome Study (CROS-II). *European Journal of Preventive Cardiology*. February 2020. https://doi.org/10.1177/2047487320905719.

• Saito M, Ueshima K, Saito M et al. Japanese Cardiac Rehabilitation Survey Investigators. Safety of exercise-based cardiac rehabilitation and exercise testing for cardiac patients in Japan: a nationwide survey. *Circulation Journal*. 2014; 78 (7): 1646-53. https://doi.org/10.1253/circj.cj-13-1590. PMID: 24837707.

• Sadeghi, M, Rahiminam H, Amerizadeh A et al.
Prevalence of return to work in cardiovascular patients after cardiac rehabilitation: A systematic review and meta-analysis, *Current Problems in Cardiology*. 2022. https://doi.org/10.1016/j.cpcardiol.2021.100876.

• Scottish Intercollegiate Guidelines Network SIGN. *Cardiac Rehabilitation: A National Clinical Guideline No. 150. Scottish Intercollegiate Guidelines Network*. 2017.
https://www.sign.ac.uk/media/1047/sign150.pdf.

• Shields GE, Wells A, Doherty P, et al. Cost-effectiveness of cardiac rehabilitation: a systematic review. *Heart* 2018; 104: 1403-1410. https://doi.org/10.1136/heartjnl-2017-312809.

• Sumner J, Böhnke JR, Doherty P. Does service timing matter for psychological outcomes in cardiac rehabilitation? Insights from the National Audit of Cardiac Rehabilitation. *European Journal of Preventative Cardiology* 2017; November 9. https://doi.org/10.11772F2047487317740951.

• Taylor R, Sagar V, Davies E, Briscoe S, et al. Exercise-based rehabilitation for heart failure. *The Cochrane Library* 2014, Issue 4. Art.No.:CD003331. http://doi.org/10.1002/14651858.CD003331.pub4.

• Visseren FLJ, Mach F, Smulders YM, et al. 2021 ESC guidelines on cardiovascular disease prevention in clinical practice: Developed by the Task Force for cardiovascular disease prevention in clinical practice with representatives of the European Society of Cardiology and 12 medical societies with the special contribution of the European Association of Preventive Cardiology (EAPC). *European Heart Journal* 2021; 42 (34): 3227–3337. https://doi.org/10.1093/eurheartj/ehab484.

• West RR, Jones DA, Henderson AH. Rehabilitation After Myocardial Infarction Trial (RAMIT): multi-centre randomised controlled trial of comprehensive cardiac rehabilitation in patients following acute myocardial infarction. *Heart* 2011; 98: 637–44. http://dx.doi.org/10.1136/heartjnl-2011-300302.

• Wood D. Is cardiac rehabilitation fit for purpose in the NHS: maybe not. *Heart* 2012; 98: 607-8.
http://dx.doi.org/10.1136/heartjnl-2012-301811.