Conclusion Despite recommendations, not a single PAD patient in this cohort was offered CR, with none achieving objectively measured MVPA participation recommendations. A large proportion presented with unhealthy lifestyles in terms of tobacco exposure, sedentary time and BMI; all adversely impacting major CVD risk factors. Whilst most were prescribed antiplatelet medications, yet a large cohort were not optimally managed for blood pressure and lipids. These findings support a call to action for CR provision in this patient population at very high CVD risk. CR provides an essential intervention in addressing all aspects of lifestyle and risk factor management to reduce recurrent cardiovascular events.

Background Cardiac Rehabilitation (CR) can reduce cardiovascular mortality and improve health related quality of life. In the United Kingdom patient uptake of CR remains low (52%), falling well short of the target in the 2019 NHS Long-term plan (85%). Mobile health (mHealth) technologies, offering biometric data to patients and healthcare professionals, may bridge the gap between patient discharge from hospital and in-person supervised exercise and physical activity (PA) advice. Early intervention could lead to improved CR uptake and enable patients to engage in regular long-term physically active lifestyles quicker.

Aim This randomised controlled trial (RCT) will evaluate the feasibility of mHealth technology when incorporated into a structured home-based walking intervention, in people with recent myocardial infarction.

Methods This is a feasibility, assessor blinded, parallel group RCT. Participants will be allocated to either CR standard care (control group) or CR standard care + mHealth supported exercise counselling (mHealth group) (figure 1). The trial was approved in the UK by the Northwest – Greater Manchester East Research Ethics Committee (22/NW/0301) and is registered on ClinicalTrials.gov: NCT05774587. Feasibility outcomes include; the number of patients approached, screened and eligible; the percentage of patients that decline CR (including reasons), agree to CR and consent to being part of the study; the percentage of patients that enroll in standard CR and reasons for drop out; and the percentage of participants that complete clinical, physical and psychosocial outcomes to identify a suitable primary outcome for a future definitive trial. Device derived data will be downloaded using manufacturers’ software and processed in R (R Core Team, Vienna, Austria) using the open-source GGIR software package (http://cran.r-project.org). Qualitative data will be thematically analyzed and coded using NVivo V.12TM software.

Strengths and limitations The MOTIVATE-CR+ intervention may increase the uptake of CR by supporting patients to become physically active between discharge and the start of supervised CR and allowing patients that recently experienced a myocardial infarction to co-design a personalized and progressive walking programme with the support of a clinical exercise physiologist. The intervention also enables participants to communicate regularly with a clinical exercise physiologist and gain feedback on the exercise sessions they complete. The
intervention is not, however, embedded within the current cardiac rehabilitation landscape, as such, future work will be needed to address how the intervention could fit within service structures.

**EVALUATION OF DIGITAL CARDIAC REHABILITATION USING MYHEART APP**

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**Background**

Cardiac rehabilitation (CR) is an evidence-based intervention that supports patient recovery following a cardiac event. It offers patients a structured education and exercise programme to aid recovery and support behavioural changes to help reduce the risk of future cardiac events/complications. The myHeart app brings digital support to patients with heart disease or recovering from cardiac surgery, delivering personalised self-management and CR programmes. It has over 50 new educational videos, an activity diary, a medication diary and enables the team to remotely support patients with heart failure, post-cardiac event or surgery.

**Aim**

To undertake a comprehensive service evaluation to gather subjective feedback from patients and CR healthcare professionals following the introduction of the myHeart app.

**Methods**

A multi-method approach, including the use of surveys and semi-structured interviews, is being used to evaluate the introduction of myHeart and the potential benefit of using the myHeart app to supplement existing CR.

**Results**

Data collection is ongoing. Thematic analysis will be undertaken using Braun and Clarke’s (2006) six-stage process.

**Conclusion**

This evaluation will provide insight into the potential impact of myHeart to supplement CR services.

**DEVELOPING SCALABLE TRAINING FOR THE DELIVERY OF REACH-HF, HOME-BASED CARDIAC REHABILITATION FOR HEART FAILURE**

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**Background**

REACH-HF is a comprehensive home-based cardiac rehabilitation (CR) programme for people with heart failure (HF). The 3-day facilitator training has trained over 500 NHS staff across the UK to date. However, to address the NHS Long Term Plan aim of increasing uptake of CR in HF to 85%, more scalable formats of training delivery are required.

**Aim**

To adapt REACH-HF facilitator training for scalable delivery in close collaboration with NHS staff involved in the delivery of CR.

**Methods**

In the first two phases we designed and developed the eLearning platform with active involvement from a patient advisory group and a service provider advisory group and tested usability of the platform with the training providers. The third and final phase consisted of the evaluation of the training course. Fifteen health professionals were trained. We conducted semi-structured interviews with 11 of these facilitators about the training and REACH-HF delivery. We also received audio recordings of programme delivery to seven patients and one caregiver to assess fidelity (quality of delivery).

**Results**

The resulting training consists of (a) an eLearning platform with core modules relating to REACH-HF programme elements and required patient-centred delivery, and (b) a group-based live session for consolidation. The platform was considered easy to use with good navigation through the modules. Trainees noted that there was a lot of content (time consuming), with perceived usefulness of specific modules being dependent on trainee background. Although sites were paid for 2.5 days per health professional for training time, some reported that this had not translated in allocation in their workload. The fidelity assessment is ongoing.

**Conclusion**

The project has developed a scalable format of delivering REACH-HF training to upskill the CR workforce in delivering HF specific rehabilitation. Some refinements (e.g. tailoring of content to trainee needs) are recommended prior to implementation.