27 November 2012

Dear Ms Williams,

PUBLIC AUDIT COMMITTEE'S REPORT ON CARDIOLOGY SERVICES

Thank you for providing a copy of the Public Audit Committee's report on Cardiology Services on 21 September which is further to the oral evidence we gave to the Committee at its meeting on 22 June about the Auditor General’s report Cardiology Services. Following that session, the Committee has asked for additional information which is attached at Annex A.

I was pleased to see the report recognised NHSScotland’s success in reducing heart disease rates. I was also encouraged by the Committee’s agreement that our Keep Well programme is the right approach to targeting health improvement in Scotland’s most deprived communities.

The Committee focussed much of its attention on the links between heart disease and socio-economic status. I think it worth reiterating that NHSScotland has helped to cut Coronary Heart Disease related mortality rates in the most deprived areas faster than anywhere else over the last decade (2001-2010). Mortality rates among all deprivation quintiles reduced but the reduction of 34.1% in the CHD mortality rate among the most deprived category has been almost double the 18.1% reduction observed in the least deprived category.

The report also highlights the wider social determinants of cardiac health, which includes housing, employment and environment. I hope the Committee is encouraged to hear that this is recognised within the assets-based approach which our Chief Medical Officer is leading on.

There is clearly still a long way to go and I hope this additional information provides the Committee with some reassurance of our commitment to providing everyone in Scotland with access to high quality health services.

Yours sincerely

DEREK FEELEY
RECOMMENDATIONS FROM THE PUBLIC AUDIT COMMITTEE’S REPORT ON CARDIOLOGY SERVICES

Each recommendation is numbered after the associated paragraph within the Public Audit Committee’s Report.

KEEP WELL

Recommendation 35: The Committee seeks confirmation from the Scottish Government as to whether it will undertake any interim evaluation of the performance of the Keep Well programme in reducing the risk of CVD in those participating in the programme.

1. The evaluation of the Keep Well programme is led and managed by NHS Health Scotland. An Evaluation Advisory Group has been established which has responsibility for overseeing the evaluation. The primary purpose of the evaluation is to assess the implementation and impact of the Keep Well interventions.

2. The Committee is aware of the two inter-connected evaluation studies:
   - The Local Variability Study is seeking to better understand the range of outcomes that the Keep Well interventions are seeking to influence in different parts of Scotland and the various approaches that have evolved in each area in order to work toward achieving these outcomes.
   - The Outcomes Analysis Study will examine the impact of the introduction of Keep Well health interventions on trends in CVD mortality and morbidity (hospital admissions) by comparing data from GP practices in Scotland participating in waves 1 and 2 of the Keep Well programme, before and after the introduction of Keep Well interventions.

3. Analysis will incorporate information from the Local Variability Study on variation in the implementation of Keep Well interventions and General Practice characteristics, with the potential to explain observed variations in outcomes such as CVD related prescribing, risk factor modification, morbidity and mortality. The outcomes analysis study will draw on routine QOF data collected for GP practices on CVD risk factors (hypertension) and prescribing of medication.

4. The study period for both the Outcomes Analysis and the Local Variability Study is 2012-2014. The final reports will be produced in summer 2014 and interim reports for both studies will be available in Spring 2013.

Recommendation 37: The Committee requests further information from the Scottish Government as to how it will evaluate which approaches are most effective at delivering Keep Well health checks to people most at risk of heart disease.

5. Due to the flexible nature of the Keep Well interventions, individual NHS Boards are implementing the programme in their areas to suit the needs of their local population. The Local Variability Study will inform an analysis of the outcome data in order to explore the extent to which variations (e.g. in prescribing, GP contract enhancement and mortality and morbidity patterns) in and between Keep Well and non-Keep Well practices can be identified and explained with reference to differences in Keep Well implementation. It may also be used to inform the design of future studies looking at the impact and cost-effectiveness of Keep Well.
HEALTH PRACTITIONER AND PATIENT RELATIONSHIPS

Recommendation 45: The Committee would request that the Scottish Government review whether GP numbers are adequate to meet the needs of patients in deprived communities and ethnic minority communities.

6. Primary medical services funding allocations from the Scottish Government to Health Boards enable them to fund GP services for their area. In addition to being based on overall patient population numbers, these allocations also take into account the additional costs associated with, morbidity and life circumstances, rurality and remoteness, and the relative age/sex weightings of the patient population.

7. In discharging their statutory obligations to provide services, including primary medical services and out of hours care, NHS Boards are required to put in place those arrangements they consider necessary to meet all reasonable requirements for their area. There is no ‘one size fits all’ approach to service provision and Health Boards are expected to design and put in place the service models that best reflect their local circumstances.

8. It is important to note that in considering appropriate service delivery, NHS Boards have more than one option for primary medical services provision at their disposal. As well as provision through contractual arrangements, Health Boards can also choose to provide services directly themselves through salaried GPs.

9. Deep End practices are situated in the most deprived areas of Scotland where life expectancy for people living in these areas of Scotland is around 20 years lower for men and 18 years lower for women, compared with those living in the most affluent areas. Further, according to a report produced by the Royal College of General Practitioners (RCGP) Scotland, deprived adults are nearly four times more likely to die from coronary heart disease between the ages of 45-74, and more than 12 times more likely to die of an alcohol related condition.

10. General Practitioners at the “Deep End” work in 100 general practices serving the most socio-economically deprived populations in Scotland (86 of which are in Glasgow). The activities of the group are supported by the Scottish Government Health Directorates and the Deep End GPs support the Government’s stated aims:
   - that health and social care services are firmly integrated around the needs of individuals, their carers and other family members;
   - that they are characterised by strong and consistent clinical and care professional leadership;
   - that the providers of services are held to account jointly and effectively for improved delivery; and
   - that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve – rather than the organisations through which they are delivered.

11. From the Scottish Government’s point of view, the Deep End initiative has been encouraging and almost certainly good value for the resources we have put into it. The group represents a genuinely bottom up initiative, with engagement and buy-in from frontline GPs. In that sense it has enabled us to hear direct from practitioners without the distorting lens of the national representative bodies. It has also raised the profile of inequalities issues, without an equal and opposite reaction from those in rural or more affluent areas.
Recommendation 48: The Committee requests clarification from the Scottish Government as to how it is supporting training of GPs and other medical professionals to work effectively with patients with comorbidity whom require a wide range of health and social care support. This is essential to ensure the patient’s journey can be followed, with timely and good links maintained with other departments such as social work and secondary care.

12. General Practice Specialty Trainees undertake either a three or four year programme, eighteen months of which is spent in Primary Care. The hospital component of training will include either a General Medicine or Medicine for the Elderly post which will expose the trainees to patients with co-morbidity in secondary care setting. In the general practice setting the trainees will be exposed to patients with co-morbidity and will be involved in liaison with social care services and secondary care in the management of these patients.

13. General Practice Specialty training is underpinned by the RCGP Curriculum. This curriculum specifically looks at aspects of patient-centred care and care of those with co-morbidity. The relevant chapters are:
   - 2.02 – Patient Safety and Quality of Care
   - 2.03 – The GP and the Wider Professional Environment
   - 2.04 – Enhancing Professional Knowledge
   - 3.05 – Care of Older Adults

14. The learning outcomes in the RCGP UK curriculum for GP training is aimed to deliver competencies in a “comprehensive approach” which explains how a general practitioner must be able to manage co-morbidity, co-ordinating care of acute illness, chronic illness, health promotion and disease prevention in a general practice setting. The regulatory body, the General Medical Council (GMC), provides core guidance to doctors (including GP’s) who have completed their training in the Good Medical Practice. This includes the requirement to keep their knowledge and skills up to date throughout their working lives, by taking part in activities of continuing professional development (CPD) which maintain and further develop competence and performance. The annual appraisal process, which contributes to the revalidation of GP’s, helps GPs to indentify their learning needs to address the healthcare needs of their patients.

Recommendation 50. The Committee therefore recommends that NHS Boards work with local authorities and GPs to identify all the community support services available in each medical practice area so that patients may be more quickly supported to make lifestyle changes following Keep Well health checks.

15. The Keep Well programme is being mainstreamed by NHS Boards between 2012 and 2015, with support from NHS Health Scotland. NHS Health Scotland is working with representatives from territorial Boards to identify and share good practice.

16. There are examples of current good practice where NHS Boards have produced directories of local services for Primary Care and other services to refer clients on to. The Scottish Government and NHS Health Scotland will work with NHS Boards to explore how similar practice can be used more widely.

17. The Scottish Government recognises the importance of community resources in supporting the health of people with, or at risk of, developing a long term condition. We have therefore invested in the development of the ALISS self management programme, otherwise known as, access to local information to support self management for people with long term health conditions.
18. The ALISS programme works through linking up currently available online local information and encouraging new contributions to make a richer set of information about local self management support in Scotland.

19. GPs will in future be able to use ALISS to quickly identify community support services available in their medical practice area. These resources can include:
   - condition-specific education programmes
   - self management courses
   - support groups
   - carers' centres
   - sports clubs
   - exercise classes
   - complimentary therapies
   - walking groups
   - leisure classes

20. Work is underway to support the support integration of the ALISS system with GP systems.

21. The Health and Social Care Alliance Scotland is now leading the roll out of the project and more information is available at: http://www.aliss.org/.

Recommendation 55: The Committee would however request specific information from the Scottish Government as to how it proposes to address the attitude within deprived communities and ethnic minority communities that poor health is to be expected.

22. The Scottish Government is committed to addressing the unfair and unjust health differences which disproportionately affect those living in Scotland’s most deprived communities. That is why the Keep Well anticipatory health checks are targeted at people over 40 living in Scotland’s poorest communities and are most at risk of poor health.

23. Equally Well (2010), the report of the Ministerial Task Force on Health Inequalities, set out the Scottish Government’s approach to dealing with health inequalities. It recognised that poor health is not simply due to diet, smoking or other life style choices. The key emphasis has been to shift the focus from dealing with the consequences of health inequalities to tackling the underlying causes such as poverty, employment, support for families and improving physical and social environments.

24. This has included the promotion of an assets-based approach, engaging with communities, to build on the resources that they have at their disposal, to promote self-esteem and the coping abilities of individuals and their communities. Examples of this work include the Equally Well test sites, which sought to promote collaboration amongst local public service providers with the aim of reducing inequalities in health and wellbeing. The Ministerial Task Force will be reconvened on 29 November 2012 to examine progress.

INDICATORS

Recommendation 60: The Committee would however endorse the AGS recommendation that the Scottish Government and NHS Boards should monitor the rates of the main cardiology procedures by different groups, particularly by patient socio-economic group and ethnicity to ensure that all patients have appropriate and timely treatment.
25. Information Services Division have reported on the main interventions used in hospital to diagnose and treat coronary heart disease including angiography, percutaneous coronary interventions (angioplasties) and coronary artery bypass graft. This information is available at the following link: http://www.isdscotland.org/Health-Topics/Heart-Disease/Topic-Areas/Operations/

26. This data is broken down by geographic location which will enable further analysis of the level of provision broken down by socio-economic group. ISD will be asked whether this data is amenable to further analysis on patterns of access by different ethnic groups.

27. We are committed to ensuring that people from deprived communities have equal levels of access to appropriate treatment and care as those from Scotland’s wealthiest areas. Key to achieving this will be to make sure people from deprived areas are aware of the risk factors and symptoms of cardiovascular disease, ensuring they are diagnosed early and can access appropriate treatment as quickly as possible. Our Keep Well Programme is central to this approach.

Recommendation 63: The Committee welcomes the provision of indicators which will enable performance monitoring across NHS Boards. The Committee, however, requests clarification as to whether these indicators will also enable better analysis of the value for money of cardiology services as well as the patterns of access and the treatment received by different socio-economic and ethnic groups.

28. The overall aim of the suite of 20 indicators is to provide meaningful and focused outcome rather than process based measures that can be used by NHS Boards to inform and drive service improvement to support the quality of care and patient experience.

29. A number of the indicators directly promote value for money in cardiac services. It is clear that by improving the quality of care for people with heart disease NHS Scotland can reduce length of stay (Indicator 2) and readmission rates (Indicator 3) both of which have significant resource implications.

30. We are committed to ensuring that NHSScotland provides care that reaches and meets the needs of all socio-economic and ethnic groups. There are already a number of mechanisms (Scottish Health Survey) and programmes (Keep Well) in place which help us to gather information and assess our effectiveness in reducing health inequalities.

31. The indicators, as published, are intended to be top level measures of the quality of cardiac care provided by the NHS. However, ISD and Healthcare Improvement Scotland will be asked whether the data collected as part of the indicator programme is amenable to further analysis on patterns of access by different socio-economic and ethnic groups.

PRIMARY PCI

Recommendation 67: The Committee welcomes the consideration being given to extending the treatment time for primary PCI which, if appropriate, will enable greater numbers of patients with a severe heart attack to be treated quickly. Nevertheless, in order for NHS Highland patients to fully benefit from any treatment time extension for primary PCI, NHS Highland has to be able to provide a primary PCI service out of hours. The Committee seeks information as to how the Scottish Government is working with NHS Highland to address this issue.

32. The primary PCI service (pPCI) in Scotland has undergone significant investment and expansion in recent years. Scotland has an outstanding optimal reperfusion/emergency angioplasty service. Our Lead Clinician on Heart Disease, Dr Barry Vallance recently noted that “once they reach hospital, patients actually get their procedure within a much
faster target time-frame than in England" The British Cardiovascular Interventional Society noted in a 2010 report that levels of access in Scotland (1510 per million people) are better than both England (1401 pmp) and Wales (1112 pmp).

33. A revised Scottish Intercollegiate Guideline Network (SIGN) Guideline on Acute Coronary Syndrome, will be issued in December. This will have important messages for services on the optimal timing for delivery of pPCI. We expect publication of the guideline to prompt a discussion around service access within each NHS board, Regional Planning Group and the Scottish Government's National Advisory Committee on Heart Disease.

34. NHS Highland have advised Scottish Government that after extensive consultation with the North of Scotland Planning Group and approval from the BCIS, they implemented a limited weekday PCI service in Raigmore Hospital in May 2010, being provided from a newly completed comprehensive laboratory catheter suite. Any patients requiring treatment out with the available service times would continue with the pre-existing clinical pathway and under go pre-hospital thrombolysis and, following review would be transferred to primarily Aberdeen for rescue PCI where appropriate.

35. We are aware that the Optimal Re-perfusion Therapy Strategy has been continuously reviewed by NHS Highland with the intention of continuously improving their PCI service. In August 2012 the service was expanded further to enable some provision of primary PCI, but it was still restricted to weekdays only.

36. NHS Highland recognise the desirable goal of providing a full 24/7 quality PCI service in the future, but recognise that this would require significant financial resource and development. They will endeavour to develop and expand a quality service as much as possible within the re-design process, but this would have to be on an incremental basis at this time in partnership with the other North of Scotland boards.

37. The Scottish Government will continue to work with NHS Boards regarding the delivery of PCI.

**DIAGNOSTIC TESTING**

**Recommendation 71:** The Committee notes the evidence from NHS Greater Glasgow and Clyde that it is to undertake a clinical services review to look at how services are being delivered and to consider the balance and range of services provided beyond 2015. However given the concerns in the AGS report and expressed by the NHS Waiting Times Centre about appropriate diagnostic testing, the Committee requests information from the Scottish Government as to how it will support NHS Boards to review their testing services to ensure they provide value for money and avoid unnecessary additional testing of patients.

38. Dr Barry Valance, Lead Clinician on Heart Disease and NHSScotland’s Diagnostic Imaging Group have agreed to consider the potential efficiencies and quality improvements to be gained through reviewing cardiac imaging services issue at the next meeting of the Group on the 24 January 2013.

**HEALTHY EATING AND EXERCISE**

**Recommendation 80:** The Committee recommends that the Scottish Government, NHS Boards and local authorities work together to support the provision of healthy food retail outlets in deprived communities (through licensing and business support) and to identify opportunities for other types of public sector premises to provide healthy and affordable food.
39. A healthy, balanced diet is essential for long term health. However, we know that for some, there are considerable barriers which make eating healthily a huge challenge, including affordability, availability, cooking knowledge and skills and access to shops. There is a large amount of work going on across Scotland, both locally and nationally, to improve our diet and address barriers to healthy eating.

40. The Scottish Government, Local Authorities, NHS Scotland and the private and voluntary sectors are all actively contributing to this agenda. Activity can vary between areas depending on the needs of individuals, local communities and the organisations in place to deliver services. The range of activity on offer is extensive, from food co-ops in hospitals to cooking classes for patients with specific conditions, from equality and diversity training to community kitchens and the provision of healthy eating information.

41. The Scottish Government is taking forward a range of initiatives to encourage and enable individuals to make healthier food choices, including the following:

Healthyliving Programme

42. The Scottish Grocers Federation (SGF) Healthyliving Programme aims to improve the supply and provision of fresh produce and healthier food choices in local convenience stores, particularly in low income areas. The programme allows local stores to stock and provide an ever widening range of healthier produce to their local community, and at affordable prices. Chillers and shelving are provided, to help shops clearly display and promote their fresh produce; this includes items such as: fruit and vegetables, chilled fruit juices, healthier yogurts and water. There are 1,223 convenience stores across Scotland covering all 32 Local Authorities and we are now requiring health boards to make hospital retailers join the Programme at the point of contract (re)negotiation. There is also ongoing work to engage with retailers, including supermarkets, near schools, encouraging them to provide healthier alternatives for local pupils and expand and widen the variety of healthy products on offer.

Community Food and Health Scotland

The Scottish Government funds Community Food and Health (Scotland) (CFHS) aims to ensure that everyone in Scotland has the opportunity, ability and confidence to access a healthy and acceptable diet for themselves, their families and their communities. CFHS does this by supporting work with and within low-income communities that addresses health inequalities and barriers to healthy and affordable food. CFHS activity includes a small grants scheme for community initiatives e.g. to run cooking classes or food co-ops, and toolkits and guides for community food initiatives.

Healthier Scotland Cooking Bus

43. The Scottish Government supports the Healthier Scotland Cooking Bus which aims to encourage greater understanding of food and health issues by teaching healthy, practical cooking skills to pupils and teachers and their local communities across Scotland. Any school or community group can apply for a free visit from the bus.

Schools

44. The Scottish Government has introduced a package of measures for schools aimed at teaching children and young people about the importance of healthy eating and health and wellbeing in general, and making the right choices in and out of school. The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 places a duty on schools and local authorities to ensure that health promotion is at the heart of a school’s activities. The Act also ensures that all food and drink provided in schools meet tough nutritional standards that help to change eating habits in Scotland. Through Curriculum for Excellence a range
of opportunities can be offered in schools to stimulate interest and commitment to developing lifelong healthy eating habits, and to explore the relationship between diet and activity.

Working with Industry

45. The Scottish Government is working closely with the food industry, including manufacturers, retailers and the hospitality sector to reduce the salt, fat and added sugar content of products and build on the positive steps they have been making over the last few years on the promotion of healthier, less energy dense food.

Recommendation 81: The Committee requests further information from the Scottish Government on how it intends to improve the clarity of nutritional information on packaging to assist people to make healthy food choices.

46. Clear, consistent labelling is essential to help consumers make informed choices about the food they buy. The Scottish Government, alongside the Department of Health and the other devolved administrations, announced in October 2012, a recommended approach to front of pack labelling – a hybrid scheme which includes traffic light indicators and % Guideline Daily Amounts. The four UK governments will now work jointly on practical guidance for implementation in early 2013, engaging the food industry and health organisations.

47. The Scottish Government supports Nutrition Diet Resources UK (NDRUK) to produce therapeutic dietary information sheets that can be used by health professionals when advising patients with certain conditions. These popular resources are available at a significant discount to Scottish health boards and encourage patients to adopt a healthier diet to aid recovery or manage their condition.

Recommendation 82: The Committee also recommends that NHS Boards and local authorities work together to provide culturally appropriate leisure opportunities, health services and cookery classes, to ensure that there are opportunities for all patients to improve their lifestyle.

48. Co-production within the context of healthcare recognises that individuals, as well as their families and communities, have an innate ability to contribute to their own health, wellbeing and recovery. This, when properly developed in conjunction with the technical skills of health, exercise and nutritional experts, increases an individual’s capacity for prevention of, and recovery from ill health.

49. Many national organisations such as the British Heart Foundation and Chest Heart and Stroke Scotland have developed services locally to enhance individual and community capacity in prevention and/or recovery from cardiac problems.

50. A specific example aimed at increasing physical activity and fitness levels within marginalised sectors of the BME community in Glasgow is the Holistic Health and Fitness initiative provided by the REACH Healthy Living Project. (http://www.reachhealth.org.uk/holistic.php). Since 2009 and 2010 respectively REACH has provided access to keep fit classes for BME elderly and young BME women. The Multicultural Elderly Care Centre (MECC) has indicated that service users have benefited both mentally and physically from this REACH service.

51. An excellent example of a service tailored to local need is the Angus Cardiac Group which won the Self Management Partnership of the Year www.anguscardiacgroup.co.uk/. This Group is member/patient led, supporting cardiac care and rehabilitation in Angus through member support, social contact, fundraising, partnership working with health
professionals and the local authority, and the promotion of patient involvement with the
NHS.

52. It is also worthwhile noting that the ALISS search engine (Access to Local Information to
Support Self Management) initially developed by Scottish Government and now hosted
and maintained by The Alliance provides an excellent way of both sharing and accessing
information on a range of local services which support self managed health care. It can
be accessed on [http://www.aliss.org/](http://www.aliss.org/)

THE ROLE OF THE FAMILY

Recommendation 87: The Committee would therefore welcome further information from
the Scottish Government as to how the Keep Well programme helps families to
encourage and support family members who require to change their lifestyle following a
health check.

53. Keep Well interventions are primarily targeted at individuals, however many NHS Boards
recognise the value of this type of approach and have included elements of family
support within their Keep Well interventions, depending on local need and resources
available. Discussions around local practices in this work is encouraged in the quarterly
meetings for Keep Well managers which encourages the sharing of best practice.

Recommendation 88: The Committee also requests information from the Scottish
Government on how the NHS involves families in the cardiac rehabilitation of family
members.

54. Cardiac Rehabilitation recognises the need for families /carer to be included in the period
following diagnosis of CHD either in the acute setting or referral from primary care.
Supporting and re enforcing the necessary lifestyle changes is a recognised role of the
families / carers.

55. Family or indeed sometimes a close friend will be included in education and information
sessions while a patient is in hospital. This will depend on patient consent and the clinical
condition of the patient i.e. pre or post intervention. Most patients welcome these
sessions being shared with family. Patients are encouraged to bring a family member or
carer to initial assessments, or clinic appointments. This includes assessments for
exercise classes, dietetic appointments and psychology appointments. Some family
members can be over protective or traumatised from witnessing a cardiac event and in
these cases cardiac psychology services will offer to work with family members (with the
patient's consent) providing specific advice, intervention or signposting to other services
as appropriate. Patients and family also have a telephone number to call for advice
during core hours. The education can also be accessed by families where interactive
sessions run during the 10 week course. The exercise classes are not accessed by
anyone other than the patient due to capacity and risk stratification issues i.e. each
person would require assessment prior to the classes.

HEART FAILURE

Recommendation 91: The Committee welcomes the funding for a national heart failure
education programme as well as confirmation that the NHS now partially funds heart
failure nurse posts. The Committee would however request clarification of:

- the future plans for heart failure nurses across Scotland; and
- the outcomes expected to be delivered (and by when) from the additional
  £150,000 funding for a heart failure education programme.

Heart Failure Nurses
56. The Better Heart Disease and Stroke Care Action Plan and Clinical Standards for Heart Disease both identify the important role that heart failure nurses have in 1) supporting the care of people with acute heart failure; and 2) supporting the education and upskilling of their clinical colleagues.

57. This sends a clear message to NHS boards about the value of heart failure nurse and should inform their decision-making and planning around heart failure services.

58. On 1 November 2012 the National Advisory Committee on Heart Disease agreed to support the establishment of a heart failure short life working group. This group will be well placed to advise NHSScotland on how heart failure nurses role can be further strengthened. The group, which will include heart failure nurse representation, is expected to have its first meeting in spring 2013.

Heart Failure Education

59. The Heart Failure Education programme, known as Heart-E, is being developed through collaboration between NHSScotland, Chest Heart and Stroke Scotland, the University of Edinburgh and the British Heart Foundation.

60. This tool will have an important role to play in supporting healthcare professionals across Scotland in increasing their knowledge, skills and confidence in the management of people with heart failure.

61. The programme will have at least seven modules to cover the core educational framework, including:
   - Heart Failure and Palliative Care in Heart Disease.
   - Healthy Heart and Investigations,
   - Primary Prevention,
   - Stable Coronary Heart Disease,
   - Acute Coronary Syndromes,
   - Cardiac Rehabilitation,

62. The first modules are expected to be launched in October 2013.

63. The same approach has previously been adopted by the stroke community in the development of the Stroke Training and Awareness Resource (STARS) with extremely positive results, both in terms of the quality of education delivered and number of staff trained.