Introduction

British Heart Foundation (BHF) Scotland warmly welcomes the Committee’s inquiry in this area and is grateful for the opportunity to contribute to it. We also welcome Audit Scotland’s review of the delivery of cardiology services and that it included a summary of key issues from patients’ perspectives, based on work done on their behalf by BHF Scotland and Chest Heart & Stroke Scotland (CHSS).

In general, NHS Scotland provides an excellent acute service. As noted in the report, survival rates for people who present to hospital with a heart attack have increased significantly, and NHS Boards, and their staff in particular, deserve a lot of credit for the achievements that have been made. However, for secondary prevention and for other areas of care, more efforts need to be made, and we suggest the Committee considers these as part of its inquiry.

As noted in the report, deaths from heart disease have fallen significantly in recent years - and by around 40% over the last decade. While improvements in cardiology services have played a significant role in this fall, studies conducted elsewhere in the UK have estimated\(^1\)\(^2\) that more than half of such gains are due to improvements in lifestyle.

We believe that there are further improvements in premature mortality that can be achieved by further improvements in lifestyle risk factors (diet, physical activity, obesity, tobacco) assisted by legislative change: such as implementing the bans on the sale of cigarettes from vending machines and on cigarette displays at the point of sale (which have been successfully passed as part of the Tobacco and Primary Medical Services (Scotland) Act, but have yet to be enacted due to legal action by tobacco companies and their agencies) and in other areas, such as the plain packaging of tobacco products (currently out to consultation).

While these prevention measures are outwith the remit of the Auditor General’s report on cardiology services, they are of crucial importance in any discussion about how to make the most out of spending on heart disease and they are likely to represent exceptionally good value for money.

We are aware that the Committee has a particular interest in the issue of inequalities in revascularisation rates between different groups: we also feel there are significant and important inequalities in other areas that we highlight below.


Cardiac rehabilitation

We welcome the references in the Auditor General’s key messages to the importance of ensuring that all heart patients who would benefit from cardiac rehabilitation should get access to this service.

BHF Scotland, along with CHSS, has campaigned for increased access to cardiac rehabilitation for many years. It is a life-saving and life-enhancing service for people with many different heart conditions, and one that represents excellent value for money. For these reasons, BHF Scotland and CHSS launched the Scottish Campaign for Cardiac Rehabilitation in 2008. The Scottish Government has endorsed the objectives of the campaign in its Better Heart Disease and Stroke Action Plan.

As is noted in the report, as well as more recently shown by an audit published by ISD Scotland, good progress has been made in providing cardiac rehabilitation to people who have had a heart attack or have undergone revascularisation although, of course, more work still needs to be done. However, there are many other areas where NHS Boards need to perform better.

The provision of cardiac rehabilitation for people with heart failure and angina is very low, and NHS Boards need to do much better to ensure services meet the needs of these patients in particular.

Some NHS Boards appear to be underperforming compared to national averages, and we believe they need to consider how they can improve their referral rates for all heart patients.

The figures published by ISD Scotland suggest that certain Boards need to improve their provision of cardiac rehabilitation services.

The Scottish Government and its agencies have been supportive of our campaigns, and have made the provision of cardiac rehabilitation a priority in both the Better Heart Disease and Stroke Action Plan and also in the NHS Quality Improvement Scotland (now NHS Healthcare Improvement Scotland) heart disease clinical standards. We were also very pleased that ISD Scotland was charged with carrying out an audit of cardiac rehabilitation services over the last year, making Scotland the first part of the UK to have such an audit funded by the statutory sector.

However, we are now concerned about what plans there are now in place to put the audit of Scottish cardiac rehabilitation services on a sustainable footing for the long term. We believe that audit of these services, and the transparency and accountability that such an audit will bring, is crucial, and would urge the Committee to ask Scottish Government officials what plans it has in this regard.

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3 Cardiac Rehabilitation in Scotland April 2010 to March 2011 [http://www.isdscotland.org/Health-Topics/Heart-Disease/Publications/data-tables.asp](http://www.isdscotland.org/Health-Topics/Heart-Disease/Publications/data-tables.asp)
Treatment and care for people with heart failure

One of the consequences of the reduced numbers of people dying from heart disease is that larger numbers are living with heart failure. As noted in the report, there were 11,226 acute admissions for heart failure last year.

A crucial part of effective treatment for people with heart failure is the provision of community based specialist heart failure nursing services. The Scottish Government’s Better Heart Disease and Stroke Action plan acknowledged this, and these services were also a key feature of the clinical standards produced by NHS Quality Improvement Scotland.

Despite evidence of a rising prevalence of heart failure, we are concerned that numbers of Whole Time Equivalent specialist heart failure nurses appear to have fallen across the country.

In addition to the obvious concern that this will have a direct impact on the care provided to people with heart failure, an overly onerous workload for these nurses will restrict their opportunity to provide training to primary care staff in how to manage heart failure patients. This has two negative consequences: firstly, without adequate primary care management, the condition of individual patients is likely to our your staff deteriorate, with obviously adverse consequences. Secondly, this deterioration of patients’ conditions is likely to require more expensive treatment, possibly requiring an acute admission.

As noted in the report, a BHF funded evaluation of the role of the specialist heart failure nurse concluded that, in addition to improving the quality of life or heart failure patients, specialist nurses input resulted in a net saving of more than £1800 per patient.

We therefore would encourage the Committee to highlight to NHS Boards and the Scottish Government our view that providing sufficient numbers of specialist heart failure nurses is essential and should be regarded as a key priority.

Community resuscitation

Another area that we have highlighted in the past as being a key area for improvement, which can make a contribution to further improving Scotland’s heart disease survival rates is by increasing the proportion of people in the community who know how to respond appropriately when someone has a cardiac arrest. Figures for out of hospital cardiac arrest are especially difficult to obtain, but a study from the South East of Scotland has shown survival from out of hospital cardiac arrest to discharge from hospital may be less than 1%.

In Seattle USA cardiopulmonary resuscitation (CPR) has been taught for over thirty years within PE lessons at all schools funded by the city government. Over half of the population of Seattle and surrounding King County are now trained in CPR, and

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4 The development and impact of the British Heart Foundation at big lottery fund heart failure specialist nurse service in England. The University of York, 2008
survival rates for witnessed cardiac arrests amenable to defibrillation treatment were very high at 49 per cent in 2010\(^5\). We want to see all Scottish schools teaching Emergency Life Support skills (including CPR) as part of the Curriculum for Excellence.

Life-saving skills are particularly important in cases of cardiac arrest. It only takes a few minutes for irreversible brain damage to occur. Many people who might otherwise die can be saved if someone applies life-saving skills on the scene. For every minute that passes following a cardiac arrest before defibrillation chances of survival are reduced by around 10 per cent.

Life-saving skills are simple, and easy to teach and learn. They can be performed without any special medical knowledge. They take as little as two hours to teach, just 0.2% of a school year. In just two hours of their school life, children can learn the skills to save a life. Teachers can include life-saving skills in a range of different subjects including PE and Science.

We believe that substantially increasing the numbers of Scottish children who are taught Emergency Life Support skills at school represents excellent value for money, and provides a potential means of tackling the gap in premature mortality rates in Scotland compared to the rest of Western Europe.

Inequalities- ethnic and socio-economic deprivation

Explaining why ethnic inequalities exist between different groups in the UK is a complicated task. There are differences in genetic makeup as well as differences in cultural and social practices between ethnic groups that might influence their risk of developing cardiovascular disease. Known risk factors such as raised cholesterol, hypertension, obesity and diabetes differ between ethnic groups and the ways in which they combine to increase the probability of CVD also differ. Additionally, BMI measurements may not be the most appropriate means of measuring obesity in non-white populations. Finally, because large proportions of ethnic communities live in deprived parts of the country, it may be difficult to separate the impact of deprivation and ethnicity on premature mortality rates in these areas.

Currently, it is difficult to monitor such inequalities due to poor recording of ethnic status by NHS Scotland. Improvements in data collection and reporting are needed.

Similarly, explaining the causal link between deprivation levels and increased prevalence of and premature mortality from CVD, as well as the reported lower rates of revascularisation and use of other services for people from deprived groups, is challenging.

However, there are steps that could be taken in an attempt to mitigate these effects:

BHF Scotland wants to see tackling inequalities in heart disease integrated into the performance measures of the NHS, and explicitly reflected in the Quality and Outcomes Framework for GPs.

We also want to see a commitment that all new government policies and services should be subject to health equality impact assessments, requiring policymakers and service providers to explicitly take health inequalities into account.

BHF Scotland is committed to reducing inequalities in cardiovascular disease and has developed a work programme designed to target our services at the areas of highest need. Our Hearty Lives programme has included projects in Dundee, Fife and Ayrshire and Arran that we can provide more detail on request.