Thank you for your email of 27 June, inviting me to provide further evidence following the Public Audit Committee’s consideration of Audit Scotland’s report on cardiology services on 22 June.

Tackling health inequalities and the equitable provision of healthcare services continue to be major strands of the Healthcare Quality Strategy and I welcome the opportunity to provide the Committee with the additional information it has requested on our efforts to improve outcomes for people living with, or at risk of developing heart disease.

We recognise that tackling inequalities needs to be an integral part of our wider approach to addressing the social determinants of health. This includes the assets-based approach which our Chief Medical Officer is leading on. It also incorporates 'Good Places Better Health', Equally Well and Health Works strategy.

**Heart Disease Indicators**

The Committee asked for a copy of the key quality indicators on heart disease developed by Healthcare Improvement Scotland as part of their Heart Disease Improvement Programme. The Indicators can be found on page 28 of Healthcare Improvement Scotland’s National Overview Report “Take Heart”. A link to this report follows: [http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=4e26ff2c-d963-46e4-a237-445df75596f3&version=-1](http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=4e26ff2c-d963-46e4-a237-445df75596f3&version=-1)

We expect Healthcare Improvement Scotland to finalise these indicators with NHS Boards this year. In addition, NHS National Services Scotland’s Information Services Division (ISD) has been asked to help develop mechanisms that will support the routine collection of indicator data in a sustainable and proportionate way. We view the implementation of these indicators as a major step forward in allowing us to monitor the performance and quality of heart disease services in Scotland.

**GP Workforce Planning**

The Committee also asked about the GP-to-patient ratio in areas of deprivation, in view of concerns about the time available for GPs consultations in deprived areas. It is worth highlighting that the National Audit Office published a report on Healthcare across the UK on 29 June, which shows that Scotland’s ratio of GPs per 100,000 people is higher than every other UK country – 80 compared with 70 (England) and 65 (Northern Ireland and Wales). The report can be viewed via the following link: [http://www.nao.org.uk/publications/1213/healthcare_across_the_uk.aspx](http://www.nao.org.uk/publications/1213/healthcare_across_the_uk.aspx)

I would like to emphasise that NHS Boards have a legal duty to secure the provision of GP services to meet the reasonable needs of their patient populations. The vast majority of these services are provided by GP contractors, with NHS Boards being the contracting body. It is for the contract holders (GP partners) to determine the appropriate mix of GPs and other staff to meet patients’ needs and carry out their responsibilities under the contract.
There is also recognition of the additional needs of patients in areas of deprivation in the calculation of Scottish Government funding to GPs for the provision of core services. In other words there is weighting given to reflect deprivation, or morbidity and life circumstances.


The results from this survey are being used to support national, regional and local workforce planning in primary care over the next few years. They will also help to inform the structure and scope of a potential repeat survey within the next few years, and further complementary work to examine in more detail, the changing nature of the primary care workforce in Scotland.

**Access to Revascularisation – (Coronary Artery Bypass Graft (CABG) and Angioplasty)**

The Committee sought clarification of Exhibit 8, in Audit Scotland’s report which reviewed access to angioplasty services. As Dr Barry Vallance, the Scottish Government’s Lead Clinician on Heart Disease highlighted in his evidence to the Committee, people from deprived areas get access to far higher levels of revascularisation overall. There are however, two different patterns of access within Exhibit 8:

- **Access to emergency revascularisation** - Table 1 included in the Annex shows that men living in Scotland’s most deprived areas access emergency revascularisation services at almost double the rate (0.86/100,000) of men living in Scotland’s least deprived areas (0.45/100,000).
- **Access to routine revascularisation** – Table 2, also included in the Annex, shows that men living in Scotland’s most deprived areas access routine revascularisation services at an above average rate - 2.05/100/000 compared to 1.90/100,000.

People from deprived areas have a higher incidence of heart disease, which might suggest that they should have access to routine revascularisation more often than they currently do. We understand however, that people from deprived areas are more likely to delay before accessing healthcare services. As Audit Scotland’s report rightly points out:

“*People in more deprived areas were more likely to have a heart attack, less likely to reach hospital alive and more likely to die during the heart attack, therefore reducing the opportunity to receive hospital treatment.*”

As I noted in my earlier letter to the Committee, we are actively working to make sure people from deprived areas are aware of the risk factors and symptoms of cardiovascular disease, make sure they are diagnosed early and can access appropriate treatment as quickly as possible. Our Keep Well Programme is central to this approach.

**Keep Well**

The Committee asked for details of any previous or planned evaluation of Keep Well. Details of evaluations carried out so far are available on the NHS Health Scotland website at: [http://www.healthscotland.com/understanding/evaluation/programme/evaluation-%20KeepWell.aspx](http://www.healthscotland.com/understanding/evaluation/programme/evaluation-%20KeepWell.aspx)
The pilot phase tested Keep Well’s ability to: engage people living in deprived communities; identify previously undiagnosed disease; and explore with patients a range of clinical and non-clinical interventions to reduce their 10-year risk of having a Cardiovascular Disease (CVD) episode. Keep Well has demonstrated its ability to refer patients to appropriate services and medical treatments with a well-documented evidence base for reducing risk. These include:

- **Smoking Cessation** - A systematic review of 20 studies concluded that quitting smoking is associated with a 36% reduction in crude relative risk of mortality for patients with Coronary Heart Disease (CHD) who quit compared with those who continued smoking.
- **Statin Therapy** – The major statin trials show a 20% reduction in total cholesterol which is thought to yield around 30% CHD mortality benefit.
- **Hypertensive Therapy** - Trials of antihypertensive drugs show a similar relative reduction in CHD risk of 15-25% and reduction in ischaemic stroke risk of 30-40%.

The lessons that have emerged from the Keep Well pilot phase have been used to inform its mainstreaming, including guidance on target populations, methods of engagement and performance indicators. As part of the mainstreaming programme, Keep Well has been extended to specific populations, such as carers, homeless people, offenders, gypsy travellers and certain ethnic groups, who, as evidence suggests, are at increased risk of CVD and other health inequalities.

The clinical and non-clinical interventions used in Keep Well are designed to reduce an individual’s 10-year risk of CVD. Inevitably this means that the full benefits of Keep Well have not yet been quantified. We also know it will be difficult to isolate the effect that any single public health intervention (in this case Keep Well) has on changes in a population’s health status. We are confident however, that the approach embodied by Keep Well is the right one. The British Medical Association’s Scottish General Practitioner Council made clear in its response to the Keep Well consultation in 2010, that it is supportive of the additional resources being directed to improve services delivered to patients in our most deprived communities.

Keep Well is now operational in every territorial NHS Board and between March 2009 and June 2012, over 180,000 Keep Well health checks have been delivered across Scotland. During 2012-15, a series of interconnected studies will be undertaken to assess the impact of Keep Well – these include:

- an outcome analysis which will consider the impact of Keep Well on hospital discharges and mortality and prescribing of medication for key clinical conditions (i.e. hypertension, ischaemic heart disease and CVD) in Keep Well GP practices
- a local variability study examining key variations in programme implementation in different NHS Boards and the extent to which CVD prevention practice differs between Keep Well and non Keep Well practices

It is anticipated that the findings from these studies will be available by early summer 2014.

In the meantime we remain committed to our primary prevention programmes and expect that Keep Well will bring real and measurable improvements for people at risk of developing cardiovascular disease in Scotland.

I hope this additional information provides the Committee with some reassurance of our commitment to providing everyone in Scotland with access to world class health services, irrespective of where they live.

Yours sincerely,

DEREK FEELEY
Revascularisation rates - Emergency Admissions

Revascularisation rates - Routine Admissions

Source: NHS Scotland - Information Services Division