Cross-Party Group on Heart and Circulatory Diseases

Tuesday 26th September 2023, 6-7:30pm Minute

Present

MSPs

Alexander Stewart MSP
Colin Smyth MSP

Invited guests

Leeanne MacKlin, National Heart Disease Improvement Coordinator

Dr Clare Murphy, Consultant Cardiologist NHS Forth Valley

Richard Forsyth, Health and Care Lead, British Heart Foundation Scotland

Non-MSP Group Members

Emma Young, British Heart Foundation Scotland

Kym Kestell, British Heart Foundation Scotland

Jonathan Roden, British Heart Foundation Scotland

Ross McGeoch, Consultant Cardiologist NHS Lanarkshire

Lynn Stewart, Heart Research UK

Kerry Ritchie, The Alliance

Katie MacGregor, Stroke Association

Brian Forbes, Astra Zeneca

Mairi Morrison, Cruse Scotland

Sophie Bridger, Chest, Heart & Stroke Scotland

David Northridge, Scottish Cardiac Society

Apologies

Agenda item 1

Welcome and introductions & Minutes of last meeting

Colin Smyth MSP, welcomed members to the meeting.

Minutes from the last meeting on 29th March were agreed and are available on the Scottish Parliament website.

Agenda item 2

Topic Discussion: Heart Disease Action Plan Priority 2: Timely and equitable access to diagnosis, treatment and care

Leeanne MacKlin, *National Heart Disease Improvement Coordinator for the Scottish Government,* presented on some of the key highlights of the implementation of the Heart Disease Action Plan (HDAP) in year 2.

Leeanne started by highlighting work done to establish a digital diagnostic platform for heart failure through the Scottish Government's ANIA collaborative. She discussed the development of the platform through the OPERA clinical trial (see Dr Clare Murphy's input below). She noted that this work had been identified to go through the ANIA collaboration for national adoption.

Leeanne discussed the current ANIA process. She noted that an MDT project team had been established which undertook work to gather evidence and review the data (IMTO), led by the SHTG. The Service Adoption Readiness Assessment has been agreed at the Innovation Design Authority (IDA). Landscape mapping of all current clinical pathways for heart failure diagnostics across each of the 14 health boards has been completed. The national value case is in progress to go to the IDA in December.

The development of 5 national pathways was then discussed. These were for Heart Failure, Heart Valve Disease, Heart Rhythm Disorders, Acute Chest Pain and Inherited Cardiac Conditions. The pathways were developed involving clinicians from across Scotland and included input from Scottish Government, other key stakeholders and the Alliance's lived experience group.

Next, Leeanne discussed work to reestablish the National Cardiac Rehabilitation group. She noted the significant changes that have happened in cardiac rehab as a result of the Covid-19 pandemic and work has been undertaken to establish a baseline of these services (See Richard Forsyth's input below)

Work to establish virtual capacity and hospital at home services for patients with heart failure were then discussed. Following work by NHS GG&C and Forth Valley, there is a

national business case to which 11 health boards have submitted a proposal to establish these services.

Finally, Leanne discussed other highlights from the second year of the HDAP including the Recruitment of a Project Lead to take forward actions of priority one, embedding Cardiac cCBT withing health boards, the publication of the 1st reports from the Scottish Cardiac Audit Programme and the funding of 4 projects through a funding call on SCAD, fast track CTCA, Sudden Cardiac Death Coordinator and Heart Manual Training.

Dr Clare Murphy, *Consultant Cardiologist NHS Forth Valley*

Dr Murphy discussed HDAP work that is ongoing to improve the diagnosis of heart failure (HF). Scottish Heart Disease statistics show that the number of discharges from hospital with a diagnosis of heart failure continue to increase year on year.

- Despite evidence to diagnose & treat early, the diagnosis of HF in the hospital setting has **grown to around 80%**, a change from when it was historically diagnosed in a community setting.
- Those who are being diagnosed in hospital have often had symptoms for several years.
- Early diagnosis of HF is crucial. Evidence shows that treatment **reduces risk of HF hospitalisation and death after only 1-month**.
- A business case has been approved to provide a blood test in primary care that would support them to diagnose or rule out heart failure before referral.

To diagnose HF in the hospital setting, echocardiography is used. However, Echocardiography is labour-intensive and requires highly trained members of staff – of which there is a shortage across the UK. This has highlighted the need for efficient pathways to minimise diagnostic delays. Work is ongoing to look at how AI-assisted could increase the efficiency of diagnosis.

Dr Murphy then discussed the OPERA project, a study established in NHS Louisa Jordan during the pandemic. The study compared the use of AI-assisted echocardiograms alongside those performed by a human operator.

OPERA reduced echocardiography **waiting times from 12 months to <6 weeks** in NHS Greater Glasgow and Clyde to find out whether they had heart failure. This represented an 89% reduction in waiting time, increased the number of people tested by 9 times and represented a cost-effective solution.

This project was included in Scottish Government work around virtual capacity. But Dr Murphy stated that the NHS is not currently set up to provide care for heart failure as an impatient service, as it has traditionally been treated as an outpatient service.

In response to this NHS Forth Valley has had a successful business case to trial the use of virtual wards to provide an inpatient HF service. This allowed the service to see patients earlier and set up care for patients at home. This resulted in 25 bed days being released per week and positive feedback from patients.

Dr Murphy then described work that has been done to establish national HF pathways and the key priorities for HF in Scotland which include: inpatient and ambulatory care, early diagnosis, appropriate resource, digitally supported care, and education. She noted that applications have gone in to expand services to implement the service changes she has described and the hope is that this will be in place this winter. She noted the importance of work like this that looks at transformations of care where people are managed out with hospital, which has the potential to support the sustainability of care for the future.

Richard Forsyth, *Health and Care Lead, British Heart Foundation Scotland*

Richard began by noting his role as the chair of the national cardiac rehabilitation committee. He noted the commitment in the HDAP to ensure the needs of people with heart disease are met through ensuring equitable access to cardiac rehabilitation.

He then discussed work that has been undertaken to scope the service provision of cardiac rehab in Scotland – noting the last scoping exercise was done in 2014/15. Since then cardiac rehab services had undergone significant changes, not least due to the impact of Covid-19. This saw services change from in person courses lasting 8 to 12 weeks, to a hybrid model where patients are supported both in person, but also digitally.

To scope the current state of service provision, Richard noted the work undertaken to create a national scoping framework that would allow for a picture of the services across Scotland that would allow for prioritisation and service improvement. This framework was circulated to all 14 health boards and was completed by all.

The results of this process highlighted that while services were delivering a personalised hybrid programme, variance existed in referral and uptake of cardiac rehabilitation. Among the main barriers to increased uptake were workforce challenges, a reduction in clinical and gym space, inconsistent referral routes and patient knowledge of services. The work also highlighted gaps in MDTs and a lack of uniform approach to data collection and service audit.

From the work, Richard highlighted that planned next steps included: creating more localised services, addressing inequities in MDTs, addressing key workforce gaps and developing a national data framework. He also noted work by the BHF to create a consensus of terminology to ensure parity in access and delivery of services across the UK.

Agenda item 3

Discussion and questions

Q.1 Colin Smyth MSP: What does this mean for individual patients – what practical changes are we seeing due to those strands of work?

Leeanne MacKlin: We need to see efficient pathways as well as for patients to be diagnosed quickly. We need to strive for parity and equity as well as prioritizing the workforce. What is the training required to achieve these goals? With the cardiac rehab work things have changed dramatically and scoping has started to realize the sources required.

Ross McGeoch: Regarding whether this is going to make a difference on the ground. There has been a massive amount of engagement from the Cardiologist community but rather the difficulty is how we are going to implement it. When you look at resource allocation HDAP has 2.2 million and the cancer equivalent has 117 million. We could probably do a reasonable amount more with a higher allocation of funds. It is not enough to do the work for it to then sit on the shelf.

Q.2 Colin Smyth MSP: Are there specific timelines to roll out these successful pilots or is there a danger that you will see them in a report but won't see them in Dumfries e.g., despite the success you're having with them?

Dr. Clare Murphy: Yes, because there is never any money. The OPERA project was funded by AstraZeneca. We get told repeatedly that the patients will look different in different areas. For years, the team in Scotland has tried to demonstrate the evidence and benefit of having a Heart failure nurse team. We have rising hospitalization currently. Phenomenal interventions for heart disease and the patients live longer and develop heart failure but we do not have the resources to then look after them. We have now generated a problem with people who have care needs which are slightly different. I see a light at the tunnel through Hospital at home. We are constantly told to make sure there is a One for Scotland approach.

However, the health boards have their own local pressures and priorities. There is a colossal amount of people engaged. It is quite difficult to get to the money no matter how much you talk on spread and scale. Maybe it is possible through the Hospital at Home programme for as it is embedded, and we do have data. Maybe we can manage to get a little bit of money from the Health Secretary for models of care which have proven that they can get people out of hospitals. One of the biggest challenges around central funding is that it is always annual which impacts clinicians' ability to transform services.

Colin Smyth MSP: Thank you for talking about that, because that is exactly what the HDAP is about and finding the barriers. Also, like Richard has said it works best when services are tailored to a certain specific need, but it is also important to look at how everyone has access and can benefit from the delivery on the ground.

Q.3 Colin Smyth MSP: There are clearly barriers to upkeep. The delivery on the ground is not reaching as many people as it needs to reach is that a fair point to make?

Richard Forsyth: The pandemic made services to be structured more from the bottom up. I agree uptake has been pretty poor and that is what rehab is ultimately designed for. You could be holding people in a rehab program for 8-12 weeks who do not need to be, but instead the services need to be personalized. There are people with more complex needs. We have a more flexible program now than post-pandemic, so we hope to see the uptake figures increasing for people with these conditions.

Q.4 David Northridge: Why don't we use IT more to support staff in delivering the rehab services in Scotland?

Richard Forsyth: We need try to make it far more accessible. For example, something like virtual factsheets which you give to every single person and can fine tune. It is still quite early to tell how the hybrid models for rehab delivery work. We do struggle with a lack of data in cardiac rehab in Scotland. Hopefully, we will work on that going forward.

Q.5 Sophie Bridger: There is nowhere near enough data in fact. We have done some research over the summer because we could not get enough information on whether people were getting enough access to rehab. It is quite concerning we do not know how many people are accessing rehab. The second thing was around self-management that you build connections after the 8-12 weeks rehab to get people to self-manage.

Richard Forsyth: Over the last 10 years we tried to build a case for Scotland to be a part of the data audit programme, but there are many flaws as they measure things, but they cannot measure the things they should be measuring. It is not necessarily an outcome of what it should be. We can sit down with the services and Scottish government to see what should we be measuring and what does success look like? We are in a fortunate position that we can build our national audit programme around that.

Q.6 Jonathan Roden: What has changed since March 2021? What isn't captured in there? Are there any things that are not covered in there that are coming up for patients? We are seeing that the number of deaths is increasing, so are there things we can build upon in the future which aren't captured?

Leeanne MacKlin: You are right Jon there has been an increase in cardiovascular death since covid, but we need to recognize the fact that it is multifactorial. Multiple patients have not accessed their GP and care as pre-covid. We need to drill down that there is a significant increase but there are many reasons for that. There are longer waiting times than before, but there are other things in play there.

Ross McGeoch: There are increasing waits for standard stuff. You are waiting 33 weeks now to see a specialist. The waiting time has increased for general care. A lot of work that is done

at a regional level which is not driven by the taskforce. The Scottish Audit Programme might highlight that.

Final responses to any points raised tonight

Dr. Clare Murphy: There is a change in the communities in terms of care services which we are not addressing and are causing huge problems and challenges. A lot of mental health problems through the pandemic for staff. Trying everything you possibly can to deliver the best possible care and not knowing where to start with these long waiting lists. Recognising that the amount of work that has been done for the actual plan is phenomenal. To take forward the good stuff to get more people to continue the work and to keep going for it.

Richard Forsyth: How can we improve this going forward? A lot of people are passionate and positive to make progress. We now have quite a good strategic plan, so I think it is quite a positive time in the rehab space.

Colin Smyth MSP: There have been a number of clear messages on all the positive work that has been taking place across the country. Thanks everyone for coming.

Next meeting takes place **Tuesday the 12th of December 6-7.30pm** on Teams on priorities 3 and 4 (workforce and data).