Heart Disease Improvement Plan

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The Scottish Government
Riaghaltas na h-Alba

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Foreword

The Quality Strategy (2010) set out a vision for NHSScotland focusing on safe, effective and person-centred care. This vision is central to our approach to the Improvement Plans across clinical priority areas such as heart disease and stroke.

This Improvement Plan identifies and prioritises what we value. In developing these plans we recognise that we won't always immediately hit upon the perfect solution. What is important is that we all work together to develop what works best for the people of Scotland - that we strive for improvement through 'doing', 'trying' and 'testing', making sure that we continually build upon what works best for patients.

Those working at the frontline of clinical care and those who have personal experience of these health issues are the ones who best understand the problems and more importantly have the ideas on how to most effectively address them. It is important that in seeking to implement and deliver the key priorities set out in this Improvement Plan people feel supported and empowered to work creatively together to deliver better care.

It is also important that we continue to encourage networks which help to develop our collaborative infrastructure for improvement in Scotland and which ensure that the focus of care is truly person-centred. Indeed, we must also link this approach clearly to our commitment to provide high quality services to the growing number of people living longer with more than one condition.

I hope that other clinical areas can learn from the approach outlined within this plan and draw upon it to think about how patient care can be improved in their area, through an approach that is clear about our aims and about the role that each of us has in improving outcomes for patients.

I want to take this opportunity to thank everyone involved in improving patient care for your efforts to date and to ask you to continue those efforts to deliver even better outcomes and experiences for the people of Scotland.

Michael Matheson, MSP
Minister for Public Health

1. Introduction

Context

1. The Better Heart Disease and Stroke Care Action Plan, published by the Scottish Government in 2009 (http://www.scotland.gov.uk/Publications) affirmed heart disease and stroke as a continued priority for NHSScotland. The Plan set out a series of actions across both disease areas that required focus and attention from a variety of partners within the respective clinical communities.

2. Whilst excellent progress has and continues to be made we will always strive to do more to deliver the best possible health and social care and to ensure that the issues we are focusing on continue to reflect current needs.

3. The purpose of this Plan is to ensure that the priorities remain current and by reflecting the progress that has been made, build upon these successes to ensure that in Scotland we continue to strive towards improved prevention, treatment and care of heart disease.

4. NHSScotland is a world leader in quality improvement and patient safety. This document sets out plans to implement a quality improvement approach across our clinical priority areas.

Quality Strategy and the Route Map

5. The NHSScotland Quality Strategy (2010) (http://www.scotland.gov.uk) is, and remains, the blueprint for improving the quality of care that patients and carers receive from the NHS across Scotland. It sets out ambitions which acknowledge:

- Putting people at the heart of everything the health service does;
- A focus on providing the best possible care; and
- Recognition that real improvement in quality of care involves all staff, both clinical and non-clinical, working at all levels in all roles.

6. The publication of the Quality Strategy, with its ambition for world class health care, encourages us all to aim for services that at least match the best that can be found elsewhere in the world. The Quality Strategy remains our vision and the anchor point which we should continually reference as we move forward.

7. Building on the Quality Strategy and emphasising the continued commitment to pursuing the three Quality Ambitions of **Safe, Effective** and **Person-centred care**, the Route Map to the 2020 Vision for Health and Social Care (2013) (http://www.scotland.gov.uk) sets out a new and accelerated focus on 12 priority areas for action. The Route Map maintains the focus on improving quality at scale with regard to both health and social care. Working in partnership – across Scottish Government, with the wider public sector, the third sector, staff and with patients - has been crucial to our past successes and will remain so as we progress further in our ambition to deliver safe, effective and person-centred care. Annex 1 maps the Heart Disease Improvement Plan priorities against those in the Route Map.

Quality Improvement

8. The publication of this Improvement Plan marks an important milestone and further develops previous work. To support improvements in the quality of care we need to recognise where we have been and where we are going. In this context chapter 2 of this Plan provides a short summary of achievements since 2009. In developing this work, whilst recognising the continuity of effort, we also want to ensure a focus going forward on locally-led quality improvement.

9. Since 2013 the Scottish Government has been encouraging the use and implementation of the 3 Step Improvement Framework for Scotland's Public Services (http://www.scotland.gov.uk). This has been supported further by the publication of the Quality Improvement Hub document on 'the spread and sustainability of quality improvement in healthcare' (http://www.qihub.scot.nhs.uk) which identifies the factors that are vital to plan for at the onset of improvement work to optimise spread and sustainability. Further information on the resources available is provided in Annex 2.

10. This approach is not about developing something new but about unlocking and channelling the collective knowledge and energy of people towards a common goal of real and lasting improvement.

11. In line with this Framework chapter 3 of this Plan sets out clear aims and priorities for Heart Disease. The methodology of the 3 Step Improvement Framework is designed to prompt self-assessment and debate. It is about getting started and 'doing': creating conditions for and implementing the improvements that will make a difference. It is easy to become distracted by a series of assumptions based on how things have always been rather than try something new. It is about encouraging people to work together locally to test and try new approaches. And where successful, work with our national advisory structures to ensure that there is spread and sustainability of these approaches.

12. In developing this Improvement Plan we have taken a partnership approach – supported by our National Advisory Committee on Heart Disease (NACHD). Implementation of this work will depend on continued collaboration between all those involved.

13. All aspects of clinical care are important and matter to people living with specific conditions. Therefore, whilst the Plan focuses energy on specific areas for improvement, it is vital to recognise that many areas of activity which are not being highlighted, are nevertheless issues which will continue to require sustained effort to maintain and continuously improve outcomes for patients.

Network Approach

14. Managed Clinical Networks (MCNs) have a crucial role in the continued development of structures and services to help support and influence the quality improvement of care and are the key vehicle for the delivery of our improvement aims. We encourage Boards to ensure that their MCNs are fit for purpose with a lead clinician working with a network manager to provide strong clinical leadership.

15. MCNs also have a key role in promoting preventative action and tackling inequalities in collaboration with the Health Promoting Health Service (HPHS)

programme in hospitals. Access and use of health services is socially patterned with people living in socio-economic deprived areas and at risk of poor health more likely to use services than those living in affluent areas. Preventative action can be integrated within the scope of secondary care with the support of MCNs and influential clinical champions, ensuring pathways for health improvement are built into clinical care to encourage and support positive behaviours and increase access to support and health improvement services.

16. MCNs role in measuring and monitoring the progress of the Improvement Plan priorities is discussed in further detail in chapter 4. This will be supported nationally by the NACHD.

Person-centred Care

17. If care is to be truly person-centred then any improvement work must not just be about health issues but also about social care. Integration of health and social care is the Scottish Government's ambitious programme of reform to improve services for people who use these services and ensure that health and social care provision across Scotland is joined-up and seamless. This Improvement Plan includes priorities relating to living with the condition.

18. As the integration agenda progresses we are committed to ensuring that we work with patients to ensure that any forthcoming priorities reflect their needs. Person-centred care will also mean recognising that many people live with more than one condition, that is have multi-morbidities, and as we take this work forward we must endeavour to ensure a holistic approach to their care.

2. Heart Disease in Scotland

History and Progress to Date

19. Although coronary heart disease (CHD) is a largely preventable disease, there are approximately 8,000 deaths in Scotland each year (7,541 people in 2012) where CHD is the underlying cause. It is estimated that around 7.3% of men and 5.7% of women are living with CHD in Scotland (Scottish Health Survey 2012).

20. The disease is caused when the heart's blood vessels, the coronary arteries, become narrowed or blocked and cannot supply enough blood to the heart. Scotland has a high prevalence of the risk factors associated with heart disease such as smoking, poor diet and physical inactivity. Treating and preventing heart disease is a national clinical priority for Scotland.

21. The 2009 Better Heart Disease and Stroke Action Plan set out a series of actions across both disease areas that required focus and attention from a variety of partners within the respective clinical communities. In relation to Heart Disease, local Managed Clinical Networks (MCNs) were asked to take forward the actions identified.

22. As a result of variation across Scotland in the way which progress was reported, and some of the Actions being superseded by other developments, representatives from Heart Disease MCNs were invited to a national workshop in May 2011. The focus of this workshop was on how the outcomes in the Action Plan could be met, while recognising the challenges that NHS Boards faced. The process identified eight key priorities with corresponding ‘measurements of success’ reflecting the issues within heart disease at that time, but ensuring strong continuity with the original ethos behind the previous actions.

23. The MCNs have provided continual updates on progress to the NACHD in relation to the eight priority areas, thus providing the NACHD with the intelligence to focus national consideration and support as required.

24. Considerable progress has been made over recent years:

- NHSScotland reducing mortality rates from coronary heart disease by over 43% in the last 10 years (2003-2013).
- A decrease in the number of new cases of CHD (incidence) over the past decade. The age and sex standardised incidence rate decreased from 361.7 per 100,000 in 2003/04 to 262.8 in 2012/13, a decrease of 27.3%.
- For those admitted to hospital as an emergency with their first heart attack, the chances of surviving at least 30 days have improved over the last 10 years from 84.4% to 91.8%.
- A reduction in heart attack mortality rates in the most deprived areas faster than anywhere else. The percentage reduction in deaths in the most deprived category (37.6%) over the last 10 years is larger than that in the least deprived category (29.0%).

- A decrease in the overall costs of prescriptions dispensed for cardiovascular drugs in 2012/13 to £111.7 million, a reduction of 29.1% on the previous year. This is the lowest cost for these drugs over the last ten years (since 2003/04).

25. The Heart Disease agenda has been advanced by a number of initiatives which includes:

Optimal Reperfusion Service
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 with the NHS introducing services for patients with a heart attack in six regional centres across Scotland (Lothian, Golden Jubilee, Grampian, Lanarkshire, Tayside and Highland). In 2012 the British Cardiovascular Intervention Society reported that levels of access in Scotland were 1618 per million people compared to England (1423) and Wales (1363).

HEARTe - Heart Education Awareness Resource and Training through E-learning
Launched in November 2013 HEARTe is a free heart disease educational resource comprising 7 core modules aligned to the priorities detailed in the Better Heart Disease & Stroke Care Action Plan (2009). The resource can be accessed by health and social care professionals as well as patients, carers and other members of the general public. The success of the eLearning tool is evidenced not only by its use but also the detailed quantitative and qualitative data which is indicative of real and positive impacts for people in Scotland.

Improving Heart Failure Services: Heart Failure Hub
Heart Failure remains an identified priority area for improvement by the NACHD. This is reflected in the establishment of a Heart Failure Hub to take forward a national programme of work in relation to heart failure. The group brings together clinicians, managers, the voluntary sector and patients to ensure a co-ordinated approach to tackling the many challenges facing heart failure teams in NHS Boards across Scotland. The Heart Failure Hub is working with the Scottish Patient Safety Programme to improve reliable delivery of the Heart Failure Bundle which is a package of evidence based interventions and a key mechanism for improving the quality of care received by heart failure patients.

Resuscitation Rapid Response Unit – 3RU
In 2014 the Scottish Government provided £200,000 of funding to support the wider roll out of the 24/7 on scene resuscitation service – which specifically responds to patients in cardiac arrest. A joint project between the Scottish Ambulance Service and the Resuscitation Research Group at the University of Edinburgh the approach has significantly increased survivability rates for out of hospital cardiac arrests (OHCA) in Edinburgh. Piloted in Lothian it demonstrated improved survival rates for OHCA in the Edinburgh area of 33% in comparison with 15 – 20% in the rest of Scotland. The 3RU team - a small team of paramedics supported by doctors, nurses, dispatchers, medical students and a resuscitations officer - won emergency medicine team of the year at the British Medical Journal (BMJ) awards in 2014 for its lifesaving efforts.

Refreshing the Priorities

26. Given progress to date the NACHD took the opportunity to ensure that the existing priorities reflected current needs. Accordingly, a series of six national and regional workshops were held between August and October 2013, engaging with approximately 140 delegates from across the heart disease community. The workshops were designed to afford delegates the opportunity to influence future direction by determining the new actions within the refreshed priorities.

27. The initial outcomes of this work were submitted to the NACHD and presented in outline at the Heart Disease Learning Forum in November 2013. The proposed refreshed Heart Disease Improvement Plan continues to provide a strong thread of continuity with previous versions, while setting challenging but realistic actions to drive forward the future direction of heart disease across Scotland.

28. It was greatly reassuring to note the level of enthusiasm and engagement demonstrated throughout the national and regional workshops, which produced staggering amount of feedback and dynamic suggestions for taking forward heart disease in a manner that fundamentally underpins the quality ambitions. Following collation and review of this feedback, it is interesting to note, that although there were a few regional specific issues identified, on the whole, there was a surprisingly high level of consistency across Scotland.

29. The following chapter details the refreshed priorities and focus on future quality improvement activities.

3. Priorities

30. The Heart Disease Quality Improvement Plan 2014 identifies six priority areas for improvement linked by an overarching aim and underpinned by two common themes that are fundamental to success. Together, these contribute towards the prevention, detection, treatment and after care of heart disease and patients with heart disease. These priorities are summarised in Figure 1.

31. The Plan mainly focuses on those actions to be taken forward directly by local MCNs. However, there are also several significant national initiatives and programmes which require on-going support, energy and engagement of the heart disease community. Four of these national issues are highlighted below.

Congenital Heart Disease Services

Congenital heart anomalies remain the most common birth abnormality with an estimated incidence of approximately 1 in 145 live births. The range and complexity of cardiac problems are enormous. Fortunately, advances in paediatric cardiac surgery and catheter intervention has increased expected survival to greater than 80%, with the result that there is a new and growing group of adults living with congenital heart disease in addition to the paediatric population. Estimates in 2010 suggested there were more than 15,600 adults in Scotland living with congenital heart disease; in fact recent ISD data suggests that this figure may be an underestimate of the true disease burden with over 20,000 first admissions with congenital heart disease at all ages recorded between the years 1986 and 2009.

The Scottish Congenital Cardiac Network was nationally designated as a National Managed Clinical Network under the aegis of National Services Division (NSD) from April 2013. This Network was established to promote the improvement of services for children and adults with congenital heart disease; co-ordinate pan-Scotland planning with NHS Boards, Regional Planning Groups, clinicians and patient representatives; and support the continued provision of safe and sustainable paediatric and adult congenital cardiac services across Scotland. The Network works closely with the Paediatric Cardiac Service (which is due to move from Yorkhill to the new South Glasgow Hospitals Campus in summer 2015) and the Scottish Adult Congenital Cardiac Service (the specialist tertiary service based at the Golden Jubilee).

For the majority of adult congenital cardiac patients, emergency treatment of acute cardiac and non-cardiac illness and obstetric care will take place in their local hospital. The challenge is to ensure local services and people with congenital cardiac conditions are able to access high-quality specialist congenital cardiac care when needed, but have effective shared care arrangements for the treatment and management of non-complex conditions. The aim therefore is a networked approach which facilitates local flexibility and the delivery of safe care close to the patient's home.

Out of Hospital Cardiac Arrest (OHCA)

Surviving an out of hospital cardiac arrest depends on a series of events occurring seamlessly - the 'chain of survival'. This includes prompt recognition of the cardiac arrest and calling for help; early, effective cardiopulmonary resuscitation (CPR), early defibrillation to restart the heart; rapid access to advanced resuscitation skills (e.g.

cooling therapy) for those requiring further resuscitation and the best possible post resuscitation care in hospital to allow the heart and brain to recover from the damage.

By building on current best practice – such as the joint project between the Scottish Ambulance Service and the Resuscitation Research Group to increase survivability rates for out of hospital cardiac arrests in Edinburgh; and the work of the British Heart Foundation, Chest Heart & Stroke Scotland and other third sector organisations, particularly in relation to cardiopulmonary resuscitation (CPR) - there is a real opportunity to improve Scotland's approach to out of hospital cardiac arrest. The Scottish Government is currently considering how best to take forward this goal.

Familial Arrhythmia Network of Scotland (FANS)

Familial arrhythmias are inherited conditions which cause instability of the heart's rhythm. These conditions can show themselves as life threatening heart rhythm disturbances, the medical term for which is 'arrhythmia'. People with these conditions usually have no symptoms until they are young adults. The first symptom of the condition may be sudden death from a life-threatening arrhythmia, an event called Sudden Arrhythmic Death Syndrome (SADS). During life, these conditions can be difficult to diagnose as they do not cause any obvious structural changes to the heart. It is important for a diagnosis to be made quickly so that family members can be screened for the condition. There are effective therapies available that can prevent SADS and allow affected individuals to lead a normal life.

The Familial Arrhythmia Network of Scotland (FANS) is a Scotland-wide managed clinical network set up to improve the diagnosis and care for individuals and their families affected by familial arrhythmia. The Network was officially launched in February 2010.

The proper care of arrhythmias requires the involvement of many healthcare care professionals including cardiologists, geneticists, counsellors, GPs, specialist nurses, paediatricians and pathologists. FANS was formed to bring together the expertise of this wide range of clinicians from all over the country, to work together with patient representatives to streamline standards of care in Scotland, ensuring best clinical practice is achieved for all familial arrhythmia patients and their families. The Network aims to improve services offered to those affected, allowing them to access appropriate treatments in a timely manner.

Transcatheter Aortic Valve Implantation (TAVI)

Aortic stenosis affects around 3% of the population aged over 75. The most effective treatment is to replace the valve through open heart surgery. Approximately 900 such operations are preformed every year. Since 2012 people too ill to undergo open heart surgery, have been able to have a specialist operation at the Royal Infirmary of Edinburgh. Transcatheter aortic valve implantation (TAVI) is a relatively new non-invasive treatment for aortic stenosis If a person is either too unwell for open heart surgery, or their heart and vessels are not suitable for aortic valve replacement, TAVI can be offered as an alternative treatment option. The procedure is less invasive, as a replacement valve is passed through a hole in the groin and advanced up to the ascending aorta of the patient. Between October 2012 and January 2014, 75 patients were treated by the Edinburgh team.

Figure 1 Heart Disease in Scotland: Priorities for Improvement

Heart Disease in Scotland: Priorities for Improvement

AIM: To improve the experience and clinical outcomes for patients living with heart disease across Scotland by supporting the community to adopt a seamless approach to the delivery of care.

Prevention of Cardiovascular Disease	Mental Health for Heart Disease
To champion focused work on inequalities and people at high risk of developing cardiovascular disease	To improve wellbeing for patients with heart disease and reduce risk of further clinical deterioration

Secondary and Tertiary Care Cardiology	Heart Disease Management and Rehabilitation
To ensure patients with heart disease receive the right investigation and treatment, administered by skilled staff in a timely, equitable and evidence based manner	To support patients with heart disease to live longer, healthier and independent lives

Heart Failure	Arrhythmias
To improve journey of care for patients with heart failure by developing a whole system approach to the delivery of care	To improve the journey of care for patients with arrhythmias by developing a whole system approach to the delivery of care

Underpinned by:

Patient Information and Engagement	To ensure patients and carers have the opportunity to be equal partners in the review, development and delivery of care
Heart Disease Data	To deliver high quality data to facilitate open review, discussion, learning and action planning

Priority 1: Prevention of Cardiovascular Disease

Aim: To champion focused work on inequalities and people at high risk of developing cardiovascular disease.

Background: Primary prevention of cardiovascular disease is now widely established and mainstreamed within the work programmes of NHS Boards Health Promotion and Improvement Departments. NHS Boards are developing health promotion programmes that are sensitive to inequalities based on social deprivation. The Health Promoting Health Service (HPHS) is one such example. Prevention lies at the heart of HPHS policy as it is about promoting healthier behaviours and discouraging detrimental ones, by ensuring that healthier choices are the easier ones and that appropriate support systems are in place to encourage and re-enforce these choices. HPHS is transformative in its mission to bring preventative action to the fore and actively change the culture of the hospitals to help support this. A Ministerial and non–executive director champion groups have been established to help take forward the actions as described in the HPHS 01(2012) letter to NHS Boards Chief executives. HPHS in collaboration with MCNs can integrate preventative action within the scope of secondary care, ensuring pathways for health improvement are built into clinical care to encourage and support positive behaviours and increase access to support and health improvement services.

Consideration is being given to socially deprived populations not accessing treatment with programmes targeting communities to encourage families to be 'healthy together' i.e. physical activity/diet/smoking/alcohol. However, there remain issues in relation to very specific groups at high risk of developing cardiovascular disease and it is, therefore, considered appropriate for Heart Disease Networks to provide a more focused approach within this area.

Actions:

1. HD MCNs should champion health improvement work, with a focus on inequalities, specifically targeting case finding strategies for people at high risk of developing cardiovascular disease.

2. The HPHS 01 (2012) explicitly states the crucial role of MCNs in championing preventative action and engaging the workforce to deliver on this with a focus on inequalities. Access and use of health services is socially patterned with people living in socio-economic deprived circumstances and at risk of poor health, are more likely to use services than those living in affluent areas. Competing priorities and a focus on clinical aspects has meant that there has been limited engagement with MCNs on this agenda but serious action now needs to be taken to integrate anticipatory care into routine practice.

Priority 2: Mental Health for Heart Disease

Aim: To improve wellbeing for patients with heart disease and reduce risk of further clinical deterioration.

Background: Although there has been significant progress over the past few years in relation to identification and intervention for people with established CHD affected by anxiety and depression, services are still patchy across Scotland with some areas struggling to access services for patients within reasonable timescales. There is also a general lack of awareness and understanding of the impact mental health has on both the individual with heart disease and the healthcare system. However, evidence to support this approach has increased in recent years, identifying that prevalence of mental health within this patient group is becoming significant with associated impact on patient morbidity and mortality leading to increased usage of the healthcare system. It is also highly relevant to note that mental health is now acknowledged as an independent risk factor for cardiovascular disease. In addition, it has been identified that having a diagnosis of heart disease make the individual more at risk of experiencing mental health problems which in turn increases the risk of further cardiac events.

Actions:

1. Develop a mental health pathway for patients with heart disease.

2. Deliver level 1 and 2 psychological support training to generic and specialist staff respectively.

Priority 3: Secondary and Tertiary Care Cardiology

Aim: To ensure patients with heart disease (including congenital heart disease) receive the right investigation and treatment, administered by skilled staff in a timely, equitable and evidence based manner.

Background: Significant progress has been made by NHS Boards, Regional Planning Groups and Scottish Ambulance Service over the past 12 years in relation to immediate treatment and intervention for patients with ST Elevated myocardial infarction. As such, it is considered time to expand the parameters of the priority to encompass wider aspects of the management of all patients with heart disease, whether this is congenital or acquired, within the hospitals in-patient and out-patient setting. The new actions outlined below provide continuity by ensuring ongoing quality improvement in relation to management of acute coronary syndromes but also expands into other areas of acute cardiac care and the ongoing monitoring and management of life-long conditions, whilst moving focus towards continuity across regions.

Actions:

1. Improved patient-centred flow into, through, between and out of hospital for patients with chest pain.

2. Develop local and regional pathways including strategy for cardiac investigation and intervention.

3. Develop clear diagnostic and treatment pathways for patients with valvular heart disease.

Priority 4: Heart Disease Management and Rehabilitation

Aim: To support patients with heart disease to live longer, healthier and independent lives.

Background: Cardiac Rehabilitation services are very well established across Scotland with all areas providing full menu based programme incorporating educational sessions to meet the individual needs of patients. However, several NHS Board areas are experiencing capacity issues due to finite resources. In many areas this has led to limited capacity to accommodate the needs of patients with congenital disease and acquired heart failure, angina and ICDs. Consequently, it is considered time that CR services were modernised around the patient with the aims of the priority expanded to include long-term management of patients via anticipatory care planning and good self management strategies.

Actions:

1. Modernise cardiac rehabilitation services.

2. Develop anticipatory care programmes for patients with heart disease.

3. Develop condition and wellbeing self-management programmes for patients with heart disease.

Priority 5: Heart Failure

Aim: To improve the journey of care for patients with heart failure by developing a whole system approach to the delivery of care.

Background: Heart Failure services are generally progressing well across Scotland despite some residual difficulties in relation to resources. However, as the incidence of heart failure rises in line with the aging population the impact on individuals and the healthcare system is becoming increasingly problematic. Improvement in the quality of care and implementation of readily accessible treatment throughout the patient journey would greatly increase patients' quality of life with associated efficiencies for healthcare system.

In addition, there is an increasing body of evidence that patients with heart failure have similar or worse symptoms burden, morbidity and mortality compared to patients with cancer. Patients with cancer have well developed, formalised palliative care services provided by appropriately trained staff to address their needs. Despite the obvious equivalent need, patients with heart failure do not. There is clear national and international policy and guidelines all stating that palliative care should be provided for patients with advanced disease including heart failure. Although many areas around Scotland are now making significant progress in relation to developing palliative care and anticipatory care planning for patients with heart failure, we still have a long way to go.

Actions:

1. Improve identification, diagnosis and long-term management of patients with heart failure.

2. Improve patient centred flow into, through, between and out of hospital.

3. Develop palliative care pathway for patients with heart failure.

Priority 6: Arrhythmias

Aim: To improve the journey of care for patients with arrhythmias by developing a whole system approach to the delivery of care.

Background: Heart Disease Networks are making progress in relation to improving management of patients with arrhythmias but in many areas this work remains at the early stages of development. Consequently, future actions seek to provide a continued focus on improving the management of atrial fibrillation as a long term condition, again, underlining the importance of developing seamless whole system services. In addition, the priority has been expanded to take cognisance of other arrhythmia conditions and the more advanced therapies including implantable devices.

Actions:

1. Improve identification, diagnosis and long-term management of patients with atrial fibrillation.

2. Improve patient centred flow into, through, between and out of hospital for patients with arrhythmias.

3. Develop pathways for the identification and treatment of patients at risk of familial arrhythmia conditions.

Underpinning Themes

In addition to the six priorities, NHS Board HD Networks should continue to address the core principles of MCNs. In particular, the following areas should underpin the Heart Disease Improvement Framework and the work on each individual priority:

Patient Information and Engagement

Aim: To ensure patients and carers have the opportunity to be equal partners in the review, development and delivery of care.

Actions: NHS Boards HD MCNs should have a:

1. Patient information strategy
2. Patient and carer engagement strategy
3. Annual programme to capture patient feedback in relation to satisfaction and experience

Heart Disease Data

Aim: To deliver high quality data to facilitate open review, discussion, learning and action planning.

Actions: NHS Board HD MCNs should have:

1. A process to review HIS HD Indicators 1-3, (mortality for myocardial infraction and congestive cardiac failure, length of stay and readmission to hospital).
2. A process to collate and review local data in relation to HIS Indicator 4 which is the indictor for quality improvement.

4. Measuring and Monitoring

32. There are already established processes in place that are embedded in the Heart Disease community around monitoring and reporting. Work will continue to ensure that patient outcome measurements are available, to ensure that NHS Boards and MCNs have the appropriate quality improvement information to enable them to measure success against the priorities.

33. The Heart Disease Improvement Plan Co-ordinator, along with the Scottish Government will continue to work closely with, and support Heart Disease MCNs to ensure that the priorities set out in this improvement plan, and wider Heart Disease work, are implemented and monitored.

Board and Heart Disease MCNs Responsibility

34. Heart Disease MCNs are encouraged to develop local improvement plans. As in previous years Heart Disease MCNs, along with their Boards, will be asked to undertake and submit annual self-assessments against the Improvement Plan priorities, and share good practice nationally. These will be assessed by the Improvement Plan Co-ordinator and reported to NACHD who will ensure that MCNs are meeting the priorities, as agreed, and take any necessary action. The Improvement Plan Co-ordinator will be able to offer support to MCNs. The NACHD will if needed highlight any issues of concern with the relevant MCN and in time raise with the Scottish Government if the concerns remain unaddressed. The NACHD does not propose to be prescriptive in terms of annual focus, however, it will seek to be reassured that each Network has a feasible plan to progress the priorities of the improvement plan.

5. Next Steps

35. This Improvement Plan sets out our continued ambition to deliver world-leading health and social care which is person - centred, clinically effective and safe.

36. Although much progress has been made we must always seek to increase the pace and scale of improvement.

37. The Plan identifies the key priorities and sets out why these issues are important. It identifies the key actions which if delivered will contribute towards improvement. The Plan also emphasizes the importance of being able to measure the impact of what we do and thereby demonstrate that change has happened.

38. This approach is about bringing together our collective knowledge and experience to make improvements. An approach which encourages people to test and try new approaches. And to ensure that we seek to spread and to sustain what works.

39. All those with a vested interest, across all levels and roles, have an important part to play in this improvement work. It is by working together, learning together and sharing that we will deliver improvements.

40. We also seek to actively engage with people to identify the issues that are important to them in living with their conditions.

41. We must ensure that the priorities remain current and by reflecting the progress that has been made, build upon these successes to ensure that in Scotland we continue to strive towards improved prevention, treatment and care for all.

Annex 1 – 2020 Route Map for Heart Disease in Scotland

Triple Aim:	Quality of Care						Health of the Population			Value and Sustainability		
HEARTH DISEASE IMPROVEMENT PLAN 2014 Delivering the 2020 Vision for Health & Social Care	Person Centred Care	Safe Care	Primary Care	Unscheduled & Emergency Care	Integrated Care	Care for Multiple & Chronic Illnesses	Early Years	Health Inequalities	Prevention	Workforce	Innovation	Efficiency & Productivity
Priority 1: Prevention of Cardiovascular Disease												
Target case finding strategies for people at high risk of CVD	■	■	■	■	■				■			
Priority 2: Mental Health for Heart Disease												
Develop a mental health pathway for patients with heart disease	■	■	■	■	■	■						
Deliver level 1 & 2 psychological support training	■	■				■				■		
Priority 3: Secondary and Tertiary Care Cardiology												
Improved patient-centred flow into, through, between and out of hospital for patients with chest pain	■	■		■	■	■						■
Develop local and regional pathways including strategy for cardiac investigation and intervention	■	■		■	■	■				■		■
Develop clear diagnostic and treatment pathway for patients with valvular disease	■	■				■						
Priority 4: Heart Disease Management and Rehabilitation												
Modernisation of cardiac rehabilitation services	■	■			■	■				■	■	■
Develop anticipatory care programmes for patients with heart disease	■	■	■	■	■	■						
Develop condition and wellbeing self-management programmes for patients with heart disease	■	■			■	■						
Priority 5: Heart Failure												
Improve identification, diagnosis and long-term management of patients with heart failure	■	■	■	■	■	■						
Improve patient centred flow into, through, between and out of hospital	■	■		■	■	■						■
Develop palliative care pathway for patients with heart failure	■	■			■	■						
Priority 6: Arrhythmias												
Improve identification, diagnosis and long-term management of patients with atrial fibrillation	■	■	■	■	■	■			■			
Improve patient centred flow into, through, between and out of hospital	■	■		■	■	■						■
Develop pathways for the identification and treatment of patients at risk of familial arrhythmia conditions	■	■				■			■			

Annex 2 – Resources and References

Better Heart Disease and Stroke Care Action Plan (June 2009)
http://www.scotland.gov.uk/Publications/2009/06/29102453/11

ISD Scotland - Heart Disease
http://www.isdscotland.org/Health-Topics/Heart-Disease

Healthcare Improvement Scotland - Heart disease service improvement
http://www.healthcareimprovementscotland.org/our_work/cardiovascular_disease/heart_disease_services.aspx

Priority 1: Prevention of Cardiovascular Disease

- SIGN 97: Risk estimation and the prevention of cardiovascular disease (February 2007)
- NICE clinical guideline 71: Familial hypercholesterolaemia (August 2008)
- Healthcare Improvement Scotland Clinical Standards: Heart Disease (April 2010)
- NICE clinical guideline 127: Hypertension (August 2011)
- CEL 01 (2012): Health Promoting Health Service: Action in Hospital Settings
- The Scottish Government: Equally Well Review (June 2013)
- Woodward M, Brindle P, Tunstall-Pedoe H. Adding social deprivation and family history to cardiovascular risk assessment? The ASSIGN score from the Scottish Heart Health Extended Cohort (SHHEC). Heart. 2006

Priority 2: Mental Health for Heart Disease

- Newhouse A, Jiang W. Heart Failure and Depression. Elsevier Inc 2014

Priority 3: Secondary and Tertiary Care Cardiology

- SIGN 96: Management of stable angina (February 2007)
- Healthcare Improvement Scotland Clinical Standards: Heart Disease (April 2010)
- Audit Scotland: Cardiology Services (February 2012)
- ESC/EACTS Guidelines on the management of valvular heart disease (version 2012)
- SIGN 93: Acute coronary syndrome (February 2013)

Priority 4: Heart Disease Management and Rehabilitation

- SIGN 57: Cardiac Rehabilitation (January 2002)
- Healthcare Improvement Scotland Clinical Standards: Heart Disease (April 2010)
- The BACPR Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation (2012)

Priority 5: Heart Failure

- SIGN 95: Management of chronic heart failure (February 2007)
- Scottish Partnership for Palliative Care - Living and dying with advanced heart failure: a palliative care approach (2008)
- Healthcare Improvement Scotland Clinical Standards: Heart Disease (April 2010)
- NICE clinical guideline 108: Chronic heart failure (August 2010)
- ESC Guideline for the diagnosis and treatment of acute and chronic heart failure (2012)
- ESC Guideline on cardiac pacing and cardiac resynchronization therapy (2013)

Priority 6: Arrhythmias

- SIGN 94: Cardiac arrhythmias in coronary heart disease (February 2007)
- Healthcare Improvement Scotland Clinical Standards: Heart Disease (April 2010)
- SIGN Prevention of stroke in patients with atrial fibrillation: A guide for primary care (January 2014)
- ESC Guideline for the management of atrial fibrillation (2010)
- ESC Guideline on cardiac pacing and cardiac resynchronization therapy (2013)

Policy Context

Route Map to the 2020 Vision for Health and Social Care (May 2013)
http://www.scotland.gov.uk/Resource/0042/00423188.pdf

The Healthcare Quality Strategy for NHSScotland (May 2010)
http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf

The 3-Step Improvement Framework for Scotland's Public Services (November 2013)
http://www.scotland.gov.uk/Resource/0042/00426552.pdf

2020 Framework for Quality, Efficiency and Value (June 2014)
http://www.qihub.scot.nhs.uk/media/607430/2020framework_12062014_final.pdf

Everyone Matters: 2020 Workforce Vision: Implementation framework and plan 2014-15 (Dec 2013)
http://www.workforcevision.scot.nhs.uk/wp-content/uploads/2013/12/Implementation-Plan.pdf

Health Inequalities in Scotland (Audit Scotland, December 2012)
http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf

Making it Easy: A Health Literacy Action Plan for Scotland (June 2014)
http://www.scotland.gov.uk/Resource/0045/00451263.pdf

Preventing overweight and obesity route map (February 2010)
http://www.scotland.gov.uk/Resource/Doc/302783/0094795.pdf

Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland (March 2013)
http://www.scotland.gov.uk/Resource/0041/00417331.pdf

Useful Websites

NHSScotland Quality Improvement Hub
http://www.qihub.scot.nhs.uk

Scottish Patient Safety Programme (SPSP)
http://www.scottishpatientsafetyprogramme.scot.nhs.uk

Person Centred Care resources – QI Hub
http://www.qihub.scot.nhs.uk/person-centred.aspx

Everyone Matters: 2020 Workforce Vision
http://www.workforcevision.scot.nhs.uk

The ALISS Project - Accessing Local Information to Support Self management
http://www.aliss.scot.nhs.uk

The Health Foundation
http://www.health.org.uk

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