Heart Disease Action Plan 2021 survey
Please see below for comments to be pasted into boxes for Addition A, B, & C

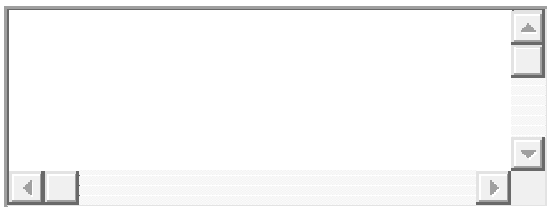
Scottish Government is working to refresh its Heart Disease Improvement Plan (2014). A draft document was attached to the email inviting you to take part in this survey.
We would like to invite you to give us feedback on the draft to ensure that we have identified the correct priorities and actions to address heart disease in Scotland.

Do you think that we have identified the correct priorities within the draft Heart Disease Action Plan?

- Yes, I think all of the priorities identified are correct.
- No, I think that one or more of the priorities are incorrect
- No, I think that an important priority is missing.
- Other

Please let us know any comments you have about the priorities identified within the plan

Addition A: see below

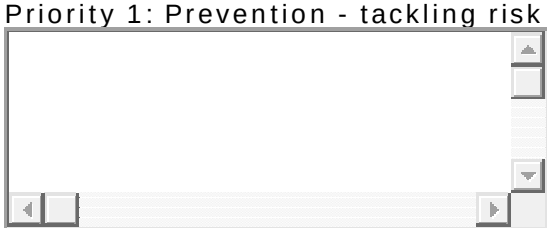

0/4000

Overall, what is your opinion on the actions set out under Priority 1: Prevention - tackling risk factors

- I agree with all of the actions identified
- I agree with some of the actions identified, but not all
- I disagree with all of the actions identified

Addition B: see below

Please let us know any thoughts you have on the actions identified within Priority 1: Prevention - tackling risk factors


0/4000

Overall, what is your opinion on the actions set out under Priority 2: Timely and equitable access to diagnosis, treatment and care

- I agree with all of the actions identified
- I agree with some of the actions identified, but not all
- I disagree with all of the actions identified
- Other

Please let us know any thoughts you have on the actions identified within Priority 2: Timely and equitable access to diagnosis, treatment and care

0/4000

Overall, what is your opinion on the actions outlined in Priority 3: Workforce

- I agree with all of the actions identified
- I agree with some of the actions identified, but not all
- I disagree with all of the actions identified
- Other

Please let us know any thoughts you have on the actions identified within Priority 3: Workforce

Addition C see below

0/4000

Overall, what is your opinion on the actions identified within Priority 4: Effective use of data

- I agree with all of the actions identified
- I agree with some of the actions identified, but not all
- I disagree with all of the actions identified
- Other

Please let us know any thoughts you have on the actions identified within Priority 4: Effective use of data

0/4000

To help us understand the range of responses to this survey, it's helpful for us to have some background information. Are you

- [ ] A healthcare professional
- [ ] Someone with lived experience of heart disease
- [ ] A carer for someone with heart disease
- [ ] A member of the National Advisory Committee on Heart Disease
- [ ] Other– Learned Society, including healthcare professionals

Text for comment boxes

Addition A:

The Society supports the overall vision and priorities. Our response recognises, and focuses on, the huge benefits that could be achieved by effectively supporting Priority 1. We have highlighted some areas for development, including broadening the scope and reach of the prevention priority, and ensuring that Priority 1 generates quality indicators that are the responsibility of the National Advisory Committee on Heart Disease to review, learn from and refine on the basis of the evidence generated. Variations in detection and management of hypertension and hyperlipidaemia may provide valuable learning from which to improve care pathways.

The Society also feels that there should be an integrated approach linking primary and secondary care for people with cardiovascular risk factors. This vision recognises the central role of primary care but not the key roles played in diabetes (by diabetologists), hypertension (clinics run in the Scottish centres by clinical pharmacologists) and complex lipid problems, including familial hypercholesterolaemia (by lipid specialists).

We would also point out the key role played by clinical pharmacologists in supporting high quality and cost-effective prescribing (at drug and therapeutics and Scottish Medicines Consortium. Clearly other healthcare professionals such as pharmacists may play an important role in quality prescribing and hypertension detection. All of these groups will play a key role in successfully delivering the vision.

We strongly urge the Scottish Government to use the opportunity provided by this review to tackle the biggest and most important challenge to Scottish heart health, which is the prevention of heart attacks and strokes, using robust preventative approaches linked to the detection, diagnosis and effective treatment of hypertension and lipid disorders.

Addition B:

Prevention

The Society strongly supports the main focus on prevention as outlined by priority 1. Prevention, by improving detection and treatment, is both cost-effective and better for patients' quality of life than treating the effects of heart disease. Indeed, prevention of hypertension reduces the risk of developing atrial fibrillation (AF), strokes, heart attacks, kidney failure and so limits the limits the risk of patient We recognise that public health approaches to lifestyle optimisation are not within the remit of this report but would welcome opportunities for preventative approaches to support and interact with them.

Building on this, and recognising that inequalities start early, child health should be a priority. A 'prevention first' approach would help address the impact of health inequalities that are rightly recognised in the strategy.

Tele-monitoring

Telemedicine and digital tools are important advances in which Scotland has played a world-leading role. The Scale-Up BP project in Edinburgh, now rolling out much more widely is beginning to make a real difference to the detection and management of people with high blood pressure and providing a higher degree of engagement and empowerment of people in managing their own care. This seems to have strong support from patients and from primary care. We would argue that that this project should now be rolled out to the secondary care hypertension services so that more empowerment is provided and more can be done in working with patients without the need for them to attend a primary or secondary care setting to optimise management and reach target blood pressure.

Whilst we recognise the enormous value of remote management (especially in the setting of the COVID-19 pandemic), we believe that this should be additional funding for research

in this area, to ensure that optimal systems of communication are developed, and that the benefits of remote management can be quantified.

In addition, these new models of care have a clear risk of increasing health inequalities: for the elderly and those with sensory deficits who may struggle with the technology. It will be important to consider the role of other ways to detect high blood pressure for these individuals, such as through support from use of pharmacy services to measure blood pressure, so that no one is excluded from the benefits of blood pressure lowering.

Addressing the Actions specifically:

Action 1:
Whilst identifying hypercholesterolaemia is relatively easy, it will be important to support the regional work done to identify genetic causes of high cholesterol; most importantly heterozygous familial hypercholesterolaemia, which takes many years off some people's lives.

Measuring blood pressure (BP) reliably is not so straightforward. It will be crucial to use reliable methods, such as home BP measurement, automated office BP measurement (and ambulatory BP measurement). Hasty measurements or those made in busy, noisy community environments will not serve to reliably identify people with hypertension.

Action 2:
We fully support Action 2.

Action 3:
It would be unwise to think that the current technology is state-of-the-art (see tele-monitoring above). This technology needs further refinement and technological improvement to offer clinicians and patients the best opportunity to work together to reduce BP.

Addition C:

The workforce exists in primary and secondary care to manage hypertension, but it is important to recognise that the specialist hypertension centres working with primary care in Aberdeen, Dundee, Edinburgh and Glasgow are run by clinical pharmacologists, not cardiologists. These teams manage patients with complex hypertension, provide guidelines for management of hypertension in primary care, and support optimal prescribing practice through formulary committees, drug & therapeutics committees and the Scottish Medicines Consortium. The Plan might be a good opportunity to realise the benefits of rational and evidence-based prescribing. This would ensure equity and ultimately be more cost-efficient. Services provided by clinical pharmacologists can and do support these aims.

There is also a need to enhance prescribing skills and medicines management – both by an urgent need to secure investment in clinical pharmacology as a specialty (training and consultant posts) and through expansion of prescribing education and training: the whole workforce should be upskilled in the use of medicines.