Written evidence submitted by the British Pharmacological Society to the British Heart Foundation's consultation on "Heart Disease in Scotland"

Consultation link: https://www.bhf.org.uk/scotheartplan

About us

The British Pharmacological Society (BPS) is the primary UK learned society concerned with research into drugs and the way they work. The Society has around 4,000 members working in academia, industry, regulatory agencies and the health services, and many are medically qualified. The Society covers the whole spectrum of pharmacology, including laboratory, clinical, and toxicological aspects. The science of pharmacology is essential for the development and testing of medicines, and for their adoption in clinical practice. Teaching and research in pharmacology are crucial to a thriving pharmaceutical and biotechnology industry in the UK. Members of the Society identify therapeutic areas of clinical need, develop novel treatments that target these areas and ensure these new treatments are incorporated into healthcare practice bringing benefit to patients. The Society publishes three scientific journals: the British Journal of Pharmacology, the British Journal of Clinical Pharmacology, and, in collaboration with the American Society for Pharmacology and Experimental Therapeutics, Pharmacology Research and Perspectives.

Consultation questions

1. Do you agree with the vision set out by this plan?

Yes
No
Don't know

The Society supports the overall vision and priorities. Our response recognises, and focus 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 does not seem to appreciate 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 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 have focused our response on Priority 1 and on consultation questions 1-6.

2. Do you think the plan identifies the most important priorities relating to heart disease in Scotland?

Yes
No

Don't know

Prevention
The Society strongly supports the 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. 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.

Digital health
Telemedicine and digital tools are important advances in which Scotland has played a 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 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.

The role of clinical pharmacology
The strategy is a good opportunity to realise the benefits of rational and evidence-based prescribing. This would ensure equity and will ultimately be more cost-efficient. Services provided by clinical pharmacologists can and do support these aims. There are central hypertension services in Aberdeen, Dundee, Edinburgh and Glasgow, run by clinical pharmacologists, who manage 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. This should be recognised in the strategy and could be included in section 3.3.3.

Similarly, section 3.4.1 should recognise the need to enhance prescribing skills and medicines management – both by investment in clinical pharmacology as a specialty and through expansion of prescribing education and training: the whole workforce should be skilled in the use of medicines.

3. Do you think there are any important priorities missing?

Yes
No

Don't know

There is currently a failure to link Priority 1 into Scottish Government oversight through the National Advisory Committee on Heart Disease. Prevention offers the best value for money in reducing heart disease but needs much more attention in the Scottish approach to reducing its burden. This could be effectively addressed by developing pathways (linking primary and secondary care) for the detection, diagnosis and management of hypertension (the largest burden; though a similar case can be made for hyperlipidaemias), , and then creating quality indicators that are managed by the National Advisory Committee on Heart Disease. This would also mean refocusing this committee (currently largely cardiology based) to include membership from primary care and the hypertension/lipid clinic community.

Preventative management of blood pressure or lipids is a critical part of Priority 1 and should be a critical part of the work of the National Advisory Committee on Heart Disease. It should recognise that most of this is not done by cardiology, but by primary care and a wide range of different specialities – including clinical pharmacology, lipid specialists, nephrology, diabetes and endocrinology and care of the elderly.

4. Please tell us what you think the current challenges to improving the detection and management of risk factors for heart disease in Scotland are?

The Society believes that there needs to be a greater focus on prevention of heart disease, particularly the detection and management of hypertension and lipid disorders, which will bring the greatest benefit in reducing heart disease burden in Scotland over the next 30 years. There is an urgent need to develop pathways of care, agreed between primary care and the specialist hypertension and lipid services, that can serve as the basis of quality indicators to address performance in the field. The challenge is recognising the importance of prevention and ensuring that it is addressed in the next iteration of the Scottish Heart Plan.

It will also be a challenge to set rigorous targets that are realistic but provide reasonable protection to the population, based on the huge evidence base we have for the benefits of treatment to targets identified by UK, European and international guidelines.

Finally, it will be important that those suffering deprivation, often at the highest risk, are not left behind in this process, and that a mixed approach is used that reaches the broadest number of individuals.

5. Do you think that actions 1 through to 4 will help to improve the detection and management of risk factors for heart disease in Scotland?

Yes
No
Don't know

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.

6. Overall, do you think that actions 1 through to 4 are the appropriate actions for Scottish Government to take over the next five years?

Yes
No
Don’t know