SCOTTISH EXECUTIVE

Health Department

Dear Colleague

CORONARY HEART DISEASE AND STROKE STRATEGY FOR SCOTLAND

Summary

1. The Scottish Executive has today published the **Coronary Heart Disease and Stroke Strategy for Scotland**, drawn up by CHD/Stroke Reference Group to take forward the recommendations in the report of the CHD/Stroke Task Force, published in September 2001. The Strategy contains an Implementation Plan Summary setting out the priorities for CHD and stroke, and this is attached, along with the recommendations in the Strategy.

2. The full text of the Strategy, the Minister's statement launching it, and further copies of this HDL are available on the Scottish Executive Health Department's website at www.show.scot.nhs/sehd and the new Coronary Heart Disease and Stroke websites at **www.show.scot.nhs.uk/sehd/CHD** and **www.show.scot.nhs.uk/sehd/stroke**. This HDL should be read in conjunction with **HDL(2002)69** on Managed Clinical Networks which we have just issued.

Action

3. All NHS Boards and their planning partners should take steps now to achieve the targets in the Implementation Plan by the recommended date. Progress will be monitored by the new national advisory bodies for CHD and stroke which have been set up, and by the Department through the revised Performance Assessment Framework.

Yours sincerely

TREVOR JONES
Chief Executive

3 October 2002

Addresses

For action
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Chief Executives, NHS Trusts
Medical Directors, NHS Trusts
Directors of Nursing, NHS Trusts
Directors of Public Health, NHS Boards
Chairs, LHCCs
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IMPLEMENTATION PLAN SUMMARY

CHD Priorities

October 2002	The Scottish Executive Health Department (SEHD) will have reviewed the Performance Assessment Framework to make sure its references to CHD reflect the content of the Strategy.
October 2002	SEHD will have given urgent, positive consideration to the proposal from ISD to establish a 3-year work programme aimed at integrating all existing CHD databases and expanding them to cover primary and community care data.
October 2002	SEHD will have re-constituted the CHD component of the Reference Group as a Project Group, with specific responsibility for drawing up detailed plans for developing the Scottish Cardiac Intervention Network (SCIN), including a timetable, costings for the development process and the identification, by December 2002, of a clinical lead with clinical and managerial credibility. The Project Group will also provide advice on CHD issues to SEHD until the CHD Policy Sub-Group of SCIN is established.
December 2002	The SCI User Group will be re-constituted, with the development and promulgation of the ECCI CHD discharge document as its top priority.
December 2002	NHS Boards will have included in their local health plan detailed arrangements, including specific timetables and targets, for developing a local cardiac services MCN in their area taking into account the experience of the Dumfries & Galloway MCN. The Network will cover all aspects of CHD from primary prevention to cardiac rehabilitation. SEHD will identify and make available pump priming funds for local MCN development. A list of all the specific issues which local cardiac services MCNs will wish to address is given in paragraph 32 of the Strategy.
October 2003	SEHD will have appointed the Lead Clinician of the SCIN.
December 2003	SEHD/NHS Education for Scotland will have created a total of 10 new Specialist Registrar posts in cardiology.
December 2003	NHS Education for Scotland will have established core competencies for all professions dealing with CHD.
January 2004	SCIN becomes fully operational.
April 2004	Each NHS Board has a local cardiac services Managed Clinical Network in operation, with a Quality Assurance programme agreed with NHS Quality Improvement Scotland as the successor to the Clinical Standards Board for Scotland.

December 2004	SEHD identifies Clinical Pharmacy Leader to support extension of pharmaceutical care in relation to CHD.

Stroke Priorities

October 2002	Scottish Executive Health Department (SEHD) will have reviewed the Performance Assessment Framework to make sure its references to stroke reflect the content of the Strategy.
October 2002	SEHD will have re-constituted the stroke component of the Reference Group as a National Advisory Committee on Stroke.
June 2003	Trusts admitting patients who have had an acute stroke will ensure that radiology departments provide appropriate amount of dedicated time each day to ensure access to CT brain imaging in order to achieve target times identified in SIGN guidelines.
December 2003	NHS Boards will have detailed plans for developing stroke MCN in their area. The Networks' functions will cover the complete spectrum of stroke services, the majority of which are provided in the community. SEHD will identify and make available pump-priming funds. A list of the specific issues which stroke MCNs will wish to address is given in paragraph 36 of the Strategy.
December 2003	SEHD/NHS Education for Scotland will have created a total of 8 Specialist Registrar posts in stroke medicine.
December 2003	NHS Education for Scotland will have established core competencies for all professions dealing with stroke.
April 2004	Each NHS Board has a stroke MCN in operation, with a Quality Assurance programme agreed with the NHS Quality Improvement Scotland.
December 2004	SEHD identifies Clinical Pharmacy Leader to support extension of pharmaceutical care in relation to stroke.
December 2005	SEHD/ISD will have established a national database for stroke based on the model developed for CHD.

Summary of Recommendations

Prevention

1. All NHS Boards should, through their local Managed Clinical Networks, develop explicit CHD and stroke prevention strategies by December 2004. These should link to, and may be an integral part of, more general strategies for primary/secondary prevention/health improvement, such as Joint Health Improvement Plans and local health plans. The strategies should adopt a 'population approach' to improving the health of the communities that they serve, complemented by a 'high risk groups approach' targeted at certain key groups, such as those with hypertension, hypercholesterolaemia or diabetes, as well as the most socially disadvantaged groups within the population. These strategies, as well as the more general health improvement strategies, must be kept under scrutiny, to take account of new evidence on prevention as it emerges.

Managed Clinical Networks for CHD and Stroke

2. Local health plans should, by December 2002, include provision for the development of local MCNs for cardiac services and stroke. NHS Boards should give consideration to making innovative appointments to MCNs, rather than to institutions.

Workforce Issues

3. The Scottish Executive Health Department and NHS Education for Scotland should introduce an immediate and substantial increase in the number of training posts so that by December 2003 there are:

- an additional 10 SpR posts in cardiology; and
- a total of 8 SpR posts in stroke medicine.

4. To take forward multi-disciplinary team working, all staff will be required to have the relevant competencies, skills and knowledge. NHS Education for Scotland should therefore establish core competencies for all professions dealing with CHD and stroke by December 2003.

5. MCNs should consider the creation of consultant therapist and specialist nursing posts to promote cardiac and stroke services in line with evolving service developments.

6. NHS Education for Scotland should ensure that by December 2003 there are organised training schemes for non-medical staff to develop both general and specialist skills in CHD and stroke care.

Information Technology and the Development and Use of Databases

7. Systems of data collection, storage and management should be established to support the development and monitoring of CHD and stroke services and to meet the Quality Assurance needs of MCNs. Nationally-agreed datasets with standard definitions should be adopted. The considerable work already undertaken in both CHD and stroke needs to be consolidated and appropriately funded.

8. Following completion of pilot studies to demonstrate the feasibility of using the recommended CHD minimum dataset in primary care, the Information and Statistics Division

Working Group should calculate the cost of rolling out the findings across NHSScotland, as part of the establishment of the national CHD database. SEHD should then fund this development.

9. The focus in terms of Scottish Clinical Information (SCI) CHD should be on the development and promulgation of the Electronic Clinical Communications Implementation (ECCI) CHD discharge document. The SCI User Group should be reconstituted by December 2002 and asked to undertake this task as a matter of priority.

10. Lead Clinicians and Network Managers of cardiac services MCNs should undertake the role of product champions of SCI CHD and in particular the ECCI CHD discharge document. This should form part of the job description of Lead Clinicians and Network Managers.

11. By October 2002, SEHD should have given urgent, positive consideration to the proposal from ISD to establish a work programme aimed at the creation of a national CHD database by integrating all existing CHD databases and expanding them to cover primary and community care data.

12. All hospitals which routinely admit patients with acute stroke should introduce systems to facilitate the collection of a nationally-defined minimum dataset for each patient admitted, in order to allow monitoring of performance against nationally agreed standards.

13. All hospitals which routinely admit patients with stroke should join the pilot phase of the Clinical Resource and Audit Group (CRAG) project to establish a National Monitoring System for hospital-based stroke services. Hospitals will need to identify a lead clinician for this project as well as staff to ensure complete data collection. Where an IT system already exists, resources should be identified to ensure its compatibility with nationally-agreed methods and datasets.

14. If the pilot phase is successful, the system should be established as an ongoing National Audit. This should be funded in part centrally and in part from contributions from participating Trusts.

15. Further development work should be resourced to establish the feasibility and methods of linking the hospital-based systems with those in primary care, to allow capture of information relating to longer-term management of stroke patients and outcome. This work should be led by the stroke MCN in each area. The overall aim is to create an integrated national database for stroke, drawing as appropriate on the lessons learned from the development of the national CHD database.

Next Steps

16. By April 2004, each NHS Board should have a local cardiac services Managed Clinical Network in operation.

17. The CHD component of the Reference Group should be re-constituted as a Project Group, with specific responsibility for drawing up detailed plans for developing the Scottish Cardiac Intervention Network (SCIN), including a timetable, costings for the development process and the appointment, by October 2003, of a clinical lead with clinical and managerial credibility. The Project Group would also have a role in educating NHSScotland about the function of SCIN.

18. The Scottish Cardiac Intervention Network should ultimately take responsibility for Implantable Cardioverter Defibrillators (ICDs), with the intention of:

- developing and maintaining guidelines and protocols, based on the National Institute of Clinical Excellence (NICE) guidelines, and the evidence which has become available subsequently, for the use of these and similar devices;

- identifying sufficient resources to increase the implant rate and the number of implanting centers; and

- monitoring quality control in conjunction with the Quality Standards Board for Health in Scotland.

19. In devising their cardiac rehabilitation programmes, MCNs should make particular attempts to ensure the participation of excluded groups, such as women, older patients and those from areas of socio-economic deprivation.

20. Lessons learned from the evaluation of 'Have a Heart Paisley' should be applied when implementing cardiac rehabilitation programmes in other areas.

21. Stroke MCNs should use the bed model generated by the Scottish Borders Stroke Study to calculate the number of beds required in their area.

22. By June 2003, Trusts admitting patients who have had an acute stroke will ensure that their radiology departments provide the amount of dedicated time each day needed to ensure access to CT brain imaging for stroke patients in order to achieve the target times identified in the Scottish Intercollegiate Guidelines Network (SIGN) Guidelines.

23. The stroke component of the Reference Group should be re-constituted as the National Advisory Committee on Stroke by October 2002.

24. By April 2004, each NHS Board should have a stroke Managed Clinical Network in operation.