Cross-Party Group on Heart and Circulatory Diseases

4 June 2024 6.20-7.30pm

Minutes

Present

MSPs

Alexander Stewart MSP
Colin Smyth MSP
Karen Adam MSP

Invited guests

Jenni Minto MSP
University of Florida
Roche Diagnostics

Non-MSP Group Members

Amgen
ASH Scotland
Astra Zeneca
Cardiac Rehabilitation Interest Group Scotland
Cardiac Risk in the Young
Chest, Heart & Stroke Scotland
Cruse Scotland
Edinburgh Napier University
Health and Social Care Alliance Scotland
Heart Research UK
Kidney Research UK
Network for Inherited Cardiac Conditions Scotland
NHS Lanarkshire
Novartis
Public Health Scotland
Resuscitation Council UK
Scottish Cardiac Society
Scottish Heart Failure Nurse Forum
Stroke Association
The Heart Manual

Agenda item 1

Welcome and introductions

Co-Convenor Colin Smyth MSP

Agenda item 2

Minutes of last meeting

Minutes of meeting held on Tuesday 5th of March to be agreed

Proposed by Colin Smyth and seconded by Alexander Stewart

Agenda item 3

Invite Karen Adam MSP and Alexander Stewart MSP to share their thoughts

Alexander Stewart MSP comments

- Alexander Stewart spoke about one of the main objectives in the report; to ensure that clinicians and healthcare professionals were consulted, and that the CPG could pass on their recommendations to the Scottish Government.
- The CPG co-conveners want to ensure that they can do the best they can to progress the recommendations from the report. The depth and wealth of talent and experience in the CPG, working in a collaborative mechanism, is important.
- Alexander Stewart considered the past challenges during Covid, stating that there are now opportunities to support progress, and the CPG co-conveners see their role as being part of that support mechanism.
- It is necessary to make sure that there is a resolve and recommendation at the end of the day, to improve the situation for healthcare professionals going forwards.

Karen Adam MSP comments

- Karen Adam highlighted that this CPG has been action-focussed, not just a talking shop and spoke on the human aspect of the CPG's purpose, reflecting on her personal experience and her desire to remove the 'What Ifs' for people impacted by issue.
- Karen Adam expressed optimism for progress going forwards, highlighting that Jenni Minto MSP was a previous member of this CPG before moving into a ministerial post

Both MSPs expressed their thanks for the support and hard work of all CPG members and healthcare professionals who contributed to the report.

Agenda item 4

Topic Discussion: CPG Inquiry Report into the Implementation of the Heart Disease Action Plan

<u>Speakers</u>

Minister for Public Health and Women's Health Jenni Minto MSP

Jenni Minto MSP (JM):

Jenni began by reflecting on her personal connection to the CPG purpose, before going on to discuss the CPG Inquiry Report into the implementation of the Heart Disease Action Plan (HDAP), extending her thanks for the support and engagement of CPG members. JM confirmed that the work on this report is welcomed by the Scottish Government, and notes how it brings together the voices of clinicians, organisations and people affected by heart disease into a constructive reassessment of the HDAP's progress

JM mentioned the new Glasgow University Population Health Building and discussed it's 'quadruple helix' work. It was compared to the CPG in how it brings together government, academics, health boards, and communities – with community being incredibly important. It is also important for the CPG to work with the government on the implementation of the HDAP, but also to challenge the government.

JM highlighted the successes of the report, before moving onto areas calling for more progress.

The successful development of the Scottish Cardiac Audit Programme (SCAP) was discussed. The HDAP clearly sets out the Scottish Government's ambition for the effective use of high-quality data to support effective decision making, understand patient outcomes, and enable better service planning. In April 2021, Public Health Scotland was commissioned to develop the SCAP, committing more than £1.5billion over 5 years to support this transformative change in access to and use of data to drive improvement in cardiac services. The second report of the SCAP was published in March and served to look at other areas, such as cardiac device data, in future reports. JM assured the CPG that the government would continue to work closely with Public Health Scotland to continue to learn from this data, support improvement in cardiac services, and further develop the SCAP

The inquiry also mentioned the work taken to improve national pathways in heart disease care, a great example of collective effort. There is now movement into a phase of gap analysis, and the outputs of this will enable the heart disease task force to develop priority areas for future work. The Scottish Government recognises that despite welcome progress, there is much to be done to meet the ambition of the HDAP.

Areas of improvements include the need to roll out innovative models of care to reduce waiting times. The Centre for Sustainable Delivery's (CSD) Accelerated National Innovation Adoption Pathway has been developed to undertake this task. It focuses on fast-tracking innovative technologies into healthcare frontlines to improve patient outcomes. The CSD is currently considering the rollout of innovations that will optimise delivery of the heart failure diagnostic pathway. The Scottish Government is working closely with them to consider the financial case for this.

The report highlights that progress in the diagnosis and management of heart disease risk factors – such as high blood pressure and high cholesterol has stalled following the pandemic. It falls on us to improve the management of these risk factors and consider approaches outside of traditional health settings.

The HDAP is clear about the importance of tackling risk factors and work in this space is progressing thanks to the Proactive Care Programme. A range of key stakeholders have already contributed, including primary and secondary care clinicians, public sector colleagues and third sector partners.

There are already some successes to note, including ConnectMe – a blood pressure monitoring service rolled out to over 98,000 people. Evaluation has shown a positive impact in reductions in blood pressure. This is making a lot of difference in women's health, as well.

JM is glad to use the opportunity tonight to reflect on successes and drive further improvement in future.

Agenda item 5

Discussion and questions

Colin Smyth MSP (CS): A relatively small amount of money has been ring-fenced for the successful projects of the HDAP, we know that a bit more money will make a real difference to projects like SCAP and Prevention services, in particular. The challenge is often dealing with the current crisis – the firefighting directly in front of us – but additional funding for preventative measures could make a difference in reducing the pressure in future years. What work is being looked at to focus more resources into what has been a success, so far, but where more work needs to be done?

Jenni Minto MSP (JM): In the context of Scotland's budget – about 50% of it goes into health. Of that, about 50% is on staff costs, and the element that's preventative is about 10/12% of the total budget, it's a small amount. I am trying to work out how, in a time of big pressure on the budget, we can shift funding from the ongoing work we need to do to keep Health Boards running and shift some of that into this innovative work. The Cabinet Secretary has just laid out the importance of shifting money into prevention. Sometimes when it's a small amount, it makes people even more innovative, and that's certainly what's happened with the money given to Public Health Scotland for the Audit. We've had several conversations about money we can put into research, but I go back to the whole thing about collaboration…I would love to find money for this, but we are in a situation where that money is becoming harder to find. I'm trying to understand decision-making that happens in Health Boards, and how we can speak more closely to the Chief Execs, and how we can pull money aside for innovation. There's going to be a national conversation around the construction of health service in Scotland, and I imagine this CPG will feed into that.

JM: Can you (the CPG) think of any new ways of doing things? There's not consistency across health boards, so to drill into that?

Ross McGeoch, Consultant Cardiologist (RM): Picking up on the point of influence, there isn't much clarity about how things get done, and how you get influence in health boards. If there's work moving forward about the structure within NHS Scotland, we would be keen to get involved in that. Because we can write the pathways and people give up their time, but then once we've got the pathways, it can be difficult for action to occur off the back of it.

JM: That's key to it. Reflecting on work at BBC Scotland and highlighting the importance of buy-in to getting people to change their way of doing things. Example, working in the Gaelic department, which had a 1/3 of the budget of English language, they looked at the way that the footage was being captured, and cut down from three workers to a single worker. Meaning that they could spend 1/3 of the filming budget on just one person, to make the money go further. When people came up with innovative ideas, I would give them some of it back, rather than keeping it internally. This motivated them to continue to make these

innovations, and there was a quid-pro-quo. The relevance here is that I was influencing them to make efficiencies, and they were influencing me by saying ‘we can make this more efficiently’. The relevance is how you get into the discussion, how there’s better coordination between management – so, health board management – and those that are doing the work.

CS: Making sure we’ve got local decision making, but avoiding that postcode lottery, which we need to get better at. I have constituents in one health board where the issue will be very different to another health board. How do we deliver that consistency while appreciating local decision making?

JM: And then in health, if you look at the Golden Jubilee with its centre for excellence, it’s a national centre pulling people in from all over Scotland. I was there visiting a friend who had been flown over from Islay. Islay is in Highland (Health Board), the Golden Jubilee is in GGC (Greater Glasgow & Clyde Health Board).

Leeanne Macklin, Coordinator of HDAP (LM): Supporting Ross’ point that it’s very difficult to influence Health Boards. Also, providing an example of how you can do things in equity, how you can do the same thing in more than one health board: I am the coordinator of the Heart Failure Hub Scotland, which brings clinicians from 14 Health Boards together, and decides national pathways, projects, and innovation for heart failure. The national pathways we’ve done for all areas of cardiology, that involved all 14 Health Board’s input, from across cardiology, in their own time.

I think the problem is in middle management, we have a bottom-up approach and the other half of the week you’re meeting national priorities and trying to make things equitable across the country. Another example, we were promised recurrent funding for a National Business Case for Hospitals at Home, particularly liver and heart failure. If it’s fixed funding for a year, how can you possibly get the right people into the right jobs on a 12-month contract? You can’t get people with experience, people need security. Without recurrent funding, it’s very difficult to convince the board to make the change. The problem comes with the bit in the middle, we want change, the people working on the floor want change, but we don’t meet in the middle.

CS: Is multi-year funding is the answer, Minister?

JM: Points from LM and RM will be fed into the conversation about this blockage. Recurrent funding is key, and it’s a refrain we get in a lot of areas of government. Third sector organisations need the confidence to do things, if you’ve got someone on a year’s contract, you spend half that time worrying about the continuation. This year, investment in the health boards has remained level, but they’ve got to make savings. It’s difficult.

LM: There was a National Business Case put forward for Hospitals at Home, a lot of the boards employed the staff; then it was given into winter pressure money and those people couldn’t be employed permanently.

Graham Rose, Novartis: Have we got the right structure in primary care to proactively identify and incentivise clinicians to go out and deal with chronic conditions like high cholesterol and blood pressure?

JM: The Cabinet Secretary was clear that nothing is off the table to be looked at, whether primary care or secondary care. The way healthcare is structured on Islay is GP practices also run the hospital, which works for a small community due to the connection and knowledge of how people access healthcare. Primary care doesn't fit into my portfolio, so I'll pass on some general thoughts. I had a great experience in Aberdeen after getting a tick bite, I had to go and see a doctor. I saw the senior nurse practitioner in a doctor's surgery who was then able to prescribe antibiotics and it worked well for me. Then I see other practices who are more traditional in how they operate, and I am also aware that because I represent a rural community, some of the structures around the GP contract doesn't work well for rural GPs. These are comments I've made personally and as a constituency MSP. As a Minister, the Cabinet Secretary was very clear today that primary care was something that has to be looked at.

Sheila Duffy, ASH Scotland (SD): In my field with tobacco, vaping and related products we know that mass media education and awareness-raising helps motivate people to move away from harmful products, and I urge you to make the most of any regulatory steps that the government takes to generate that awareness because that will give a free hit of advertising and awareness-raising. I mention the regulations from the 2016 Act, which could go a long way to closing the marketing and promotion of vapes. The other question is, can we look at levying a health tax for health harming products, to bring in revenue for some of the work you've been talking about? Can we generate money from a health tax system on tobacco and vaping companies?

JM: On your point about advertising, BBC news have a piece just now about small shops and the background of the photo is vapes. This free advertising isn't helping, and I've asked if we can send a note to the BBC about that. On tobacco and vapes, I thought Rishi Sunak would want to have a legacy, and that legacy could have been on tobacco and vaping, and I'm disappointed that we've lost that, at this point in time. This was a good piece of 4-nation collaboration from the beginning consultation; officials from the 4 nations were in the room. 11% of the responses came from Scotland, that shows how embedded the understanding is in Scotland for improving regulations on tobacco and vaping. I think that tells a very strong story. When the election was called, I had a meeting about the infected blood inquiry with a member of the cabinet, and I asked him to press the importance of tobacco and vaping to the then-public health minister. I've also spoken to my officials and asked them to look at what other steps we can take. I hope that this is one of the top priorities for legislation to be brought back after the 4th of July.

The 2016 Act, we felt it was better to bring everything together, which is why I've spoken to my officials to see what more we can do. The health tax, I'll come back to you, and we can have a separate conversation about that. I think it's something that needs to be talked on more widely than just health.

SD: Just briefly, the regulations are complementary to the proposals that were in the 4-nations legislations. You have the power to lay the regulations, which you have taken, and they were consulted on again in 2022. They would make a difference - you can do something now to make a difference to the future of Scotland and I would urge you to do that under existing devolved health powers.

JM: And that's the question I've asked my officials.

David McColgan, BHF Scotland (DM): Returning to LM's comment, when we developed the HDAP we had 100 patients and 75 clinicians involved, and there was no middle management involved. I wonder if the weakness of the current strategy is that it's seen as a government strategy and not seen as a strategy for heart disease in Scotland. I don't think there's anyone but yourself, Minister, who could pull 14 middle-management from the Health Boards together and get them to agree to the strategy. If there's an opportunity to get everyone signed up to the strategy, not just NHS Tayside or NHS Forth Valley… I wonder if the next iteration of this project is - how do we get NHS Chief Executives to say that's a priority for them, as well, and then held to account in some way shape or form. Is that possible? BHF would support the government in trying to pull something like that together.

JM: If I can take that away with my officials we can see if we can get that set up.

James Cant, RCUK (JC): I would like to build on the point and give a UK perspective. I contend that Scotland is the perfect nation in terms of size to be able to do things at scale. We're big enough and small enough at the same time. I will defend middle managers, here, because they are in an impossible situation. Chief Executives find themselves in an impossible situation. We need to be kind, we need to empower them, we need to be clear that we will support the difficult decisions that they will have to take. For us to do this, Chief Executives need to stop doing something else, and it might be something that will hit the local headlines. I love the cross-party consensus in Scotland and use that consensus to empower Chief Executives and embolden them.

JM: It comes to that level of trust, to say 'this isn't working, can you help me'. That environment is what we need in our health boards. You must make difficult decisions based on evidence, which is why the Audit work is so important, and the ability to have conversations in environments like this.

Iain, cardiac patient: How are you going to present this to the public?

CS: Reports such as this give us an evidence base to raise issues in Parliament. And our challenge as MSPs is to make sure that off the back of this report we'll be raising questions in Parliament, we're tabling motions in Parliament. And to an extent this gets across to the public, it's an issue of huge importance to people out there, and now we have the evidence to raise those points.

Morag Hearty, ConnectMe (MC): ConnectMe are hoping to be rolled out to 100,000 people across Scotland by the end of this month. Reflecting on LM's point about the data, we do need to have consistency and sustainability. I feel heartened by this report and want to see it moving forward.

JM: And 100,000 is a news story, linking back

Damian Crombie, AstraZeneca (DC): Delighted to see the innovation project OPERA be referenced. It's a great example of when NHS academia and industry worked together to face a common challenge.

JM: It's more than a quadruple helix, it's a quintuple helix.

Lis Neubeck, Edinburgh Napier (LN): There's not very much reference to the research going on in Scotland into cardiovascular disease, and much of these great projects are hinged on the research that we're doing. So please don't forget the cardiovascular research, and can we make sure research and clinicians come together to influence policy.

CS: I completely agree.

JM: There's so many people in Scotland that want to share their stories, and that's increasing awareness of heart conditions in Scotland. And that's where I'll end.

Agenda item 5

Next meeting of the CPG

17th September 2024, March 2024, 6-7.30pm, Microsoft Teams