1. BACKGROUND AND CONTEXT

“Together for Health – a Heart Disease Delivery Plan” was published by the Welsh Government in 2013 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government’s expectations of the NHS in Wales to prevent avoidable heart disease and plan, secure and deliver high quality person-centred care for anyone affected by heart disease. It focuses on meeting population need, tackling variation in access to services and reducing inequalities in health outcomes across 6 themes.

For each theme it sets out:

- Delivery aspirations for the prevention and treatment of heart disease
- Specific priorities for 2013-2016
- Responsibility to develop and deliver actions to achieve the specific priorities
- Population outcome indicators and NHS assurance measures

The vision:

Our vision for heart care is for:

- People of all ages to have as low as possible a risk of developing heart diseases and, where they do occur, an excellent chance of living a long and healthy life, wherever they live in Wales.
- Wales to have incidence, mortality and survival rates for heart disease which are comparable with the best in Europe
We will use a range of indicators to measure success. These are being developed and will be refined over time and will include indicators such as:

- Coronary disease prevalence rates: % patients under 75 living with coronary heart disease (If care improves, and mortality avoided, prevalence could increase, i.e. patients live longer duration and hence prevalence rises)
- Circulatory disease mortality rates under 75 per 100,000 population.
- Survival following out of hospital cardiac arrest
- Cardiovascular death in relation to average life expectancy - potential years of life lost.

**The Drivers:**

There are good reasons for heart disease to be a key priority area for NHS Wales.

According to the latest figures available from the Welsh Health Survey, 20% of adults are being treated for high blood pressure and 9% for any heart condition, excluding high blood pressure.

The most significant\(^1\) cause of heart-related ill health and death is coronary heart disease (particularly angina and heart attack). Although death rates in Wales have been falling over the last 3 decades, they remain around 15% higher than in England\(^2\). In addition, death rates vary significantly across Wales; the death rate in the most deprived fifth of wards is almost a third higher than in the least deprived fifth\(^3\) - showing the pronounced impact of poverty and the socio-economic determinants of health. While coronary heart disease is a largely preventable cause of ill health and death, the latest figures show that major risk factors remain high\(^4\):

- 23% of adults report smoking, with 20% of adult non-smokers reporting regular exposure to other people’s tobacco smoke indoors
- 57% of adults were classed as overweight or obese; amongst children the figure was 35% (of whom 19% were obese)
- 43% of adults reported drinking above guidelines on at least one day in the past week

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\(^1\) Welsh Health Survey 2011, Welsh Government statistics released September 2012
\(^2\) Trends in Coronary Heart Disease 1961-2011, British Heart Foundation, 2011
\(^3\) The Cardiac Disease National Service Framework for Wales, Welsh Government, 2009
\(^4\) Welsh Health Survey 2011, Welsh Government statistics released September 2012
Only 29% of adults reported being physically active on 5 or more days in the past week

These risk factors highlight the focus on coronary heart disease and promotion of healthy hearts as a theme. Coronary heart disease is, however, just one part of the picture and this Delivery Plan, covers heart conditions more broadly. It highlights the importance of providing high quality detection and treatment of all major heart diseases, including:

- Heart failure (predominantly caused by coronary heart disease)
- Arrhythmia management, including management of atrial fibrillation (frequently a consequence of coronary disease)
- Congenital heart disease (in children and adults)
- Inherited or idiopathic cardiac conditions, including cardiomyopathies

What do we want to achieve?

The Delivery Plan sets out action to improve outcomes in the following key areas between now and 2016:

- Promotion of healthy hearts
- Timely detection of heart disease
- Fast and effective care
- Living with heart disease
- Improving Information
- Targeting research
2. ORGANISATIONAL PROFILE

Organisational Overview

Betsi Cadwaladr University Health Board is the largest health organisation in Wales.

We provide a range of primary, community, mental health and acute hospital services for a population of around 688,000 people across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham) as well as some parts of mid Wales, Cheshire and Shropshire.

We employ around 16,772 staff and have a budget of around £1.2 billion. We are responsible for the operation of three district general hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and WrexhamMaelorHospital) as well as 22 other acute and community hospitals, and a network of over 90 health centres, clinics, community health team bases and mental health units.

We also coordinate the work of 121 GP practices and NHS services provided by North Wales dentists, opticians and pharmacies.

The Betsi Cadwaladr University Health Board Heart Disease Delivery Plan has been developed by the North Wales Cardiac Network which represents stakeholders from across the Health Board as well as external agencies. The Plan is developed in response to the Welsh Government’s “Together for Health” – Heart Disease Delivery Plan (2013) and details work currently underway as well as our plans for delivery of the HDDP as well as the Cardiac Disease National Service Framework (updated 2009).

Our vision is that people in North Wales will have increased years of healthy life and reduce avoidable inequalities in health outcome.

The North Wales Cardiac Network is integrated within the Health Board structure and offers a robust and sound framework for the planning and delivery of cardiac services across north Wales. The Network is a partnership of stakeholders across primary,
secondary and tertiary who work together to plan and delivery cardiac services to provide safe, equitable and quality care to cardiac patients. The Network’s broader remit extends across Wales, with formal links to the Welsh Government and the South Wales Cardiac Network. Working with the all Wales bodies, such as the Welsh Cardiovascular Society, Welsh Health Specialised Services Committee, the Welsh Ambulance Services NHS Trust, Public Health Wales as well as the local Community Health Council, the third sector, national Charities such as the British Heart Foundation, arrhythmia Alliance and the Atrial Fibrillation Society and patient groups. The Network is an ambassador for supporting the principles of sharing best practice to drive up standards and thus improve services for the benefits of patients and their families.

The Network has a comprehensive work programme which includes the actions required to delivery our plans for heart disease – see action plan at [annex 1].

In December 2012, the Health Board was successful in securing capital monies from the Welsh Government to build a second cardiac Catheter Laboratory at the YGC site. This means that with 2 adjacent laboratories on one site, we will be able to bring angiography and PCI services currently being undertaken at Liverpool Heart and Chest Hospital (LHCH) and the Countess of Chester Hospital (CoCH) to north Wales. This will provide a local service and means that many patients will be able to receive their care closer to home and we will also be in a position to offer a Primary PCI service for heart attack patients in the near future.

The delivery of this plan is made possible by the commitment and leadership of many health professionals, clinicians and managers across the Network dedicated to improving cardiac services for their patients.

Cardiology services are provided in a number of ways. Each District General Hospital in North Wales provides acute in-patient and coronary care across all 3 sites with general cardiology at outpatient clinics and also within some community clinics provided to meet local need such as at Deeside Community Hospital. Additionally, there are specialist services for:

- Simple pacemaker and complex defibrillator implantation and follow up
- Familial Hypercholesterolaemia (FH) Service
- Genetics
- Adult Congenital Heart Disease (ACHD)
Overview of Local Health Need and Heart Disease Challenge

The Heart Disease Delivery Plan requires each Local Health Board to carry out local population needs assessments to promote healthy hearts and treat heart disease, review their services in the light of that assessment, identify gaps between need and current provision and identify where service provision needs to change to meet demand.

The North Wales Cardiac Network acknowledges the support of Dr Christopher Johnson, Speciality Registrar in Public Health and Dr Peter Stevenson, Consultant in Public Health who provided the Needs Assessment. The Executive Summary is below with the full document which can be accessed by clicking on the embedded document below, “Needs Assessment” (see page 10).

Executive Summary
This Needs Assessment has been produced as part of the North Wales response to the Welsh Government Heart Disease Action Plan. It is based around a template and indicators developed by the Public Health Wales Observatory and follow the Heart Disease Delivery Plan themes: promotion of healthy hearts, timely detection of heart disease and fast and effective care. It also contains a basic corporate needs assessment element.

Population Health Profile
- The permanent resident population of North Wales is estimated to be over 688,000 and is expected to increase by above 5% to over 723,000 by 2026
- The population structure is older than that of the rest of Wales and the number and proportion of those over 65 is expected to increase, impacting on the incidence and prevalence of heart disease where risk increases with age.
- There are significant differences in life expectancy and healthy life expectancy between the most and least deprived areas for both males and females.
- The number of deaths from cardiovascular diseases has been decreasing over recent years. Heart disease accounts for over 60% of these.
- Decreases in mortality rates achieved across Wales have not been achieved uniformly within North Wales. Improvements in Anglesey and Gwynedd have failed to keep pace with improvements in Wales or the rest of the North Wales region.
- However, age standardised prevalence of heart disease is lower than the all Wales rate.
Promotion of healthy hearts

- Almost 1 in 4 adults in North Wales smoke. Smoking prevalence peaks at age 24-35 and declines into older age possibly as a result of increasing smoking related death and illness.
- Smoking prevalence is socially determined with the prevalence of smoking doubling between least and most deprived quintiles.
- Changes in smoking prevalence have been minimal over recent years, and recent improvements have not affected the inequalities gap.
- 30% of young adults non-smokers report exposure to second hand smoke indoors. 20% of children are exposed to second hand smoke in their homes.
- Over half the adult population of North Wales is overweight or obese and this is increasing over time. Also 1 in 4 children are overweight or obese. Both adult and childhood obesity are more prevalent in the most deprived areas.
- The proportion of adults who are overweight or obese doubles between the 16-24 and 45-54 age groups.
- Less than one in three of adults report meeting physical activity guidelines. This is decreasing over time in some areas. Over one in three of adults are classed as sedentary.
- Achievement of physical activity guidelines decreases with age, and drops from approximately 1 in 3 adults at 45-54 to 1 in 5 aged 65-74.
- Nearly half of the adult population consume more than guideline levels of alcohol and over one in four binge drink at least once per week.
- Consumption of harmful levels of alcohol and binge drinking are more prevalent in the least deprived communities and in middle age groups.
- Nearly one in five adults who have been diagnosed with high blood pressure has received no recent lifestyle advice from their GP.
- Basic interventions have to be delivered better and more consistently whenever possible. New, more holistic, targeted approaches to producing a shift in behaviours will be needed if significant impact on heart disease is going to be achieved.
Coronary Heart Disease in Primary Care

- The crude prevalence of Coronary Heart Disease in North Wales is over 4% and is the second highest in Wales. Age standardised prevalence is lower than the Welsh average demonstrating the impact of the older population structure.

- Substantial differences in estimates of prevalence of Coronary Heart Disease and Hypertension are obtained from Quality of Outcomes Framework and from the Welsh Health Survey, indicating that not all patients with Hypertension or Coronary Heart Disease are placed on appropriate registers.

- Only 40% of patients between 40-70 have had their blood pressure recorded in the previous five years.

Fast and Effective Care

- Heart diseases account for two thirds of all emergency admissions for cardiovascular diseases in Wales. Admissions are split evenly between Coronary Heart Disease and other heart diseases. This is different from the burden on mortality from each.

- Rates of emergency admissions for coronary heart disease, revascularisation procedures and angiographies are lower in North Wales than Wales as a whole. The burden on health services may be skewed as age standardisation removes the influence of population age differences.

- Indicators available for this needs assessment do not allow the speed, effectiveness or appropriateness of care to be analysed.

Corporate Needs Assessment

- The needs outlined in this brief corporate needs assessment are more finely detailed than the needs identified in the epidemiological and comparative section. Consequently, evidencing this professional understanding of need with the data is not possible at this stage.

Priorities

Priorities for local prevention
• Understand key population risks throughout the life course identifying when changes in behaviour occur (e.g. people stop taking physical activity, become overweight, or take up smoking).

• Target resources to delivering interventions which prevent the change in behaviour in a timely manner proportionate to need and inequalities in health.

• Reduce smoking prevalence and inequalities through
  o developing a clear understanding of the social and economic pressures in communities (e.g. deprived communities) and age groups where smoking rates are highest
  o support intensive targeted interventions to specifically address smoking cessation and uptake with target groups
  o advocate increased action at a population level including (e.g. plain packaging, second hand smoke exposure in children)
  o ensuring that every contact with health services is used to both prevent smoking uptake and encourage cessation

• Reduce the proportion of the population who are overweight and obese
  o better understand why individuals are likely to become overweight or obese in early adulthood and how this can be prevented
  o ensure effective interventions and pathways for prevention, treatment and management of childhood obesity are routinely available and systematically implemented
  o support intensive targeted interventions to specifically address weight and diet issues with deprived communities
  o advocate increased action at a population level to ensure healthy food is available to all

• Increase physical activity levels especially in older population groups
  o better understand why individuals stop exercising as they get older and how this can be prevented
  o support interventions with target age groups to increase participation in physical activity
  o better understand the motivations and barriers for undertaking physical activity
  o consider interventions within a settings approach

• Reduce alcohol consumption and binge drinking
  o better understand the social changes that are causing demographic shifts in alcohol prevalence
  o advocate increased action to reduce the promotion and marketing of alcohol for home consumption (e.g. prevent multi-buy (BOGOF) deals, minimum unit price for alcohol)
- increase awareness of harmful alcohol consumption in less deprived areas

Priorities for local delivery

- Services should aim for all patients to have their risk factors measured and risk of heart disease considered as per the NICE guidance at contact with primary care and appropriate action taken to reduce risks
- Primary care services should aim to give prevention and lifestyle advice to all patients seeking treatment for key conditions (e.g. hypertension)
- Consider a data development agenda to ensure that local conditions are understood and changes can be monitored in a way that supports evidence based service development.
- Develop a programme of service review / audit to enable data to be collected which can be used to test and validate the needs described in the corporate needs assessment. The full Public Health Needs Assessment document can be viewed by clicking the caption below.

Needs Assessment -
PHW CJ 18.11.13.pdf
3. DEVELOPMENT OF Betsi Cadwaladr University Health Board LOCAL DELIVERY PLAN
HEART DISEASE

In response to the “Together for Health – A Heart Disease Delivery Plan” (2013), Health Boards are required, together with their partners, to produce and publish a detailed local service delivery plan to demonstrate a systematic approach to progressive implementation of the Cardiac National Service Framework, the Welsh Health Specialised Service Committee Review of Cardiac Services and the Heart Disease Delivery Plan. The LHB Executive Leads for Heart Disease will need to report progress formally to their Boards against milestones in these delivery plans and publish these reports on their websites at least annually.

Following a Cardiac Network Workshop attended by stakeholders in October, we had the opportunity to review the Heart Disease Delivery plan in conjunction with the existing comprehensive Cardiac Network Work Programme. The Cardiac Network has been in place since 2002 and has been the framework for putting in place the collaborative approach to planning and improving cardiac services across north Wales. Since 2009, the Network has been integrated within the BCUHB and continues to work side by side with health board staff, (primary, community, secondary and tertiary care) as well as many external agencies and organisations to develop services. The success of the Network is made possible by the commitment and leadership of many health professionals, clinicians and managers who work together and are dedicated to improving cardiac services for the benefit of patients in north Wales. The Cardiac Network Programme has been updated and forms the Health Board’s Action Plan to deliver the Heart Disease Delivery Plan by 2016.

The workshop was a collaboration between the Health Board, Network and Public Health and we are pleased that Public Health Wales has supported the Network on the Needs Assessment required to inform the plans. Agreement was reached following discussion with regard to the priority areas for delivery between now and 2016. Many of the priority areas, for example, introducing a Primary PCI service for North Wales as well as the expansion of a Heart Failure Community Service to work in collaboration with Heart Failure Teams across the HB have plans in development as part of the Network work programme and integrated into the Health Board’s 3 year Plans. In 2012, we were successful in our bid to the British Heart Foundation for Health Communities Initiative Awards for monies to support a Heart Failure service in the Conwy and Denbighshire localities which is led by a small clinical team who commenced in January 2013. The new service fills a gap in service provision identified by the Heart Failure Network clinical group where prior to the new service, no structured service provision was in place in the community to support the secondary care heart failure team at YGC.
Good data collection, analysis and review are integral to developing efficient and effective services. This has to be built in to each of the themes below and reported to the Cardiac Network to ensure informed decisions are made about priorities and effective use of resources.

The Cardiac Rehabilitation Teams are well established across the north Wales region. Historically, these teams developed independently and through different funding sources. Now working within one Health Board and as stakeholders of the Cardiac Network, the teams are providing a multidisciplinary team approach across the six counties. By continuing to review the services collaboratively, the team aim to provide comprehensive rehabilitation programmes for all priority group patients as guided by the British Association for Cardiovascular Prevention and Rehabilitation Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation 2012.

The themes set out in the Plan are not mutually exclusive.

Following the local population needs assessment and review of service provision; we have drawn up actions to be undertaken during the period 2013-2016. These actions are detailed in the Network Work Programme/Action Plan at annex 1.

**PROGRESS 2014-2015**

Considerable PROGRESS has been made against our local priorities for 2014:

For progress relating to Promotion of Healthy Hearts – see below section 4.1

The North Wales Cardiac Centre opened its doors to patients in August 2014. The building and Commissioning of a **Second Cardiac Catheter Laboratory** at YGC has provided additional capacity for Angiography and PCI to be undertaken locally. The additional capacity has seen a repatriation of all angiography and PCI from Chester and Liverpool to North Wales, thus providing a local service for NW patients.

Plans have been approved by the Health Board to provide a **Primary PCI Service** for heart attack patients. The implementation plans are underway and it is hoped that the service will commence late in 2015.
Plans have been approved for the development of Integrated Heart Failure Service across North Wales. The implementation plans are underway and builds upon the BHF Heart Failure Community Service.

**The Heart Failure service**
In 2012, the North Wales Cardiac Network successfully bid for funding from the British Heart Foundation to introduce a community heart failure team for the Conwy and Denbighshire locality areas for North Wales.

The community team has been designed to reflect the service established in the North West Wales, which has proved successful in reducing hospital admissions due to heart failure since its inception. The team is responsible for diagnosis, treatment and management of Heart Failure patients in the community in the form of Heart Failure diagnostic clinics. The success of these clinics has resulted in more patients identified and treated in the community with heart failure with a positive impact upon reducing hospital admissions due heart failure. Patients have been consulted with regard to their experience of the community service and have been extremely complimentary, citing the significant difference the community intervention has made to their health and wellbeing.

Additionally, the Health Board has approved a Cardiac Network Business case which demonstrated the benefits of increasing the level of heart failure service to deliver improved clinical and quality of life outcomes for patients. This means additional resource has been made available to support the current BCU heart failure teams. This will ensure that where appropriate, patients are managed in the community, hospital admissions and length of stay are reduced and improvements are made to end of life care for patients with heart failure. The model of care which will be provided will achieve equity of access for the North Wales population, raising the heart failure standard across the Health Board. This especially relates to how heart failure care can be provided as part of an integrated long term conditions (LTC) model of care in partnership with other key stakeholders and agencies. Our plans demonstrate how we will deliver our Organisation’s aspirations regarding LTC management and frailty, deliver care closer to home, and improve workforce sustainability.

The additional resource will mean that the time limited British Heart Foundation funding for the community Heart Failure project which will be integral to the new model, will receive substantive funding. The new services set up in the community for patients will continue.

**The Familiar Hypercholesterolaemia (FH) Service**
The systematic identification of individuals with FH within BCUHB continues to progress well. Our collaborative, pro-active work on FH was presented very favourably by the All Wales medical advisor on FH at the recent National Audit of Cardiac Services in North Wales.
Wales (2014). In BCUHB we have established very good communication between secondary and primary care regarding high risk individuals (FH), and continue to see appropriate patient referrals. Additionally, our Cardiac Catheter Laboratory patient attendance lists are systematically reviewed against historic LDL levels - thereby identifying many more potentially eligible individuals for genotyping for FH. Working closely with BCUHB service user and Patient Heart Support groups, our effective work has attracted attention from other areas / regions and we frequently asked to present at conferences. Most recently our FH nurse has been invited to join a working group in London supporting the national implementation of ‘systematically Identifying Familial Hypercholesterolaemia in Primary Care’.

The Adult Congenital Heart Disease (ACHD)
The development of the Adult Congenital Heart Disease (ACHD) Service in North Wales has over the past 3 years, undergone major redevelopment and redesign. The ACHD service is now fully integrated as a Hub and spoke model with Manchester as the hub and Wrexham Maelor as the designated spoke for north Wales. This integral working allows patients to be seen locally and supports shared care and multi-disciplinary team working across North Wales and Central Manchester Foundation Trust.

Additional capacity has means that the service can be rolled out across North Wales, working with cardiology consultant colleagues to provide assessment and follow up for all ACHD patients where appropriate.

The ACHD service in North Wales meets recommendations set out in the Heart Disease Delivery Plan; Theme 3, Delivering Fast and Effective care as well as Standard 7 of the Cardiac Disease National Service Framework (2008). Standard 7 states that patients with moderate and severe ACHD conditions should be followed up in an ACHD hub or spoke. Patients with simple ACHD conditions should be seen once in the ACHD spoke clinic with a plan for long term care made and followed by local follow up.

National Cardiac Audits
There is full participation in the national mandatory Cardiac Audits (Heart Failure and MINAP).

The North Wales Cardiac Network Heart Failure Clinical Guidelines have been updated following NICE. The clinical guidelines have been ratified at the Network Board and circulated to clinicians in primary and secondary care in April 2013. All Network Guidelines are promoted at each of the Network Training Events. The Cardiac Network has run Training workshops in:
1. CVD Conference, Together for Health March 2013
2. Heart Failure Master class – November 2013
3. Palliative Care Workshop in partnership with the British Heart Foundation to manage end stage Heart Failure patients – 20th March 2014
4. ICD Deactivating Training Workshop – April 2014
5. CVD Conference, The Holistic Approach, May 2014

We have implemented a new cardiology image and data management system which will support the Multi Disciplinary Teams (MDT) approach, especially for more complex conditions or where specialist opinion is required

**Research Projects**

1. R&D approval for REVEAL (CV008) has been received for the Glan Clwyd site
   Paper in progress - Prof Michael Rees: Do patients with chest pain and normal coronary arteries have anti phospholipid syndrome?
   Glan Clwyd Hospital has been accepted as a potential clinical trial site for Sanofi trial with Dr Subkovas as PI. Research support from NISCHR CRC is currently being sought
2. Thrive study results reported at ACC in March 2013
3. Odesssey Trial - Dr Subkovas/ Waterfield Local investigators - Screen started
4. REVEAL STUDY - screening coming to close - 155 patients currently randomised
5. Dr Subkovas has now enrolled 7 patients in the odesssey trial,
6. finished recruiting and am following up 160 patients in the REVEAL trial
7. Dr Karthikayan is the local investigator for GLOBAL LEADERS

Sept 2011 report
March 2012 report
Dec 2012 report
September 2013 report
September 2013 report
September 2013 report
Feb-14
Feb-14
Feb-14
In addition to moving forward with our implementation plans for Primary PCI and Heart Failure, our priorities for 2015 will include:

1. **Chest Pain clinics** – Improve access to chest pain clinics for primary care.

2. **Cardiac Rehabilitation** - We will review our provision of Cardiac Rehabilitation (CR) and update our plans by providing a multidisciplinary approach to the delivery of Cardiac Rehabilitation services across BCUHB. We will review the provision of CR to current patient groups through the all Wales Cardiac Rehabilitation Group as well as develop plans to expand the service.

   We will continue to provide audit data for the National Database (NACR) and where there are gaps, we will work with the Cardiac Network to develop proposals to meet those gaps. We will continue to review the CR referral system of patients from inpatient activity through to discharge home and referral received as outpatients from a number of sources. We will continue to work with our partners: localities, National Exercise Referral Scheme (NERS) and Heart Failure teams, as well as other agencies to ensure that CR provision meets the needs of patients with newly diagnosed Heart Failure by providing effective care.

3. We will through the Cardiac Network review the provision of **Palliative care** for all Heart Failure Patients, linking with the all Wales Palliative Care and End of Life Delivery Plan.

4. Improve access to cardiac diagnostics for patients. We will develop a **Cardiac Imaging Plan** and working with our national partners, develop a business case for the provision of **Cardiac MRI**.

5. We will work with our Third Sector partners to co-ordinate and support bids for posts and projects by engaging in local stakeholder meetings as well as the Network Board to understand and gain an understanding of this activity.

**Working with our partners on a national level in Wales in 2015**
The Heart Disease Implementation Group has agreed a number of priorities for the 12 months that will be addressed at a national level.
1. Developing a consistent model for the delivery of cardiovascular risk assessment.
2. Delivering the cardiac waiting time target through more effective pathways
3. Developing and piloting component or differential waiting time targets.
4. Consider new workforce models of delivery that release capacity.
5. Improving participation and case ascertainment in National Clinical Audits.

British Association for Cardiovascular Prevention and Rehabilitation Standards and Core Components for Cardiovascular Disease Prevention and Rehabilitation 2012

4.1 Promotion of healthy hearts

The priorities for 2013 – 16 are:

1. Work with a broad range of partners and with an all Wales approach (including Local Service Boards and the third sector) to:
   - Raise awareness of healthy living
   - Signpost existing sources of information, advice and support relating to lifestyle change\(^5\)
   - Develop and deliver local strategies and services to tackle underlying determinants of health inequality and risk factors for coronary heart disease
   - Target resources in population areas of high risk (such as areas of deprivation) and areas of high impact (including early intervention actions with children to tackle prevention from outset of life)

2. Support and facilitate GPs, practice nurses and community pharmacists to proactively:
   - Use every opportunity in primary care to promote healthy lifestyle choices and smoking cessation

\(^5\)Including, for example, Stop Smoking Wales, Fresh Start Wales, Change 4 Wales
BetsiCadwaladrUniversity Health Board/North Wales Cardiac Network – Author Catrin Hanks – HDDP Plan Progress – v2 24.02.15
Heart Disease Delivery Plan – up to 2016
• Ensure consistent provision of testing and treatment for risk factors such as high blood pressure and cholesterol

We plan to work with our Public Health colleagues and the Third sector to ensure that people are aware of and are supported in minimising their risk of premature cardiac disease through healthy lifestyle choices and medication where appropriate.

The North Wales Cardiac Network has at least two regional clinical training days per year. The programme is aimed at a range of health professionals, in particular primary and community care, GPs and Practice Nurses. Clinical Guidelines produced by the Network are also presented in the context of delivery. Additionally, many of the various specialist nurses run local educational workshops across BCU for primary care colleagues, for example, heart failure, ECG training and arrhythmia workshops.

The Network’s programme includes updating clinical guidance against the latest evidence base working with a number of clinicians, for example, AF, Statin, Chest Pain Guidelines, Antiplatelet, Heart Failure and Hypertension. This list is not exhaustive.

Patients (together with their families/carers) under the care of all specialist cardiac nursing services (including allied health care professionals: occupational therapists, physiotherapists, exercise physiologists, dieticians) have structured and systematic lifestyle information and support to make healthy choices and participate as partners in self care behaviours.

In addition, the British Heart Foundation supports North Wales with a number of primary prevention activities:

• Rhyl has the status as a BHF Heart Town and a result the focus has enabled 10 health awareness days and a fit for work half day seminar to date.
• A funded BHF Schools Heartstart Project in Flintshire and Denbighshire.
• Partnership working with WAST on community resuscitation awareness, training and placement of funded Public Access Defibrillators.
• Promotion and Heart Matters magazine and BHF health education resources (several available in Welsh Language).
• BHF Heart Helpline and BHF website available to all.
Targets

The Welsh Government Delivery Framework 2013-14 includes a Tier 1 target to improve uptake of smoking cessation services.

The Tier 1 Target is essential to the prevention of heart disease.

PROGRESS:

Health Risk Behaviours / Individual ‘Lifestyle’ change

1. Smoking:

Outcomes indicators include achieving the Tier 1 smoking cessation target and reaching the Welsh Government target for a reduced general population prevalence of 20% by 2015 and 16% by 2020.

BCUHB in addition to taking action to improve levels of smoking in the general population is developing plans to target high risk groups for smoking such as mental health patients, those living in areas of relative deprivation, routine/ manual workers and long term unemployed/ never worked groups.

Key actions taken by BCUHB to increase the percentage uptake of smoking cessation services and therefore improve the likelihood that a quit attempt will be successful include:

• Local implementation of National Marketing Campaigns: Stoptober, UK No Smoking Day and ‘Don’t be the one’
• Development, launch and implementation of BCUHB Smoke Free Policy
• New projects to improve outcomes:
  ➢ Target Setting – Workplace/ Routine and manual workers:
    70% of the population who smoke record that they would like to stop, so a trial intervention to raise awareness of specialist smoking cessation services and the risks of continuing to smoke was developed, providing knowledge, opportunity and motivation (as COM B model, Michie and West UCL).
Sessions were held in 4 workplaces to offer brief intervention and the opportunity to join a stop smoking group. 40 people were recruited and will be contacted by Stop Smoking Wales with the offer to either join a 7 week group, or individual visits to a local Level 3 Community pharmacy stop smoking service if they prefer. This trial will be evaluated and all 40 participants contacted at the end of the 7 weeks to evaluate participants experience and outcomes, before the project is rolled out and offered in other workplaces.

Similar ‘Roadshows’ are now being planned across workplaces in North Wales informed by the trial above.

### Target setting - Primary Care and General Practice:

- A project to improve referrals from General Practice to specialist smoking cessation specialists in community pharmacy or Stop Smoking Wales.
- Further investment in the number of community pharmacies providing L3 services for Stop Smoking is also being maximized.
- Presentations to GP Cluster meetings, Locality meetings. (partnerships), and GP Practice Manager meetings have been undertaken, and individual practice presentations continue to be well received, with follow up meetings being requested.
- A GP Locally Enhanced Service (LES) was developed with 64 of the 114 GP Practices in North Wales currently taking part, and providing data for clinical audit.

### Target setting - Secondary care, including acute, maternity and mental health:

- A Smoke Free Group is being established on each acute hospital site to take forward key actions in the BCUHB policy.
- The policy has been mapped to NICE guidance PH 48 and a review of progress made to inform further work.
- Helping staff who smoke to stop remains an important aspect as they are seen to lead by example and may become local champions to facilitate change in their peers, patients and communities.
- A continued focus on maternity to help mothers and families stop before ill health symptoms develop (from mid 30s) and so that children grow up in smoke free environments with less chance of taking up smoking themselves in their teens.
- A project also focuses on promoting a smoke free culture by hospital grounds being smoke free. Implementation of this is being supported by partnership working with the Local Authorities to enforce littering legislation when cigarette stubs are dropped.
Social Marketing / segmentation

- Youth Stop Smoking: ‘Girls with dreams’
  This campaign in Wrexham was developed following a series of focus groups across North Wales with 11-13 year old girls in 2013/14 which identified low self esteem as a key risk in taking up smoking. This campaign target audience is young and high users of social media therefore it utilises Facebook, Twitter, Instagram, and Pinterest to maximize reach. It is a joint project with Wrexham LSB.

- Routine and manual workers: This year 2014/15 the focus groups have complimented the National Campaign ‘Don’t be the One’, and focus groups have taken place with this segment of the smoking population to explore what will help them to make a successful quit attempt. The report will be used to inform future work including campaigns.

Increasing the availability of specialist advice for Stop Smoking

Two training sessions to provide Level 3 training are planned over 2014/15.

- Session one will increase service availability in more rural areas.
- Session two will increase service availability in special groups e.g. mental health patients. It has been identified that mental health patients record wanting to stop smoking in similar numbers to the general population, however they do find it more difficult to stop and an enhanced service will be beneficial. Also for those in long stay and high security units where other services may not be available.

2. Obesity and Overweight

- Severe and morbid obesity: BCUHB are currently responding to the requirement by Welsh government for all Health Boards to establish a Level 3 specialist weight management service for adults with severe and morbid obesity (body mass index 40 + or 35 + with existing co-morbidities). Final amendments are currently being to the business plan for approval by March 2015.

- Obesity in pre Type 2 diabetes, maternity, and children and young people - Community and Primary Care Weight Management Services: BCUHB aim to commence a business plan for Level 2 services targeting specific population groups e.g. General Population: Fit4Life Wales, physical activity projects and nutrition projects.
3. Harmful Alcohol use

- Alcohol brief intervention training – further sessions were undertaken by the Public Health team in October with BCUHBs partner organisations.
- The implications/ link for development of overweight and obesity around alcohol use is also explored.

4. Physical inactivity and sedentary behaviour

- National Exercise Referral schemes continue from strength to strength in North Wales and BCUHB are exploring with LA Leisure colleagues how learning from the schemes can be shared to a wider population group.
- Implementing Physical Activity Brief Intervention in Primary Care (NICE Public Health Guidance). This supports the population approach to reducing overweight and obesity in the general population, but also underlines the importance of achieving and maintaining physical activity guidance for all adults irrespective of weight. The emerging evidence for the independent risk of sedentary behavior is also being shared.
- Working with partners to improve access to walking and cycling opportunities.

5. Nutrition

- BCUHB public health dietetics are working with community groups to improve cooking and nutrition skills, providing excellent resources which are simple, nutritious, affordable versions of popular ‘fast foods’.

6. Integrated risk behaviour change: the key risk behaviours for ill-health described above all contribute together to the full range of non communicable chronic conditions development, and it has been shown that there is a socioeconomic gradient, with those in the most deprived groups recording a cluster of unhealthy behaviours and often multiple chronic conditions. Therefore BCUHB are identifying projects that will start to address this:

- Exercise referral staff have undertaken training in motivational interviewing and promote brief intervention for other risk behaviours such as smoking and alcohol use.
- MECC – Make Every Contact Count: Level 1 and Level 2 training packages are in development that will improve motivational interviewing skills and support brief intervention / prevention. The aim is to train the trainer in various settings so
as to improve reach. Initially trials will be undertaken with health staff in Mental Health CPG and with a Poverty Reduction group in Conwy.

- Health Information Hubs – will be developed working with partners, Localities and SPOA (Single Point of Access) developments to provide further information to assist individual behavior change.

- BCUHB Staff Health and Wellbeing Group – BCUHB have achieved Gold Corporate Health Standard and staff are encouraged and supported to improve their own health and lead by example in Making Every Contact Count regarding the risk behaviors described above. Stress reduction and management is also a key priority. BCUHB is trialing the latest version of Champions for Health for Public Health Wales and a stress management and mental wellbeing model will be added in January 2015 following BCUHB request.

(Level 3 pharmacy has just commenced as part of a phased introduction across Flintshire in September 2013)

**Structures and local work to support achievement of targets**

**Prevention**

In addition to tobacco prevention work implemented through the national Healthy Schools Scheme and Assist (peer led support in secondary schools located in deprived areas) all 6 Local Authorities in North Wales have implemented Smoke Free Playground policies. The North Wales Tobacco Alliance of which BCU, through the Cancer CPG, is a member supports the Smoke Free Cars initiative and hosts the new Young People Social Marketing Campaign. Other campaigns are supported through BCU throughout the year, i.e. No Smoking Day and ‘Stoptover’.

**Obesity**

*Progress on local initiatives and agreed priorities (adults)*
Progression of work though local delivery groups have now resulted in a number of key priorities and products for 2013/14 which are as follows:

- To produce a profile of community weight management activity at Level 2 of the Obesity pathway for discussion at locality level
- To undertake a Health Impact Assessment of Flintshire Local Development plan
- To develop a proposal (in conjunction with North Wales Planning group) to stage a North Wales workshop for those involved in planning (local authorities, transport authorities and the NHS) to raise awareness, highlight current activity and mechanisms to improve health and reduce health inequalities through the process of spatial planning
- Expansion of the current ‘Food wise for Life’ programme across North Wales with a focus on opportunities for implementation within community settings (e.g. Communities First)
- Undertake an evaluation of the Weight Watchers demonstration programme within the North East Flintshire
- Further scope opportunities to extend the Lifestyle management programme (formerly the Orthopaedic Lifestyle Management programme) with reference to the National Exercise Referral scheme
- Hold an annual event to update stakeholders on overall progress and continuing challenges with implementation of the obesity pathway in February 2014

Maternal obesity and childhood obesity – local progress

The Healthy and Safe Weight in Pregnancy Pathway has now been approved and is due for implementation, although the issue of dietetic input to the pathway is awaiting final resolution.

A new local task and finish group has been set up in May 2013 to focus on childhood obesity. There has been a focus to date on maternal obesity, with a dedicated delivery group and a 2 year delivery plan in place. Locally there has agreement that there now needs to be a wider focus which will include childhood obesity. This is particularly relevant in light of the publication of the Child Measurement Programme (CMP) findings, following which there will be a challenge to organisations in relation to their approaches to childhood obesity.

It has therefore been agreed that we will use the CMP findings to understand baseline prevalence and set some targets for reducing prevalence over time through our collective efforts. The local group considered the following:

- Acceptance of the breadth of the issue and the need to take a pathway approach in considering both the prevention and treatment aspects and acknowledging that wider partners such as LA’s and leisure have key roles to play.
• It was acknowledged that while some children who have been identified as overweight or obese do get support from psychology and/or paediatric dieticians, there isn’t currently a systematic approach to this, in terms of identifying, referral and interventions. There is therefore currently an issue regarding equity of access to services and ensuring a BCU wide consistent approach.
• It is going to be important to agree and define our interventions especially in light of recent decisions not to take forward MEND in North Wales.
• There was broad agreement that the issues around childhood obesity are related to but also different to maternal obesity, and there was support for setting up a separate group initially to scope the work that needs to be undertaken both strategically and operationally. This will be separate from but linked to the maternal obesity delivery group.

Examples of local work

Partnership with Healthy and Sustainable Pre School Scheme (HSPSS)
Dietetics work in partnership with and support the Healthy Schools/ HSPSS officers within the 6 North Wales counties. A key criterion of this scheme is nutrition. Settings submit evidence to the HSPSS team (education) to achieve their award. Dieticians to date have been involved in advising the HSPSS officers, reviewing evidence, and in some cases attending with officers to undertake site visits to settings.

The ‘Tiny Tums’ best practice certificate
This seeks to reward early childcare settings for following best practice on food and drink provision within their setting. To date it is operational across the East and Central BCUHB area, focusing on nurseries and since 2012 includes playgroups. Food and drink provided by the settings are assessed in detail by a Registered Dietitian using a standardised check list; this ensures consistency and compliance with the ‘All Wales food and health guidelines for early years and childcare settings’. Those settings that achieve this award are providing what we would consider to be the ‘gold’ standard for food and drink within their setting as it requires more ‘in depth’ assessment than just achieving the nutrition criteria for HSPSS.

Cascading Community Food and Nutrition skills – Level 2
Dieticians deliver the ‘general’ level 2 (Agored Cymru) community food and nutrition skills course. This is run across North Wales and targets primarily those working with groups in the community (paid/ volunteers). Recipients of training have included youth workers, fruit and vegetable cooperative volunteers, communities first workers, National Exercise on Referral staff, flying start staff,
luncheon club volunteers etc. The training seeks to increase skills and knowledge amongst community workers to enable them to cascade basic nutrition messages to the group they work with. This work is evaluated (post training and now 6/12 post training).

**Dewch i Goginio!/ Come and Cook! Toolkit**
This toolkit has been in development during 2012 and provides a trusted and locally developed resource for community based staff and volunteers to support them in taking a proactive approach to increasing practical cooking skills whilst promoting healthier eating practices within the family. Materials are nearing completion and some early groups have commenced in using the materials, the resource will be fully evaluated. Funding for the toolkit was provided via funds from BCUHB charitable funding/ Well Being Activity grants (Local Authorities)/ Communities First/ Way of Life project (Conwy) and Dietetics (via its support workers) will be supporting roll out of the toolkit across the 6 counties over this next financial year. Those that have completed and achieved the Level 2 course (above) and have a community group to work with are eligible to use the toolkit.

**Introducing Community Food & Nutrition Skills- Level 1**
Currently Dietetic support workers deliver this accredited course directly to groups (members of the public) within the community. Delivery has focused on vulnerable or hard to reach groups including young care leavers, older men and foster carers and is focused on support them to increase their personal skills and knowledge on food and nutrition to make changes to their/ their families eating habits/lifestyle. Evaluation is undertaken and work, particularly with groups of older men who are living alone/ separated or widowed from their partner is being developed further in partnership with Age Concern North East Wales.

The staffing to deliver this work has been funded mainly through a former capacity grant (now substantive) from the Welsh Government with the emphasis being on increasing capacity through training frontline workers. This has benefits in that the training is delivered by qualified Dietitians with the skills to pass on the right messages, but is also address the delivery end of services taking pressure away from dietetics who do not simply have the capacity to deliver services to the obese population as a whole. There is however, a lack of dietetic capacity to support the implementation of the evidence based BCUHB Pre-pregnancy, Antenatal, Labour and Postnatal Integrated Care Pathway (ICP) for women with a raised BMI of 40 or over to dietetic services. The CEMACH report (Confidential Enquiry into Maternal and Child Health) identifies that effective weight management should be available at local levels and pathways for referral into these services are incorporated into local maternity guidelines for preconception, antenatal and postnatal care; the issue remains for us locally that we are not meeting these recommendations.
Weight management services in the Community

There are 2 areas that BCUHB have developed in relation to community weight management services, these are the “Lifestyle program” and the “Foodwise for Life” programme.

The Lifestyle Programme

The Lifestyle Programme has a specific focus on patients with orthopaedic hip and or knee problems that may necessitate surgery. The idea being that if they have a BMI of greater than 35, then they get referred to the lifestyle program to reduce weight and improve their strength in and around the knee/hip joint pre/post surgery – should surgery be required. The first programs started in December 2012 and January 2013 and early results are encouraging. Funding for this program has been made substantive from April 2013, with money identified by the Health Board through surgery avoidance. The team consists of Physiotherapists, Dietitians and National Exercise Referral staff (NERS) who deliver programs in Leisure Centres across North Wales.

There are discussions taking place within the Health Board that such a program may be extended to other groups of patients and the BMI threshold reduced. This would have a significant impact on the numbers of patients attending and would not be possible without identified funding and the facilities to run programs/groups – i.e. Leisure centre capacity, if that is the model adopted.

Foodwise for Life

Foodwise for Life has been produced by Public Health Dieticians in Wales with support from Welsh Government to support people to make healthy lifestyle changes. The program has been produced to be delivered by non Dieticians who have been trained and supervised by a Registered Dietitian. The training program will support delivery of level 1 and level 2 of the obesity pathway. It is an 8 week scripted programme including the key healthy eating messages and supporting the Change for Life themes. This is to ensure consistency. The programme would ideally be delivered in conjunction with an exercise programme. Foodwise for Life tutors must complete the following essential nutrition training before delivering Foodwise for Life;

- The Agored Cymru accredited Level 2 Community Food and Nutrition Skills (CFNS) training (3 credits) delivered by Registered Dieticians (30 notional hours of learning).
- Facilitating Foodwise half day delivered by Registered Dieticians.
- Refresher nutrition training (1 day) delivered by Registered Dieticians to be completed every 2 years.

Progress to date involves a partnership development with NERS who will deliver programs across each of the 6 local authorities that cover BCUHB. Initial plans are to run 3 programs per year per local authority and NERS staff have received the required training above and are in a position to start September 2013. Dietetics will provide some initial support to provide quality assurance,
utilising the “Lifestyle” Dieticians during the first stages of delivery. Referral will be via the traditional NERS referral route, with obese patients supported by having the additional 8 week Foodwise for Life program, in addition to the extra exercise they receive.

This has potential to span a wide variety of groups, with Communities First also showing an interest at this moment in time. Again, to ensure the process is managed and monitored appropriately, there is a dietetic component required to ensure training of future staff groups who deliver can take place and the quality assurance can be provided. This is crucial to ensure consistent nutritional advice is given.

At the moment such developments are in their infancy and outcomes will need to be closely monitored to assess impact and benefit to individuals and the wider population as a whole, over time. It is clear that weight management services in the community need a joined up approach but also a consistent strategic focus to how this is tackled. Historically, there has been no investment in specific weight management services in Wales as there has been in areas of England, and this has lead, in part, to Wales having some of the highest rates of obesity in the UK for adults and children.

**4.2 Timely detection of heart disease**

The priorities for 2015 – 16 are:

1. Identify and implement ways of raising public awareness of the symptoms of heart disease and the importance of seeking urgent medical advice and raise awareness of when to ring 999, seek advice from NHS Direct and when to contact their GP
2. Provide GPs with timely access to diagnostic testing and procedures for heart disease, increasing direct access to testing (at the point of care or from a central laboratory), without need for secondary referral, where appropriate
3. Provide rapid access services to meet GP and patient need
4. Provide GPs with timely access to specialist cardiology advice through telephone and email, speeding diagnosis for people who may not need referral to a clinic
5. Ensure adequate access to cardiac catheter laboratories, matched to population need
6. Raise symptom awareness of GPs and ensure through audit that people are referred to secondary and tertiary care in line with national guidance and referral protocols and pathways agreed by the cardiac networks
7. Provide specialist cardiology advice within 24 hours for those admitted to hospital with suspected heart disease - reorganising delivery of services to achieve this where necessary
8. Ensure effective collaboration between the All Wales Medical Genetics Service, Cardiac Networks, Hospital Lipid Clinics and GPs to use the Familial Hypercholesterolaemia Cascade Testing service to identify and treat individuals with Familial Hypercholesterolaemia and reduce the high risk of this group developing early onset heart disease.

9. Ensure effective use of arrhythmia specialists and the All Wales Medical Genetics Service to ensure patients with inherited heart conditions have appropriate advice and testing and that specialist advice is provided to interpret the results.

We are supporting the implementation of the local and national action plan to identify and treat systematically those patients with familiar hypercholesterolemia (FH) through the national cascade testing. This service is led by the all Wales FH Group and led by north Wales clinicians', Dr Yee Ping and the FH Specialist Nurse, Rob Gingell. See progress section above.

We have commissioned a second cardiac catheter laboratory at YGC.

As part of the WHSSC Cardiac Services Review, funding was identified for genetic testing in carefully selected families with HOCM, Long QT syndrome and CPVT. MDTs have been set up in north Wales which link to SW. This service is initially for a 2 year period and funded across Wales.

The North Wales Cardiac Network update clinical guidelines and have a series of education days in which cardiovascular symptom awareness is raised to GPs and Practice nurses.

The North Wales Cardiac Network has successfully led clinical work groups as well as ‘task and finish’ groups to develop and deliver on specific core activities over many years. We will continue to utilise this approach to review the priorities outlined in this plan and work together across north Wales to share best practice between sites and localities.

**Our priorities for delivery in 2015-16 are:**

- We will improve access from primary care to the acute setting by a review of cardiology chest pain clinics and diagnostics to identify more effective services which may see some services move to primary care, for example, the pilot for primary care cardiac monitors.

- We will continue to improve the quality of referrals to secondary care to ensure optimal use of resources and reduce waiting times for those patients who need to be seen by ensuring the optimal use of NT pro-BNP testing for suspected Heart Failure.
• We will review referral processes; for example utilise the NICE pre-test probability assessment before referral. We will provide feedback to practices on performance.

• We will review the capacity and demand for chest pain referrals and review service modelling (if required) to ensure equity of access across all three hospital sites. We will identify areas in the care pathway areas that do not add value for patients. By re-modelling, the objective will be to reduce inappropriate referrals to the Emergency Department (ED); however we may need to increase capacity to achieve this.

• We will develop an awareness raising campaign for opportunistic pulse screening for Atrial Fibrillation (AF) with health professionals, the Welsh Ambulance service as well as pharmacies and conduct a ‘Know your pulse’ campaign. 1000 Lives and Atrial Fibrillation (AF) were approved in October 2013 and Audit+ module is available now for primary care.

• We will develop a Health Board/Cardiac Network Imaging Strategy.

4.3 Fast and effective care

The priorities for 2015 – 16 are:

1. Organise services to ensure people admitted because of diagnosis with a heart disease are assessed by a consultant cardiologist, within 24 hours of admission to hospital
2. Start definitive treatment in a timely manner, with a focus on driving down waiting times and meeting clinical need. As a minimum treatment must start in line with the 26 week Referral to Treatment waiting times target for cardiac disease
3. Deliver prompt and equitable access to appropriate interventions, including new diagnostic procedures, technologies, treatment and techniques, in line with the latest evidence and guidance and with evidence based policies and priorities agreed by NHS Wales
4. Ensure all complex surgery is undertaken with peri-operative care standards as in the ERAS project
5. Use the 1000 Lives Plus Programme as a means to support and guide improvements to services for people with acute coronary syndrome, heart failure, atrial fibrillation and in need of anti-coagulation where appropriate and needed
6. Manage effective transition to quaternary services in England where needed
7. Coordinate effective discharge and timely repatriation of patients to local hospitals as soon as clinically appropriate following treatment in line with discharge plans and the All Wales Repatriation Policy
8. For patients who need it, ensure effective transition to appropriate palliative and end of life care, in line with the Delivering End of Life Care Plan
9. Develop an NHS Wales policy on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, ensuring that this always respects individual patient wishes
10. Review provision of defibrillators in public places and community first responders, within LHB areas, ensuring - in liaison with the WAST and the British Heart Foundation - that there is adequate provision and training and an effective first responder in place

7A consultant cardiologist is someone on the General Medical Council’s specialist register with a Certificate of Completion of Training (CCT) or Certificate of Completion of Specialist Training (CCST) in cardiovascular medicine or cardiology, who is employed as a consultant, spends the majority of their direct clinical care programmed activities caring for patients with heart disease and who undertakes regular continuing professional development of relevance to the care of patients with heart disease.

Our priorities for 2015-16 are:

- We are currently planning a 24/7 Primary PCI service for north Wales.

- We are developing a integrated Heart Failure services to deliver improved management of care for heart failure patients across primary, community and secondary care. The expansion of our Heart Failure service will allow us to further reduced unplanned admission/re-admission and length of stay. This not only meets our aims to support unscheduled care but importantly offers patients and their families/carers support as they come to terms with and live with this disabling condition. This supports patients to better engage in self-care behaviours and medical treatment. It also will enable us to develop our palliative and end of life care for this group of patients. See Progress section above.
• We will ensure that our heart failure patients are assessed in line with the Clinical Health Board’s Frailty Scale – see embedded document.

• We have repatriated all PCI and angiography from our English providers in line with the Health Board’s Repatriation Strategy

• We will review our revascularisation rates, referrals and waiting times to understand variation.

• We will review our local device implantation service to develop a strategy.

• We will review Referral to Treatment times and in particular review the number of patients waiting for follow up appointments

• We will review how we could provide 24/7 cardiology advice across BCUHB to provide on call cover and also what steps would be necessary to be able to ensure all patients admitted to hospital with a cardiac diagnosis might be seen by a consultant cardiologist

• We will develop a deactivation policy for patients with internal defibrillation devices; which includes how we deal with the increasing complexities of end-of-life care in this patient group and NSACPR decisions

4.4 Living with heart disease

The priorities for 2015 – 16 are:
1. Plan and deliver services to meet the on-going needs of people with heart disease as locally as possible to their home and in a manner designed to support self management and independent living. This should include as appropriate:
   - Evidence based follow-up in the community where possible
   - Drug and device management
   - Cardiac rehabilitation (including psychological management and exercise)
   - Exercise programmes (such as the National Exercise Referral Programme)
   - Guidance on healthy lifestyle and self-care to minimise further ill health

2. Assess the clinical and relevant non-clinical needs of people with a diagnosis of a long term heart disease and – in liaison with patients (and where appropriate family/carers) - record relevant clinical and non-clinical needs and wishes as the basis of implementing care in a care plan. This should include adults with congenital heart disease. The care plan should include information on what the diagnosis means for the patient, what to look out for and which service to access should problems occur; it should be reviewed at appropriate points along the pathway.

3. Make arrangements to ensure that information in the care plan or GP letter is available both to the patient and recorded on clinical information systems - and is accessible to others who have clinical responsibility for the patient, including out-of-hours GP services, on a 24/7 basis.

4. Provide access to expert patient and carer programmes when required

5. Work proactively with third sector services and provide effective signposting to information and support, enabling patients to easily access support services

**Our priorities for 2015-16 are:**

- We are reviewing our provision of Cardiac Rehabilitation (CR) and update our plans by providing a multidisciplinary approach to the delivery of Cardiac Rehabilitation services across BCUHB. We will review the provision of CR to current patient groups through the all Wales Cardiac Rehabilitation Group as well as develop plans to expand the service.
- We will continue to provide audit data for the National Database (NACR) and where there are gaps, we will work with the Cardiac Network to develop proposals to meet those gaps.
- We will continue to review the CR referral system of patients from inpatient activity through to discharge home and referral received as outpatients from a number of sources.
• In line with the Health Board’s repatriation programme and the development of the second Cardiac Catheterisation Laboratory at YGC, we will review the demand for local CR services, possibly linking with the Welsh Clinical Portal.
• We will continue to work with our partners: localities, National Exercise Referral Scheme (NERS) and Heart Failure teams, as well as other agencies to ensure that CR provision meets the needs of patients with newly diagnosed Heart Failure by providing effective care.
• We will through the Cardiac Network review the provision of Palliative care for all Heart Failure Patients, linking with the all Wales Palliative Care and End of Life Delivery Plan
• We will work with our Third Sector partners to co-ordinate and support bids for posts and projects by engaging in local stakeholder meetings as well as the Network Board to understand and gain an understanding of this activity.

4.5 Improving Information

The priorities for 2015 – 16 are:

1. Ensure IT infrastructure supports effective sharing of clinical records/care plans
2. Put effective mechanisms in place for seeking and using patients’ views about their experience of heart services
3. Monitor and record performance against the Cardiac Disease National Service Framework and through annual self-assessment against the Quality Requirements and use the results to inform and improve service planning and delivery
4. Ensure full (100%) participation in mandatory national clinical audits, delivering significant improvements on current low participation rates - to support service improvement and support medical revalidation of clinicians – and ensure that findings are acted on
5. Participate in and act on the outcome of peer review
6. Publish regular and easy to understand information about the effectiveness of heart services
**Our priorities for 2015 are:**

- We will fully participate and comply with all the national mandatory Cardiac Audits which will provide assurances regarding the quality of care for patients. The information will also support our Peer Review programme across Wales. Additionally, we anticipate Wrexham Maelor Hospital becoming a pilot project DGH site for the National Heart Failure audit 2013-2014. This project will scrutinise the quality of data captured about individuals admitted with heart failure and the complexities of coding these admissions. This data will allow us an in-depth analysis of the pathway of care these patients receive.

- As part of our specialist workstreams looking at the adequacy and development needs of patient care plans, these work streams will be asked to identify mechanisms for seeking patients’, their families and carers’ views about their experiences of our services across the interface. Additionally, the Network will explore how to formally link with established methods within BCUHB for accessing patients’ views and feed this information back to the work streams. Some of the nursing research activity discussed under the following section (Research) addresses the use of patient stories.

**4.6 Targeting Research**

**The priorities for 2015 – 16 are:**

1. Support and encourage protected research time for clinically active staff (in primary as well as secondary and tertiary care)
2. Build on and extend academic training schemes to develop a highly skilled workforce
3. Promote collaboration with key research initiatives such as CVRG-C and HBRU
4. Promote public health research, for example to identify the best ways of working with those who are most disadvantaged or to demonstrate how services meet individual and population needs
5. Invest in accurate collection of key clinical data in a format that can be incorporated into the SAIL (Secure Anonymised Information Linkage) database for population-level health and social care research including focus on epidemiology, impact of interventions on outcomes, clinical trail scoping and service delivery modelling and assessment
6. Collaborate effectively with universities and businesses in Wales to enable a speedier introduction of new evidence-based and cost-effective technology into the NHS

Our priorities for 2015-16 are:

- We will develop a research culture led by Professor Michael Rees, Academic Professor of Radiology and Cardiology, and link with Cardiovascular Research Group by understanding firstly where potential resources may be targeted effectively, for example the BHF research funding. The current HB research budget to be identified to advise the National HDDP Implementation Group.

- We aim to explore the feasibility of developing and encouraging our nurse-led research programme. We now have several specialist nurses involved in either doctoral or masters research activity; much of which focuses on qualitative patient experience.

5.0 PERFORMANCE MEASURES/MANAGEMENT

The Welsh Government’s Heart Disease Delivery Plan (2013) contained an outline description of the national metrics that LHBs and other organisations will publish:

- Outcome indicators which will demonstrate success in delivering positive changes in outcome for the population of Wales.
- NHS assurance measures which will quantify an organisation’s progress with implementing key areas of the delivery plan.

Indicators and assurance measures will be further developed by the All Wales Heart Disease Implementation Group. Progress with these outcome indicators will form the basis of each LHB’s annual report on heart disease. They will be calculated on behalf of the NHS annually at both a national and LHB population level. LHBs will produce an initial progress report in March 2014 and full annual reports in March 2015 and March 2016.
LHBs will also report progress against the local delivery plan milestones to their Boards at least annually and to the public via their websites. It is expected that Local Delivery Plan and their milestones are reviewed and are updated annually from March 2015.