Cross-Party Group on Heart and Circulatory Diseases

12 December 2023 6-7.30pm

Minute

Present

MSPs

Alexander Stewart
Colin Smyth

Invited guests

Claire-Louise Cassidy
Janet McKay

Non-MSP Group Members

Kym Kestell
Mairi Morrison
Richard Forsyth
Sandra McLeod
Brian Forbes
Graeme Rose
Katharine McIntosh
Fiona Brownlie
Sophie Bridger

Apologies

Carol Mochan
Karen Adam
Gillian Mackay

Agenda item 1

Welcome and introductions

Co-Convenor Colin Smyth MSP

Agenda item 2

Minutes of last meeting

Minutes of meeting held on Wednesday 26th September to be agreed

Proposed by Alexander Stewart and seconded by Jonathan Roden

Agenda item 3

Topic Discussion: Heart Disease Action Plan Priorities 3 & 4: Workforce and Effective use of data

Speakers

Claire-Louise Cassidy, National Clinical Coordinator, Public Health Scotland

Claire-Louise began by setting out that previous data audit arrangements saw that all data was submitted to the National Institute for Cardiovascular Outcomes Research (NICOR) within NHS England which annually reports on performance. She noted that it was very much a one-way street with no involvement from Scottish clinicians, and they had no say in the report or on what key standards could be. There was no formal governance around performance or concerns, as well as no opportunity to ask questions or make edits. It became apparent that some of the boards hadn't been submitting data, but there were no questions asked.

The initial aim was to create a Scottish Cardiac Audit Programme (SCAP) similar to the National Cardiac Audit programme. However, there were lots of concerns on how to get a proper picture since Scotland is a smaller country. It was then decided that SCAP would use the data in NICOR that people were already used to submitting. This allowed for a better understanding of the Scottish picture and the ability to benchmark against the rest of the UK.

The current report has data on 4 of the 5 domains previously submitted to NICOR such as PCI, TAVI, Adult cardiac surgery, and congenital. SCAP previously submitted Cardiac rhythm management to NICOR, but it hadn't been properly set up as boards were not submitting data. A new data input tool called REDCAP was also implemented which is a cardiac rhythm management tool that has added in further procedures for structural heart disease. Cardiac rhythm management and structural heart disease are areas in development to be reported on in 2024. The next planned SCAP publications are in January of 2024 and October 2024.

Claire-Louise then discussed the issue of improving data quality. Missing data was a significant issue with some of the datasets included in the first publication. Claire-Louise noted that this issue was resolved through the engagement with local teams, the provision of the redcap data collection tool and the linking of data with other national datasets. SCAP worked with local teams to identify areas that would benefit from the development of a RedCap database to support local data provision.

TAVI was the first audit area to make use of RedCap and over 1000 records have been entered across boards since going live. Teams have all committed to sending in data

quarterly. This allows SCAP to run clinical dashboards, if there are any business cases SCAP can make the dashboards as specific as needed. Additional dashboard views are in the process of being developed for clinical service leads and the heart disease task force.

Clinicians are included in the SCAP steering group meetings which allows them to have a say and shape the priorities. Closer engagement has allowed quicker responses to data queries and improved data quality where specific issues were identified.

SCAP works closely with the Scottish Government policy team to explore how data can support policy discussions, development, and evaluation. Recent work with the short life working group for women's heart health highlighted the potential areas for quality improvement and working across service to explore differences in care delivery.

Initially there was a lack of engagement from clinical teams and an initial resistance to change regarding SCAP. However, this turned around after the first publication of the SCAP report and it became clear how beneficial it had been. The NICOR benchmarking has proven to be a bit difficult especially for congenital where there are single sites, so it is imperative that they have someone that they can benchmark against. SCAP is also benchmarking against the previous year rather than the most current one when benchmarking against NICOR.

Engagement with the data teams has improved the quality, as well as allowing a 3-month window to clean data and linkages with other national data sets to support missing data.

SCAP has started scoping work to develop audits to help manage chronic conditions such as heart failure, hypertension, and cardiovascular disease, but SCAP does not currently have the resources to fully engage and take that further. Future SCAP reports will also look at patient reported outcome measures. Future SCAP development work could also include a congenital registry and the provision of effective data collection tools for cardiac rehab.

Janet McKay, Consultant Nurse, NHS Ayrshire and Arran

Janet McKay spoke about the importance of the nursing workforce to cardiology. She further discussed the purpose of the Transforming Nursing Roles (TNR) Paper 08 from 2021. This paper included a review of Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) roles within Scotland. The paper looked to maximise the contribution to the Nursing, Midwifery and Health Professionals (NMaHP) workforce & to push the traditional boundaries of professional roles.

The TNR paper aimed to provide strategic oversight, direction & governance to develop and transform NMaHP roles and to meet the current and future needs of Scotland's health & care systems. Especially as clinical nurse specialists are recognised as being an integral part of the workforce. However, there is a diverse array of job titles and a lack of clear demarcation from other roles. The workforce of Clinical Nurse Specialists (CNS) also struggles with the fact that more than 50% of CNS are over 50 years old.

The TNR paper recommended that the Commission NHS Boards reviewed all Clinical Nurse Specialist Roles by undertaking a data cleanse to establish the numbers of Nurse specialists who map across to a new definition outlined in the TNR paper.

It further recommended to support the development of a generic level 6 Clinical Nurse Specialist/Specialist Nurse Practitioner job description and a Level 7 Advanced Clinical Nurse Specialist job description to help support national consistency.

The final recommendation was to undertake a comprehensive piece of work to explore how to position education for both the Nurse practitioner/Advanced Nurse Practitioner and Clinical Nurse Specialist/Advanced Clinical Nurse specialist within an education and career pathway. And to include Advanced Clinical Nurse Specialists within the advanced Practice Academies.

Janet McKay then discussed the benefits of the CNS role. Clinical Nurse Specialists make a valuable contribution to health and social care in a range of ways including:

a) Delivering services close to home
b) Developing innovative service delivery frameworks
c) Promoting seamless care across sectors
d) Developing and implementing care plans
e) Monitoring, reviewing and amending treatment plans of care for people with long-term conditions to prevent unrequired hospital admissions
f) Helping other staff to develop new skills by providing education and training

She further discussed the actions undertaken in HDAP Priority 3: Workforce. This included the mapping of the current cardiology CNS workforce. As well as the agreed umbrella cardiology CNS title to support coding of specialist roles and agreed core cardiology CNS competences at band 6 and 7. This was facilitated by the Short Life Working Group with wide representation across Scotland. Finally, this included support for the development of educational routes.

Janet McKay stressed that it is important to note how much of a difference it makes to specialist nursing to have a clear and concise framework in place. The Heart Disease Action Plan has made that difference.

Agenda item 4

Discussion and questions

Colin Smyth: Do we now have consistency across all health boards on what a specialist cardiac nurse is? Is there national guidance on what kind of level of provision a health board should have in their local area?

Janet McKay: The short life working group has recommended what the titles should be to the Government. However, to move forward the boards still have to accept that. Some of the boards have already started doing that, but it is not done across all boards yet. We are expecting that will develop in the next year or so.

Colin Smyth: Recruitment is a big issue – Does having those specialist roles make it easier to recruit for, rather than a general role?

Janet McKay: If I go out tomorrow to recruit for a nurse to join my team, I won't have a problem. The issue for me will be that it takes me 2-5 years to train a specialist nurse. Most of the people in my team have more than 9 years of specialist training and they were 20

years in cardiology before that. That really is the problem for specialist nursing in Scotland. We've got an aging population so the time it takes to train people properly will cause a problem at some point. We will be left with a less qualified workforce if we do not start to make plans now.

Colin Smyth: It's interesting because obviously a part of the action plan is trying to fill gaps. You are still at the start of that process and at an early stage. You're getting to a point where once you've got that definition across health boards you can start to measure and find out where those gaps are.

Janet McKay: Currently there's only one MSc in specialist nursing however not in cardiology. The requirement to be a level 7 nurse you have to at least have a postgraduate diploma. We have a gap in educational opportunities for the well-trained nurses. The aim is that everybody in a specialist role does have a postgraduate role or a master's at level 7, or a PgCert when working at level 6. We have a big challenge of getting the workforce to that point.

Mairi Morrison: You said that the findings say that 50% of clinical nurse specialists are over 50 years old, does that present another difficulty filling those gaps as those nurses move on?

Janet McKay: That certainly is an issue for specialist nursing. It is not the filling of the gap, but rather filling the gap with appropriate specialised individuals. There is a big difference between a qualified cardiology nurse and then a qualified nurse that can do a specialist nurse job. Because as a specialist nurse you are individually responsible for a patient. These people have to make decisions on clinically sick people. So, you cannot put someone in that post without support and training.

Graeme Rose: Now that you have a picture of the number of specialist nurses, is there a difference between urban and rural boards of where the specialists are?

Janet McKay: In terms of rural and urban boards, we have the data of what the percentage of nurses per area is, but generally speaking, specialist nursing is not differentiated by urban and rural. There will the exact same nurses per 100,000. There will be, however, slightly different problems. The development of the service is different because of the environment.

Graeme Rose: Is the SCAP data able to expand on the collection of data in blood pressure or is it constrained in that?

Claire-Louise Cassidy: We've got atrial fibrillation (AF) and hypertension are a part of our clinical conditions work in the pipeline. However, we do not have the resource to properly scope it, so we cannot take it much further. We've got the experts in the field for AF, hypertension, cardiovascular disease, and heart failure and asked them to write an aspirational list of the things they would like to be looked at to be measured. We then see what we can report on with a plan dependent on what resources we get. It will likely be that heart failure will take priority. We might be able to increase our scope much further if we focus on heart failure.

Graeme Rose: Is there any reason why cholesterol is not on that list alongside AF and hypertension?

Claire Louise: It's factored a bit in to the cardiovascular disease bits but not specifically. It's just dependent on the data we can get in linkage with lab work. It's quite difficult to report on. It certainly does trickle into some of the KPIs that have been identified.

Alexander Stewart: You mentioned that some boards had issues with data submissions, and this had to be resubmitted. Could you explain that a little further?

Claire-Louise Cassidy: Previously NHS Lanarkshire had been submitting their PCI data directly to NICOR and hadn't realised that the way they had been submitting it from two different systems they weren't merging properly. When they gave it to us, we worked out what the problems were and helped them work back. So, we were able to improve their data collection processes. We then went to different data sets such as Scottish ambulance service, where the board had struggled to get that data. We now do that on a regular basis.

Alexander Stewart: That has a knock-on effect for the staffing levels when you are trying to assess what staff is required. Because if the data is not correct that skews some of the data.

Claire-Louise Cassidy: Most of the problems with the data where we are doing linkages there's two main areas. One is around the Golden Jubilee patients; the data manager does not have the same access to the notes. The data is all sitting in the Royal Infirmary. So, we said we will pull that linkage for you. We can then offer it to people who might have the same issue. Our ability to link with the national stroke data set has given the national clinicians a lot more confidence in the data.

Jonathan Roden: One of the things the inquiry is trying to find out is on how we can support the work going forward – are there any particular barriers to this work progressing or any things that the NHS or Government can be doing to be accelerating this piece of work?

Claire-Louise Cassidy: From a SCAP perspective our biggest ambition would be to be able to start reporting on chronic conditions, which is something we haven't been able to do before. However, this is limited due to funding and resource. We have extended ourselves as much as we can to take a first step regarding scoping – I would imagine the breath of how things can be developed we'd probably have to focus on waiting times rather than getting into chronic conditions. However, if we would be able to get touching on chronic conditions it would make a massive impact.

Janet McKay: From a specialist nursing point of view, it would be around education. The government has tried to support the universities to develop pathways to help, but even if you have the pathways there's not enough nurses. It's a huge commitment to get nurses to do their masters, as well as the work and cost that factor into this. One of the challenges for all specialist nurses includes the fact that often you have to leave work to do the training, it's not easy to get that built in. Any opportunities that can be achieved to help free people up to then get them the education they need would be a great help, because we are struggling to do that currently.

Agenda item 5

Next meeting of the CPG

5th March 2024, 6-7.30pm