

## **A summary of the BCS response to the government's consultation on the NHS 10 Year Plan**

### **Workforce planning and future needs**

Our ageing population with its attendant multi-morbidity means we will need far more specialists to diagnose, treat and manage our patients. Waiting lists are currently increasing, and without extra capacity we will not be able to reduce them. We need better workforce planning, based on reliable population and morbidity data and predictions, to determine the number of cardiology specialists that will be needed. This includes consultant and resident cardiologists, cardiovascular nurses, cardiac pharmacists, cardiac physiologists and other scientists working in cardiovascular medicine.

### **Curriculum reform**

Cardiology training has been diluted as a result of service provision requirements in general medicine and poor recruitment in other medical specialty areas. A reform of the cardiology curriculum is urgently required to ensure that cardiologists emerge from training equipped to perform competently, which is not currently the case. They need more exposure to both simple and complex cases where they can acquire and hone the skills we will depend on them having to practice at a world class level. There is particularly concern in the areas of TAVI (Transcatheter aortic valve intervention) and congenital heart disease where there is a considerable projected shortage of adequately trained workforce to manage the ever-growing population of patients needing specialist treatment.

### **Retention and career management including research capacity**

In addition to maintaining training standards, we need to stop the people we do have in post leaving due to experiencing burnout/low morale and inflexible work patterns. We need to offer consultant job plans that are attractive to a broad range of people, to attract good candidates to fill cardiology jobs across the country and across all the subspecialties. Those jobs need to be sufficiently flexible over time to retain those people to the end of a full career.

A particular area of concern is the lack of emphasis in research being an important part of clinical training. UK Cardiology takes pride in leading in much research and innovation internationally due to the high academic profile over the past few decades. There is erosion of the academic pool and excellence as a result of the constant emphasis in clinical service provision with the resultant crisis of poor academic appraisal of new technology and lack of high performing academic leadership.

### **Managing cardiovascular risk factors**

We need to prioritise cardiovascular risk factor management, ensuring adequate resources and effective clinical pathways to facilitate early diagnosis of conditions such as hypertension, hyperlipidaemia and diabetes. This includes increased use of digital technology for early diagnosis and treatment of CV conditions using digital health technologies, effective innovations in digital platforms, virtual wards, and coordinated remote monitoring and management. Digital health and technology are currently relatively limited areas in the specialist cardiology curriculum and need to be developed, in addition to academic and research expertise in this crucial area as we explore its potential.

### **Tackling inequalities in access to prevention, diagnosis and treatment in cardiovascular disease**

Those most at risk of disease are often the hardest to reach due to factors such as social deprivation, language barriers, cultural issues, poverty and other causes. We need to reduce inequalities in access to prevention, diagnosis and treatment in cardiovascular disease – across sex, race, social deprivation, under-represented communities and for those in rural areas. We should make it easier for people, especially the most socioeconomically deprived that bear the brunt of CV morbidity, to lead healthier lives (cheap healthy food, low salt in our food, reduced alcohol consumption, cities that are geared around public transport, cycling and walking rather than the car). This includes supporting disadvantaged groups to take up testing, screening and other opportunities to catch risk factors early – there are good local examples of meaningful and effective local engagement.

### **Moving care from hospitals to communities**

Patients in cardiology wards need specialist care from doctors and nurses, relying on dedicated equipment and the availability of more intensive care beds/coronary care units in close proximity should the patient's condition start deteriorating. We do not currently have the infrastructure for effective and safe community based delivery of hospital-level care of patients.

Our current inability to discharge hospital patients when they are ready to be discharged is already a huge problem due to lack of community care and delays in social care availability. This needs addressing urgently and in advance of any expansion of CV services into the community as it would bring the immediate benefits of freeing up availability for hospital care.

Cardiology relies heavily on the availability of diagnostic hardware, for example echocardiology machines, CT scanners and other technology, and the specialist staff who manage it. To move more than a fraction of these hospital-based facilities would entail a major investment in both the equipment and staff to run them, as we would not be able to release the existing equipment from our hospitals into the community. The efficiency of providing everything on a single site would be lost, particularly in rural areas, and affect the training of resident doctors.

To enable cardiology services, particularly testing, to move into the community, we will need a major investment in extra equipment, staffing, training and retraining, and research into what we can safely provide given the current hospital-based nature of the specialty, and fully funded pilot studies.

### **Making better use of technology in health and care**

Current obstacles to making better use of technology in health and care include the lack of a single patient database across the NHS, joining primary, secondary and community care records; the lack of interoperability between systems and records; lack of reliable access to computers or technology for NHS staff; poor wifi; inadequate numbers of terminals; poor, unreliable hardware and software that causes delays to clinics, patient management and procedures; piecemeal introduction of software solutions without adequate thought to how they need to integrate with other systems; and lack of recourse to fast IT repair services.

For patients unable to use or navigate the technology effectively for whatever reason, this can harm the relationship with the medical professional or create barriers in accessing care.

We need a heterogeneous digital platform landscape that could encompass and cope with a multitude of different Electronic Health Record systems, databases and platforms used by different hospitals and specialties. Systems implementation with a full understanding of the specific needs of specific pathways would be helpful, with scalable pathways. Special measures should be put in place

to support those unable to use the technology. Specific funding should be available for technological innovation, that cannot be diverted to keep basic services running.

We should introduce a national system for cardiac surgical referral from non-surgical centres - one system for entering data that allows all surgical centres to be options for the patient (depending on skillset, waiting times etc) and prevents hospital referrers from having to ring and discuss with multiple different centres, either electively or as an emergency.

### **Tackling the causes of ill health**

Cardiovascular disease does not have as high a public profile as cancer and some other conditions, and should have a much higher profile in public health campaigns, due not only to the significant morbidity and mortality, but also the beneficial impact of effective preventative measures instituted early and appropriately.

There is a lack of public awareness of the importance of maintaining a healthy heart due to ineffective public health education from primary school onwards. The school curriculum could include more on disease prevention such as the harms of smoking, the benefits of eating a healthy diet, and exercise. We need to engage people at a younger age in measuring and being aware of their blood pressure, weight, cholesterol and lipid levels. The majority of CV risk factors need to be identified proactively and earlier through primary care, for which we will need an increase the number of primary care staff and funding for the extra activity.

Funding for public health campaigns has been reduced to a bare minimum, this should be increased. More protective legislation is needed to prevent public use of and exposure to harmful products eg legislation to ban smoking for those under 16. We should mandate changes to product composition to reduce salt, sugar and fat and introduce a minimum unit price for alcohol.

We need to develop the evidence that spotting cardiac disease early actually improves long term outcomes. There have been major projects brought in by various governments without researching whether they actually lead to improved outcomes - for example rapid access chest pain clinics, CV screening in primary care. The NHS could be a big part of developing the evidence with cohort studies potentially. We need to put our efforts into screening programmes that genuinely improve hard outcomes.

We should make hospitals centres of health - where people choose to go to walk in green spaces/exercise/eat healthily, and decarbonise the NHS as far as is practical. The biggest long term risk to UK health is from climate change so it makes no sense for the NHS itself to be a major polluter. We should lead by example. Practical options include putting solar panels on all suitable hospital roofs, working with procurement and suppliers to reduce plastic waste, using our volume buying to push suppliers to change their packaging, and making NHS transport systems all-electric.

Long-term funding is needed for projects which are likely to take some time, to allow stability of project staffing and workload, and more ring-fenced projects to prevent monies being diverted to general running costs.