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Foreword from Dr Stephen Cross - Lead Clinician

This report covers the two-year period of time that the Coronary Heart Disease Managed Clinical Network (CHD MCN) has existed. I have been Lead Clinician since November 2005, having taken over from Dr Ken Oates.

The Managed Clinical Network for Coronary Heart Disease is an essential tool to ensure a Highland wide approach to service development and to assist with regional planning.

The major issue for regional planning at present is the development of a local angioplasty service which will have beneficial ramifications for the whole of Highland viz recruitment and retention of staff, patient pathways, ensuring more timely and more accessible cardiac interventions.

Stephen Cross
Clinical Lead Consultant Physician

Purpose of Managed Clinical Network for Coronary Heart Disease

The CHD MCN was established in 2004. Its purpose is to ensure that patients in Highland with Coronary Heart Disease experience a high quality seamless service. This is being done through creating a culture in which Patients, Public, Health Professionals and Voluntary Services link to review existing services and plan future provision. Making the best use of available resources is key in this activity.

Activities of the CHD MCN are planned in accordance with 'Strategy Update 2004 - Coronary Heart Disease and Stroke in Scotland' (Scottish Executive), NHS Highland’s corporate objectives, evidence based practice and to promote quality assurance.

Sue Menzies
Network Manager, CHD MCN

Quote from Dr Ken Oates, Consultant Public Health Medicine

“It was a privilege to work with colleagues on the CHD MCN over the past few years. Particular thanks are due to Ms Sue Menzies, the Network Manager for her tremendous enthusiasm and skill in taking the work programme forward. There have been various key improvements made in the care of people with heart disease. Death rates from CHD have declined and the quality of care and life both improved. Many of these improvements are highlighted in this report.”

Ken Oates
Consultant Public Health Medicine
### Year 2004

#### Summary of key milestones

**February**
- Coronary Heart Disease Managed Clinical Network formed
- Network Manager in post
- Funding obtained from Scottish Executive Health Department (SEHD) to support CHD MCN in implementing the National Coronary Heart Disease & Stroke Strategy
- New Opportunities Funding received to establish Cardiac Rehabilitation Service in Highland
- Diagnostic equipment for Cardio respiratory department purchased
- Troponin T testing 7 day service established

**April**
- Community Thrombolysis Sub Group formed
- Heart Failure Nurse Service Sub Group formed

**July**
- Healthy Weight Strategy group formed

**August**
- Guidelines for provision of Community Thrombolysis standardised

**September**
- Rapid Access Chest Pain Clinic started

**October**
- Pilot of Scottish Collection on Information – Acute Coronary Syndrome

**November**
- Funding Secured from Scottish Executive Health Department to recruit Patient and Carer Communications Officer for CHD & Stroke

**December**
- Community Thrombolysis service - dual approach with Scottish Ambulance Service and GPs

### Year 2005

#### Summary of Key Milestones

**February**
- CHD MCN Planning Event

**March**
- Audit/Evaluation of Rapid Access Chest Pain Clinic

**April**
- Quality Assurance Framework sub group formed

**June**
- Recruited Healthy Weight Strategy Officer
- Training and Education Strategy agreed
- Training and Education programme developed for delivery in Community Health Partnerships (CHP)
- Primary Care Collaborative developed in North and Mid Community Health Partnerships

**August**
- Highland Heartbeat Centre complete
- Percutaneous Intervention workshop

**October**
- Funding Secured for Heart Failure Nurse Service – NHS Highland and British Heart Foundation partnership (BHF)

**November**
- Highland Heartbeat Centre officially opened
- Recruited Patient and Carer Communications Officer for CHD & Stroke
- Agreed principle of direct access for GPs to Echocardiography Service

**December**
- Completed Patient Pathways for Heart Failure and Chest Pain
- Reviewed Patient Pathways for CHD in Raigmore

### Year 2006

#### Summary of Key Milestones

**January**
- Implement Scottish Collection of Information national data base for Acute Coronary Syndrome

**February**
- Links made with Chest, Heart Stroke Scotland and Highlands Voluntary Support Groups – Phase 4 Cardiac Rehabilitation

**March**
- Complete Quality Assurance Document
- Agreed principle of direct access to Exercise Tolerance Testing

**April**
- Guidelines complete for Angina, Left Ventricular Dysfunction and Statins

**May**
- CHD MCN Planning Event
- Development of CHD Web Site
Coronary Heart Disease Pathways and Guidelines

One of the primary focuses of the CHD MCN is to ensure that patients with Coronary Heart Disease experience a smooth patient journey through services.

In 2005 the network developed Highland-wide patient pathways for Chest Pain and Heart Failure. This involved extensive consultation with groups pan-Highland.

This process was extremely positive, which resulted in far more than completion of pathways. Many issues were raised to be addressed by the CHD MCN. Most importantly lines of communication were enhanced between all involved.

The pathways and supporting guidelines for Angina and Left Ventricular Failure will be available to all on the NHS Highland Extranet and the Coronary Heart Disease website.

Primary Prevention of Coronary Heart Disease

Highland Healthy Weight Strategy

Obesity is a major public health issue and is a recognised risk factor for Coronary Heart Disease which represents a major threat to Scotland’s current and future health. The consequences of our food obsessed, sedentary environment are not easy to overcome but there are strategies that can help.

Highland’s strategy aims to take a broad view of the influences on weight, which extend beyond individual responsibilities. A multi-agency steering group is guiding the work and development of the strategy.

Highland’s strategy acknowledges that the prevention and treatment of obesity needs action at all levels, including for example, taxation policies, social welfare benefit reform, EU Common Agricultural Policy, changing community environments, and increasing the availability of affordable healthy food.

To date a mapping report of what resources currently exist in Highland has been completed. This will be set out in a directory and made available to people to aid access to help.

A Care Pathway mapping the patient’s journey has been developed and all staff involved are being consulted with. This aims to ensure that the most appropriate treatment is accessed for the patient at the right time. Guidelines for the treatment of over-weight and obesity will support this.

Highland Smoking Cessation Service

The CHD MCN has maintained close advisory links with the Highland Smoking Cessation Services leading up to approval by the NHS Highland Board of the new Tobacco Strategy. A significant element is the Tobacco Action Plan for 2005 to 2008 including the expansion of a network of smoking cessation advisors across Highland. A combination of dedicated advisors, existing primary care staff, and a smoking cessation advisor for in-patients at Raigmore Hospital are all trained to deliver specialist smoking cessation advice.

The community pharmacy smoking cessation service has also been developed with an additional 10 pharmacists recruited to the scheme to bring the total to 15.

NHS Highland staff will be able to access smoking cessation support either through Occupational Health at Raigmore Hospital or from the community smoking cessation advisors.
**Beating Heart Disease in Highland**

**Diagnosis of Coronary Heart Disease**

**Rapid Access Chest Pain Clinic (RACPC)**

The RACPC was established using resource from the Scottish Executive Health Department. Two clinics take place every week in Outpatients at Raigmore Hospital and have the capacity to see 4 patients per clinic. Referrals are made directly to the Cardio Respiratory department by phone and followed up with a referral via Scottish Collection Information (SCI) Gateway or faxed information.

The RACPC is for patients thought to have new onset angina, not for existing patients to obtain an earlier appointment or for patients with Acute Coronary Syndrome. There are set criteria for referral to the clinic. These can be found with the patient pathway on the Extranet and on the CHD MCN website on its completion in June 2006.

**Diagnostic Services**

The CHD MCN looked at patient pathways for Heart Failure and Chest pain last year. This process included extensive consultation with groups of people representative across Highland.

One of the outcomes from this piece of work was recognition of the fact that Primary Care Practitioners require easier access for their patients to diagnostic testing for CHD in order to provide appropriate treatment in a timely manner. This is in line with national recommendations from the report ‘Building a Health Service Fit for the Future’ (Kerr) that patients should be treated as near to their own homes as is possible.

**Direct Access to Echocardiography**

The increasing demand for echocardiography within Primary and Secondary care. New criteria are being drawn in consultation with GPs to enable patients to be referred to the echocardiography service for a screening echo. A report will be returned to the GP with advice on whether the heart is normal, or if further assessment is required.

Recruitment of trained staff to a vacant post continues to be a problem, and will need to be addressed before these developments can be implemented fully. However, we have been supported this year by the Cardiology Specialist Registrar, Dr Barclay, who has been providing additional outpatient sessions within the new Heartbeat Centre.

**Direct Access to Exercise Tolerance Testing**

The CHD MCN is in early stages of negotiating this service. An initial pilot offering 4 direct access GP appointments per week has been discussed. Criteria for referral will be made available.

Review of access to other tests is underway.

\[\text{"I didn’t wait long for the appointment – about a week. It was great being able to get the tests done on the same day and then to find out the results."}\]

Nursing staff support the clinic. Every Patient has an ECG performed on arrival in the clinic and blood tests as necessary. They are seen and assessed by a Physician. In the current audit it was found that Exercise Tolerance Tests are carried out on 82% of patients attending the clinic. These are provided by Cardio Respiratory Technicians.

Echocardiograms are carried out on 48% of patients, 19% of which are done on the same day by Medical Physics staff. Onward referral to Myocardial Perfusion Scanning and Angiography are available.
Beating Heart Disease in Highland

National Waiting Times

Waiting times are dictated by the Scottish Executive Health Department and are reported on monthly.

In Highland we are meeting the waiting time of 26 weeks for new out-patient clinics and 8 weeks for coronary angioplasty.

Troponin T Testing

This laboratory test was introduced in 2004 and ensures the early and accurate diagnosis of patients with chest pain.

This enables those with cardiac pain to receive appropriate treatment at a much earlier stage, while those with non-cardiac pain can be given reassurance and discharged home.

Treatment of Coronary Heart Disease

Community Thrombolysis

In 2005 there was a major change in management of people presenting with acute chest pain in Highland. This was as a result of partnership working between the Scottish Ambulance Service and GPs to provide a dual response wherever possible to these calls across Highland.

The emergency vehicles are equipped with telemetric facilities to assist decision support for diagnosis and treatment of heart attack. Paramedics are trained in the delivery of Thrombolysis a clot-busting drug.

Scottish Collection Information – Acute Coronary Syndrome

This is a national initiative, which aims to provide an IT solution for collection of CHD data in Scotland. This is the first step in moving towards a full patient management system, including electronic linkage with all areas involved in the care of CHD patients.

Highland worked with the National Team in 2004/05 to pilot the system. The final web based system is currently in the process of being rolled out across Highland. This will enable us to monitor and review our treatment of acute coronary syndrome.

Cardiac Rehabilitation

New Opportunities Funding received to establish Cardiac Rehabilitation in Highland

“Absolutely great - gives and boosts confidence.”

Classes have been established throughout Highland to provide exercise and information for patients with Coronary Heart Disease.

By December 2005, 546 people throughout Highland had benefited from the increased provision and locally accessible classes.

The next phase is to establish ongoing community based exercise sessions for cardiac patients to encourage them to maintain activity and lifestyle changes by providing motivation and support on discharge from their hospital based programme.

“The classes are great, I have met people and can talk about our experiences. It has given me more confidence and understanding in what I can now do.”
Beating Heart Disease in Highland

Highland Heartbeat Centre

This centre, located in the grounds of Raigmore Hospital, was opened in July 2005 and built from money raised by public subscription following a campaign run jointly by British Heart Foundation, The Highland News Group and NHS Highland. The campaign raised £1.1 million in total over a 2-year period.

The main role of the centre is to provide a venue for increasing the provision of cardiac rehabilitation classes and clinics, to provide a resource for staff in the community working to support cardiac patients and a base for cardiac research.

Several staff training events have already been hosted here and the number of Cardiac Rehabilitation classes have increased.

Cardiac patients throughout Highland will have enhanced support due to £73,000 surplus in the campaign fund. Part of this money will be used for staffing to enable further expansion of the Rehabilitation classes at Raigmore but also to look at supporting patients in Highland on immediate discharge from Hospital following a cardiac event.

The money will also be used to purchase a stock of Lothian Heart Manuals. This is a 6 week “DIY” 'get yourself back to normal' programme for patients to follow on discharge home after a heart attack.

Comments from a Patient

“I attended two Rehabilitation Courses - one after a heart attack and the other after surgery. The later course was in the new Heartbeat Centre where the new facilities helped to make it a much more ‘customer friendly’ experience.

Previously you had to wait for the class to start in a general waiting area where it was not so easy to make conversation. Now there is a changing room where you can get ready beforehand and you then wait with other class members in a lounge area local to the gym. The new equipment in the gym also allows the exercises to be more varied. For some it also gives an incentive, as being allowed to use the equipment, means that progress is being made and you are getting fitter. After the exercises, most of the ‘Information Talks’ are now held in the lecture room that has built-in projection and sound facilities. This helps you to take in the information more easily and of course it is more comfortable than the gym area.”
Scottish Primary Care Collaborative

North Highland Update:
We are almost at the end of year one and North Highland GP Practices have achieved commendable improvements in their CHD measures from an already high baseline.

The Practices have been working hard on:
- Validation of their registers
- Health promotion
- Establishing proactive call/recall systems
- Systematic and proactive screening
- Partnership working with the MCN, Community Pharmacist, Specialist Practitioner for Cardiac Care and others to improve service co-ordination and smooth the patient journey.

The GP Practices attended three national Learning Workshops where they had protected time to identify and share improvements both as a North Highland Team but also with other Practices in Highland and Scotland-wide.

<table>
<thead>
<tr>
<th></th>
<th>Average % of CHD patients on Aspirin</th>
<th>Average % of CHD patients on a Statin</th>
<th>Average % of post MI patients within the previous 12 months on Beta-Blockers</th>
<th>Average % of CHD patients with a last recorded BP reading below 140/80 within the previous 12 months</th>
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</thead>
<tbody>
<tr>
<td>April 2006</td>
<td>94%</td>
<td>89%</td>
<td>96%</td>
<td>69.5%</td>
</tr>
<tr>
<td>% Improvement</td>
<td>12%</td>
<td>19%</td>
<td>34%</td>
<td>5.5%</td>
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Mid Highland CHP Update:
All five Practices in Mid Highland CHP are coming to the end of year one of the SPCC improvement programme and they have all made commendable improvements in the care of their patients with CHD. The work they have undertaken is similar to what has happened in the North Highland Practices.

Mid Highland CHP Delegates attend ‘team time’ during Learning Workshop 3 at St Andrew Bay Hotel in February this year.

<table>
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<tr>
<th></th>
<th>Average % of CHD patients on Aspirin</th>
<th>Average % of CHD patients on a Statin</th>
<th>Average % of post MI patients within the previous 12 months on Beta-Blockers</th>
<th>Average % of CHD patients with a last recorded BP reading below 140/80 within the previous 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2006</td>
<td>96%</td>
<td>90%</td>
<td>96%</td>
<td>66.75%</td>
</tr>
<tr>
<td>% Improvement</td>
<td>13.6%</td>
<td>8%</td>
<td>35%</td>
<td>17%</td>
</tr>
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</table>
Beating Heart Disease in Highland

Secondary Prevention

Heart Failure Nurse Service

“Without the Heart Failure Nurse, I would feel lost and feel no one (except family) actually cared. As we know heart failure cannot be resolved, so to have someone who appears to genuinely care enough to give the best possible quality of life to a patient is beyond measure.”

(Quote from patient survey)

The CHD MCN has secured an agreement with British Heart Foundation (BHF) to jointly establish a Heart Failure Nurse service in Highland. BHF will fund three whole time equivalent nurses in Highland for three years followed by 50% funding for two subsequent years. It is planned that the Team Leader for this service will be in post by August 2006.

Heart Failure Nurse Service

AIMS

- Improve the quality of care for patients with chronic heart failure in the Highlands.
- Regular follow-up and assessment to detect early clinical deteriorations
- Continual adjustment and optimisation of therapies
- Close monitoring of blood chemistry
- Assist patients in self management
- Education of pharmacology and non pharmacology
- Act as an intermediate between consultant and GP
- Provide support for patients and carers

Quality Assurance

A draft Quality Assurance Framework document has been completed. Much of its content has been gleaned from the pathway activity.

All areas involved have been asked to agree content ready for the Quality Assurance Sub Group to review. The document will then be assessed by Quality Improvement Scotland in order that NHS Highland’s CHD MCN becomes accredited.

It is intended that this document be used as an action plan to drive activity of the Network over the next year.

Communication

The CHD MCN produces a newsletter twice a year, which is widely distributed and also available on the NHS Highland web site. Monitoring Reports are returned to the Scottish Executive Health Department twice a year.

A Coronary Heart Disease website is currently under construction. It is due for completion in July 2006.

Training and Education

One of the principles of the CHD MCN is to ensure that education and training potential is used to the full.

A Sub Group was established to ensure this principle was fulfilled.

A training package was developed in 2005/06, based around the patient’s journey through services for CHD. This was provided in each CHP, at their Protected Learning Time sessions. A multi disciplinary team of people from across Highland committed their time to provide this. The network is extremely grateful for their input.

Evaluation of these events has proved to be very positive. The Sub Group will meet again this year to plan future activity.

Voluntary Support Groups

The Network has developed links with Chest Heart and Stroke Scotland (CHSS). It is planned to address the issue of Phase 4 Cardiac Rehabilitation (continued lifestyle changes such as exercise in the community) in Highland with local Voluntary Support Groups.
Beating Heart Disease in Highland

Patient and Carer Communications Officer for CHD & Stroke

This six-month project focussed on the information a patient with CHD receives when they attend Raigmore Hospital. Information currently available was identified along with structures and procedures in place for distribution.

Patient focus groups were held in February 2006. These were very effective in ensuring that the experiences of the patients were and their suggestions for improvement were brought to the attention of the CHD MCN.

These discussions along with talking to staff involved, resulted in a report on Patient Information being issued in May. A number of recommendations are currently being implemented.

These include a new information sheet and poster for the Rapid Access Chest Pain Clinic, a leaflet for patients experiencing Chest Pains, amending existing in-house literature and ensuring that some procedures are changed so that all patients receive the same level of information.

This information has been produced in a template that can easily be adapted for use in other areas of Highland if desired.

Financial Summary of CHD MCN 2005/06

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Budget £</th>
<th>Spend £</th>
<th>Slippage £</th>
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<tbody>
<tr>
<td>Highland Heartbeat Appeal</td>
<td>1,100,000</td>
<td>1,027,000</td>
<td>-73,000</td>
</tr>
<tr>
<td>New Opportunities Funding</td>
<td>125,800</td>
<td>90,026</td>
<td>-35,774</td>
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<tr>
<td>SEHD - CHD/Stroke Business case - CHD MCN</td>
<td>42,000</td>
<td>42,000</td>
<td>0</td>
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<tr>
<td>SEHD - CHD/Stroke Business case - One stop clinic</td>
<td>30,093</td>
<td>26,286</td>
<td>-3,807</td>
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<td>SEHD - CHD/Stroke Business case - Chest pain clinic</td>
<td>23,232</td>
<td>11,994</td>
<td>-11,238</td>
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<tr>
<td>SEHD - CHD/Stroke Business case - Echocardiography</td>
<td>54,477</td>
<td>24,020</td>
<td>-30,457</td>
</tr>
<tr>
<td>SEHD - CHD/Stroke Business case - Troponin</td>
<td>13,000</td>
<td>13,000</td>
<td>0</td>
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**Total**

1,388,602 1,234,326 (154,276)

Supporting Information

Highland Heartbeat Appeal
Following completion of the Highland Heartbeat Centre, a £73,000 surplus was identified. This is being used to enhance exercise classes in the centre and increase support for patients in the community.

New Opportunities Funding (Big Lottery Fund)
There are a number of reasons for the appearance of slippage in this budget. Due to phasing of start dates for different locations, some areas have not yet reclaimed all their costs, there have been recruitment issues and money for British Association Cardiac Rehabilitation Phase 4 training for Year 2005/06 has been carried forward. This slippage will be carried forward for use in developing Phase 3 and Phase 4 Cardiac Rehabilitation in Highland.

Scottish Executive Health Department (SEHD)
Due to issues around recruitment of staff over the past two years there has been significant slippage in the SEHD funding. This resource is non-recurring and has been used to purchase equipment and refurbish clinical areas.
CHD MCN Steering Group Purpose
The CHD MCN Steering Group oversees all aspects of the network. It is responsible for agreeing and setting the network strategy, and sanctions the structure, deliverables, timescales and working responsibilities. Its membership represents all relevant interests.

<table>
<thead>
<tr>
<th>Name of Member and Alternative</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Liz Batstone</td>
<td>Vascular Nurse, SE Highland CHP representative</td>
</tr>
<tr>
<td>Heather Fraser</td>
<td>District Nurse</td>
</tr>
<tr>
<td>Gwen Calder/ Alison Fraser / Liz MacDonald</td>
<td>ITU/CCU Charge Nurse</td>
</tr>
<tr>
<td>Stephen Sandison</td>
<td>Staff Nurse CCU</td>
</tr>
<tr>
<td>Fiona Clarke</td>
<td>Health Promotion Specialist</td>
</tr>
<tr>
<td>Helen Corrigall</td>
<td>Cardiac Rehabilitation Co-ordinator</td>
</tr>
<tr>
<td>Claire Savage</td>
<td>Cardiac Rehabilitation Co-ordinator</td>
</tr>
<tr>
<td>Stephen Cross</td>
<td>Clinical Lead, Consultant Physician</td>
</tr>
<tr>
<td>Colin Farman</td>
<td>Medical Physics</td>
</tr>
<tr>
<td>Fiona Dawson</td>
<td>Senior Chief CCSO</td>
</tr>
<tr>
<td>Daveen Lowson</td>
<td>Patient Representative</td>
</tr>
<tr>
<td>Dave Currie</td>
<td>Scottish Ambulance Service</td>
</tr>
<tr>
<td>Andy Fuller</td>
<td>Scottish Ambulance Service</td>
</tr>
<tr>
<td>Dr Catherine Higgott</td>
<td>GP North Highland CHP representative</td>
</tr>
<tr>
<td>Catriona Sutherland</td>
<td>Cardiac Rehabilitation co-ordinator, North CHP rep</td>
</tr>
<tr>
<td>Thomas Ross</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Mary Morton</td>
<td>Pharmacist Prescribing Adviser</td>
</tr>
<tr>
<td>Iona McGauran</td>
<td>Medical Directorate Nurse Manager</td>
</tr>
<tr>
<td>Anne McIntyre</td>
<td>Patient Representative/British Heart Foundation</td>
</tr>
<tr>
<td>Mike Young</td>
<td>British Heart Foundation</td>
</tr>
<tr>
<td>Anne Melia</td>
<td>British Heart Foundation</td>
</tr>
<tr>
<td>Dr Stewart MacPherson</td>
<td>GP Mid Highland CHP representative</td>
</tr>
<tr>
<td>Sue Menzies</td>
<td>Clinical Network Manager</td>
</tr>
<tr>
<td>Dr Ken Oates</td>
<td>Consultant in Public Health Medicine</td>
</tr>
<tr>
<td>Linda Kirkland</td>
<td>General Manager Medical Directorate</td>
</tr>
<tr>
<td>Angus MacKiggan</td>
<td>Assistant General Manager Medical Directorate</td>
</tr>
<tr>
<td>Ronald W Rice-Garwood</td>
<td>Patient Representative</td>
</tr>
<tr>
<td>Gavin Brown</td>
<td>Patient Representative</td>
</tr>
<tr>
<td>Mary Parham</td>
<td>Allied Health Professional CHP representative</td>
</tr>
<tr>
<td>Roseanne Urquhart</td>
<td>Head of Healthcare Strategy</td>
</tr>
<tr>
<td>Fiona Matheson</td>
<td>Primary Care Collaborative CHD</td>
</tr>
</tbody>
</table>

CHD MCN Sub Group’s Purpose
CHD MCN Sub Groups of clinicians, patients and other interested parties will be formed with the purpose of discharging specific components of the project implementation plan. Working groups may be permanent or short-life in nature according to specific need.
Further Information

If you require further information on any of the CHD MCN’s activities or you would like to be actively involved please contact:

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This Annual Report was compiled by CHD MCN.  
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