Service Framework for Cardiovascular Health and Wellbeing

Welcome to the easy access version of the Service Framework for Cardiovascular Health and Wellbeing.

It sets out what you can expect from the Health and Social Care (HSC) services in Northern Ireland if you have a cardiovascular illness or you care for someone who does.

Publication Date: 28 May 2014

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Introduction

Welcome to the easy access version of the Service Framework for Cardiovascular Health and Wellbeing.

It sets out what you can expect from the Health and Social Care (HSC) services in Northern Ireland if you have a cardiovascular illness or you care for someone who does.

The full document is more than 200 pages long. You can get a copy by using the contact information on the Service Framework for Cardiovascular Health and Wellbeing page of this document.

Sometimes we use medical or complicated words. These words appear in bold type and you can look them up in a list at the end of the document.

The list also explains some words that are in brackets and the roles of the organisations that Come under the headings 'Who is responsible for making sure it happens?'

Ten standards are marked with this symbol:

This means the standard is general and has health and social care messages for everyone not just for people with cardiovascular illness.

A few words from the Minister

As the Minister for Health, Social Services and Public Safety I am determined to make sure all health and social care services are safe, effective and focused on the individual.

Service frameworks are for setting out the standards of care that service users and their carers can expect to receive in health and social care.

HSC organisations also use the frameworks in planning and delivering services.

The Service Framework for Cardiovascular Health and Wellbeing was first published in 2009. We also have frameworks for respiratory disease, cancer, mental health, learning disability and older people.

Now here is the new Service Framework for Cardiovascular Health and Wellbeing. It has been reviewed and updated from the original version to make sure that it contains the right standards that will improve the health of the people of Northern Ireland who have, or are at risk of getting, cardiovascular disease.

I believe that these standards will transform the quality of health and social services for those suffering from or at risk of developing cardiovascular disease.

Edwin Poots, MLA
Minister for Health, Social Services and Public Safety

Communication and Involvement

The following standards are included in the Communication and Involvement section

- Standard 1 Communication
- Standard 2 Involvement
- Standard 3 Independent Advocacy
- Standard 4 Identify and Supporting Carers

Standard 1

Communication

Everyone delivering health and social care should communicate effectively with patients, clients, carers and the public.

How we know it's working

By March 2014 we will find out how many patients, clients and carers are satisfied with the communication in the HSC. We will then report what we find and set a target to improve this by March 2015 and March 2016

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to make sure everyone working in the HSC communicates well with everyone using HSC services.

Why is it important?

As well as keeping everyone clear and well informed, good communication has a big impact on things like preventing disease and the management of long-term conditions.

Standard 2

Involvement

Patients, clients, carers and the public should have opportunities to get involved in the planning, delivery and monitoring of the care they receive.

How we know it's working

By March 2014 we will find out how many HSC staff job descriptions contain duties about getting patients, clients and carers involved in their care. We will then set targets to improve this during 2015 and by 2016 aim to include such duties in all new job descriptions.

By March 2014 we will find out how many people are satisfied with their involvement in their care. We will then set targets to improve this and report on the progress by March 2015 and March 2016.

By March 2014 we will find out how many HSC staff need training in getting patients, clients and carers involved in their care. We will develop and start a training programme. By March 2015 we will find out how many staff are trained in getting patients, clients and carers involved in their care. We will then set targets to improve this and find out again in March 2016 how many staff have been trained.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to make sure that all patients, carers and the public get involved with their care.

Why is it important?

Research shows that involving patients and the public in health and social care is better for patients, helps communication and improves outcomes of care.

Standard 3

Independent advocacy

Anyone using HSC services should be able to get an **independent advocacy** service if they need it. This applies to carers too.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to provide independent advocacy services so people have someone on their side making sure they have more control over their health and social care.

Why is it important?

Independent advocacy can make a real difference to people's lives by allowing HSC users and their families to express their views and wishes.

Standard 4

Identifying and supporting carers

All HSC staff should identify carers (whether they are parents, family members, siblings or friends) at the earliest opportunity so they can work in partnership with them and make sure they have the support they need.

How we know it's working

By March 2015 we will make sure at least 20% of staff in a range of settings take part in carer awareness training. By March 2016 this will be at least 50%.

Every year we will find out how many carers are offered and how many take part in carer assessments. We will then set targets to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to recognise carers as individuals in their own right and as key partners in providing care and support, so that they feel valued and able to get the support they need.

Why is it important?

Carers are key partners in the provision of health and social care. Involving carers in the planning, delivery and monitoring of services improves outcomes for the carer and cared for person.

Health Improvement and Protection

The following standards are included in the Health Improvement and Protection section

- Standard 5 Healthy eating
- Standard 6 Physical activity
- Standard 7 Smoking
- Standard 8 Alcohol
- Standard 9 Emergency life support
- Standard 10 Safeguarding people

Standard 5

Healthy eating

All HSC staff, as appropriate, should give relevant healthy eating advice and support to all HSC users.

How we know it's working

We know that in 2012 about one in three people in Northern Ireland said that they were eating 'five (pieces or portions of fruit or vegetable) a day'. We want to keep it that way or improve it if possible by one percent every year.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to make sure that users of health and social care services, where appropriate, get the right healthy eating advice and support.

Why is it important?

Evidence shows that eating a well-balanced diet can help prevent diseases linked to being overweight and can help people to be healthier and feel better.

Standard 6

Physical activity

All relevant HSC staff should give support and advice on appropriate levels of physical activity.

How we know it's working

By March 2014 we will find out how many people take the recommended amount of physical activity every week. We will then set a target to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to ensure that users of HSC services get good advice and support for physical activity to promote good health.

Why is it important?

Physical activity promotes good health and helps prevent disease

Standard 7

Smoking

All relevant HSC staff should advise people who smoke to stop. They should know about **smoking cessation** services and direct smokers to them.

How we know it's working

We will increase the number of people who go to smoking cessation services by 4% each year by March 2014, March 2015 and March 2016.

We will make sure that at least 5% of people who smoke go to smoking cessation services by March 2014, March 2015 and March 2016.

We will increase the number of people using smoking cessation services who have stopped smoking four weeks and a year afterwards by 2% each year by March 2014, March 2015 and March 2016.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want people who are ready to stop smoking to get specialist smoking cessation services in a choice of settings.

Why is it important?

Smoking is a major health hazard and one of the main risk factors for many types of cancer.

Standard 8

Alcohol

All relevant HSC staff should provide support and advice on appropriate levels of alcohol consumption.

How we know it's working

By March 2014 we will find out how many people have been screened for too much alcohol consumption. We will then set a target to improve his.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to make sure that people who drink harmful amounts are aware of the dangers of alcohol and get the right advice at the right time.

Why is it important?

Drinking too much alcohol is associated with many diseases. There are also links between too much alcohol and injuries and violence.

Standard 9

Emergency life support

Health professionals should work with schools, workplaces and communities to increase the emergency life support (ELS) skills of members of the public.

How we know it's working

We know that in 2010 a quarter of adults in Northern Ireland said that they had been trained in ELS skills. By March 2015 we will make training available across Northern Ireland. We will then set a target to improve this.

By March 2015 we will develop an information system to find out how many people survive out of hospital heart attacks because they got ELS and CPR. By March 2016 we will find out how many people survive out of hospital heart attacks because they got ELS and CPR and set a target to improve this. By March 2017 we will check if we are achieving the target.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **The Public Health Agency**

What are we trying to achieve?

We want to increase the chances of more people surviving out-of-hospital heart attacks by training more people in ELS skills.

Why is it important?

Most heart attacks happen out of hospital. Someone dies of a heart attack every seven minutes in the UK. Awareness and training in ELS or **CPR** will give people the ability to deal with life threatening emergencies. The knowledge and skills provided will also benefit individuals and communities.

Standard 10

Safeguarding people

All HSC staff and anyone providing services on their behalf should make sure that people of all ages are safe from harm through abuse, exploitation or neglect.

How we know it's working

By March 2014 we will find out how many HSC organisations and those providing services on their behalf have safeguarding policies, safeguarding plans and safeguarding champions in place. We will then set targets to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**
- **Patient and Client Council**
- **Regulation and Quality Improvement Authority**

What are we trying to achieve?

We want to prevent harm taking place and keep people safe. We also want to respond effectively if there is a concern that someone has been or is likely to be harmed

Why is it important?

People of all ages have the right to be safe from harm and to have their welfare promoted and human rights upheld.

High blood pressure

The following standards are included in the high blood pressure section

- Standard 11 Preventing high blood pressure
- Standard 12 Drug treatment for high blood pressure

Standard 11

Preventing high blood pressure

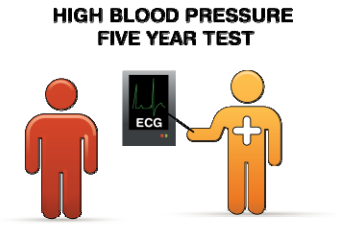
All adults should be advised on how to keep their **blood pressure** at the right level and have it checked every five years from age 45.

How we know it's working

By March 2015, March 2016 and March 2017 we will make sure that at least 90% of patients aged over 45 have had their blood pressure noted on their GP record within the past five years.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**



What are we trying to achieve?

We want to monitor high blood pressure (**hypertension**) in adults so we can spot it early, give advice on lowering it, and treat it if necessary.

Why is it important?

High blood pressure can lead to long-term organ damage. The earlier we can identify it, the earlier we can give advice and treat it.

Standard 12

Drug treatment for high blood pressure

Drug treatment to reduce high blood pressure should be offered to all people under 80 years who have **Stage 1 hypertension** and organ damage, **cardiovascular disease**, kidney disease, **diabetes** or a one in five chance of getting cardiovascular disease over the next ten years. Drug treatment to reduce high blood pressure should also be offered to everyone with **Stage 2 hypertension** regardless of age.

How we know it's working

By March 2015 we will make sure at least 85% of patients with high blood pressure who have had their blood pressure measured in the previous nine months have a reading of 150/90 or less. By March 2016 and 2017 we want this to be 90%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to offer appropriate drug treatment and monitoring to patients who suffer from high blood pressure.

Why is it important?

Treating and monitoring high blood pressure reduce the risk of patients having a stroke or developing kidney, heart and other diseases.

High cholesterol

The following standard is included in the high cholesterol section

- Standard 13 Preventing high cholesterol

Standard 13

Preventing high cholesterol

Everyone with a family history of familial hypercholesterolaemia (**FH**) should be identified and treated. Their names should be kept on a register to help identify, test and treat other family members who might be at risk.

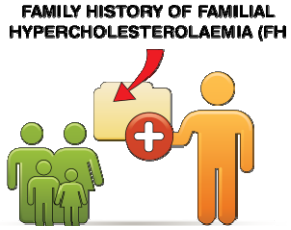
How we know it's working

By March 2015 we will identify at least 28% of people who may have FH. By March 2016 we will increase this to at least 34% and by March 2017 to at least 40%.

By March 2015 we will find out the number of patients with FH who have had their LDL cholesterol reduced by more than 50%. We will then set targets to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**



What are we trying to achieve?

We want to identify how many people have FH and how many relatives might be at risk. We want to make them aware of their condition and treat them.

Why is it important?

People with FH have greatly increased risk of **cardiovascular disease**. They often do not know they have the condition. It is important to diagnose people with FH as early as possible, ideally in childhood. A register for sufferers and relatives is an efficient way to identify, test and treat these patients.

Heart conditions

The following standards are included in the heart conditions section

- Standard 14 Irregular heartbeat
- Standard 15 Chronic heart failure
- Standard 16 New onset chest pain
- Standard 17 Cardiac rehabilitation
- Standard 18 Acute coronary syndrome

Standard 14

Irregular heartbeat

Anyone with an irregular heartbeat (atrial fibrillation) should have their risk of **stroke** assessed and treated as soon as possible.

How we know it's working

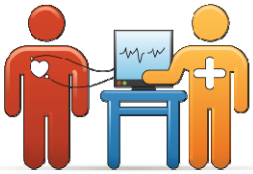
By March 2015 we will make sure at least 60% of patients over 65 have a documented assessment of atrial fibrillation. By March 2016 this will be at least 65% and by March 2017 at least 70%.

By March 2015 we will make sure at least 70% of patients with an irregular heartbeat and a 3% risk of having a stroke have the appropriate blood thinning treatment. By March 2016 this be at least 80% and by March 2017 at least 90%.

By March 2015 we will make sure at least 50% of patients with an irregular heartbeat and a 4% risk of having a stroke have blood thinning treatment. By March 2016 this be at least 60% and by March 2017 at least 70%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**



What are we trying to achieve?

We want everyone with an irregular heartbeat to have their risk of stroke assessed and appropriately treated.

Why is it important?

Atrial fibrillation is the most common type of irregular heart beat and a major cause of stroke. Blood thinning drugs and treatments can restore and maintain proper heart rhythms and improve quality of life.

Standard 15

Chronic heart failure

All patients diagnosed with **chronic heart failure** should be managed by a specialist team from **diagnosis** to the end of their life.

How we know it's working

By March 2015 we will make sure at least 70% of patients referred for assessment of **left ventricular failure** have their **BNP** levels recorded in their referral documentation. By March 2016 this be at least 75% and by March 2017 at least 80%.

By March 2015 we will make sure at least 80% of patients referred for an **ECHO** to investigate left ventricular failure have their procedure completed and reported on within nine weeks, and within two weeks if their BNP level is greater than 2000. By March 2016 this be at least 85% and by March 2017 at least 95%.

By March 2015 we will make sure at least 60% of patients with chronic heart failure caused by left ventricular failure are offered the appropriate drug treatment. By March 2016 this be at least 65% and by March 2017 at least 70%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**

What are we trying to achieve?

We want patients, families and the carers of people with chronic heart failure to have specialist care and support from the time of diagnosis to the end of the patient's life. This includes specially trained staff, working with suitable equipment in an appropriate environment.

Why is it important?

People with chronic heart failure often have a poorer quality of life than those with other chronic conditions. Management by specialist teams will help improve their quality of life.

Standard 16

New onset chest pain

All patients with new chest pain suggesting **angina** should be examined at a specialist clinic within two weeks of being referred by a doctor.

How we know it's working

By March 2015 we will make sure at least 90% of patients are seen at a specialist clinic within two weeks of a referral by a GP or appropriate clinician, not counting those who don't attend. By March 2016 this will be at least 95% and by March 2017 at least 98%.

Who is responsible for making sure it happens?

- **Local Commissioning Groups**
- **HSC Trusts**

What are we trying to achieve?

We want all patients with new chest pain that might be due to angina to be examined at a specialist clinic within two weeks of being referred there by a doctor.

Why is it important?

A specialist clinic can provide a complete, accurate and fast **diagnosis** for people with suspected angina, helping doctors to assess patients with new chest pain quickly.

Standard 17

Cardiac rehabilitation

All patients who need **cardiac rehabilitation** should get it from a specialist team.

How we know it's working

By March 2015 we will make sure at least 60% of patients referred for cardiac rehabilitation receive **phase 1**. By March 2016 this will be at least 65% and by March 2017 at least 70%.

By March 2015 we will make sure at least 95% of referred patients who are suitable for treatment receive **phase 2 cardiac rehabilitation**. We will maintain this figure by March 2016 and March 2017.

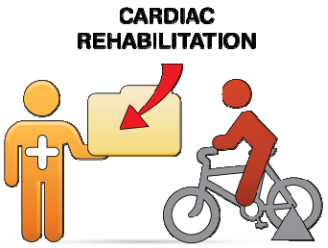
By March 2015 we will make sure at least 80% of patients who are suitable for treatment are invited to join a **phase 3 programme** of cardiac rehabilitation. By March 2016 this will be at least 85% and by March 2017 at least 90%.

By March 2015 we will make sure at least 45% of patients invited to join a phase 3 cardiac rehabilitation programme start it. By March 2016 this will be at least 50% and by March 2017 at least 55%.

By March 2015 we will find out how many patients accept a referral to a community exercise programme (**phase 4 cardiac rehabilitation**). By March 2016 we will increase this by 5% and by March 2017 by another 5%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**



What are we trying to achieve?

We want all patients who need cardiac rehabilitation to be helped by teams who can give the right treatment to every patient.

Why is it important?

Cardiac rehabilitation gives the best physical, mental, social and lifestyle support to help the patient to get back to normal life and prevent heart disease from getting worse.

Standard 18

Acute coronary syndrome (ACS)

All patients suffering from a heart attack should have the appropriate treatment within the recommended time for their condition.

How we know it's working

By March 2015 we will make sure at least 80% of patients have an **angioplasty** within 90 minutes of arrival in hospital for emergency treatment. By March 2016 this will be at least 85% and by March 2017 at least 90%.

By March 2015 we will find out how many patients with a heart attack who are suitable for treatment have an angioplasty within 120 or 150 minutes of calling for help. We will then set targets to improve this.

By March 2015 we will make sure at least 60% of patients with a heart attack not needing emergency treatment have a dye test and appropriate treatment within 72 hours from **diagnosis**. By March 2016 this will be at least 65% and by March 2017 at least 70%.

By March 2015 we will make sure at least 50% patients who need heart surgery urgently have their operation within seven days of being accepted by the surgical team. By March 2016 this will be at least 60% and by March 2017 at least 70%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**

What are we trying to achieve?

We want all patients suffering from a heart attack or a serious **cardiac event** to get the right key hole or open heart surgery within the recommended time.

Why is it important?

Heart surgery improves the chances of survival and recovery and reduces the length of hospital stay if patients can be treated in a specialist centre and within recommended timelines.

Stroke

The following standards are included in the stroke section

- Standard 19 Mini stroke
- Standard 20 Suspected stroke
- Standard 21 Stroke rehabilitation
- Standard 22 Stroke review

Standard 19

Mini stroke

Anyone suspected of having a **mini stroke** should have rapid specialist assessment, **diagnosis** and treatment to avoid a major stroke and other **cardiovascular** problems.

How we know it's working

By March 2016 we will make sure that at least 50% of all patients with a confirmed mini stroke and at high risk of a major stroke have a specialist assessment and a brain scan (if needed) within 24 hours. By March 2017 this will be at least 60%.

By March 2016 we will make sure that where needed at least 50% of high-risk mini stroke patients have access to specialist brain scanning within 24 hours, seven days a week, and that lower-risk patients have access to these brain scans within seven days. By March 2017 this will be at least 60%.

By March 2016 we will make sure at least 80% of mini stroke patients who look for medical attention receive blood thinning and **cholesterol** lowering treatment within 24 hours. By March 2017 this will be at least 85%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want anyone suspected of having a mini stroke to have rapid specialist assessment and treatment to avoid a major stroke.

Why is it important?

Mini strokes are a warning sign that a further stroke may happen soon. It is important that they are always investigated so that appropriate treatment can be given as soon as possible. With treatment, the risk of a further stroke is greatly lessened.

Standard 20

Suspected stroke

Everyone suspected of having a stroke should have rapid access to specialist assessment, brain scans and emergency treatment, including **clot-busting drugs**.

How we know it's working

By March 2015 we will make sure that at least 10% of patients assessed and found to have a stroke get clot-busting drugs within four and a half hours of their symptoms starting. By March 2016 this will be at least 11% and at least 12% by March 2017.

By March 2016 we will make sure that at least 80% of people who have had a stroke have brain scans within 12 hours of the stroke. By March 2017 this will be at least 85%.

By March 2015 we will make sure that at least 75% of patients who have had a stroke receive clot-busting drugs within 60 minutes of getting to hospital. By March 2016 this will be at least 80% and it will be at least 85% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **The Public Health Agency**

What are we trying to achieve?

We want everyone suspected of having a stroke to have specialist assessment and emergency treatment quickly, including brain scans and clot-busting drugs.

Why is it important?

Strokes are a medical emergency. Rapid assessment and treatment are essential because the sooner a person receives them, the less damage is likely to happen.

Standard 21

Stroke rehabilitation

Everyone who has had a stroke should have access to a specialist team in a stroke unit as soon as they go into hospital.

How we know it's working

By March 2015 we will make sure at least 80% of patients who have had a stroke are admitted to a stroke unit or similar hospital bed. By March 2016 this will be at least 85% and by March 2017 at least 90%.

By March 2016 we will make sure at least 50% of stroke patients leaving hospital continue to get their rehabilitation from staff in the community. By March 2017 this will be at least 60%.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want everyone who has had a stroke to have access to a stroke unit and **stroke rehabilitation team** when they go into hospital, during their stay, and after they come out.

Why is it important?

Stroke units and stroke rehabilitation teams save lives and reduce long-term disability. Research has shown that patients managed in a specialist stroke unit are less likely to die and more likely to regain their independence compared to people managed on general wards.

Standard 22

Stroke review

Everyone who has had a stroke should be reviewed by Trust stroke services after six weeks and six months, and then by their GP 12 months after leaving hospital and annually after that. Their emotional and mental health should also be assessed.

How we know it's working

By March 2016 we will make sure at least 70% of patients who have had a stroke have timely specialist and GP reviews. By March 2017 this will be at least 75%.

All Trusts should have ways of providing a service that offers psychological and emotional support to stroke survivors and their carers.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want everyone who has had a stroke to be well supported and cared for when they come out of hospital.

Why is it important?

Good support and care after a stroke, including social care, psychological support, counselling, rehabilitation and help with mobility, prevents further strokes and other **cardiovascular disease** and can reduce the disabling effects of a stroke.

Conditions of the blood vessels

The following standards are included in the conditions of the blood vessels section

- Standard 23 Abdominal aortic aneurysm (AAA)
- Standard 24 Carotid artery stenosis – rapid access
- Standard 25 Diabetic foot
- Standard 26 Amputations
- Standard 27 Lymphoedema
- Standard 28 Varicose veins
- Standard 29 Leg ulcers
- Standard 30 Blood vessel abnormalities
- Standard 31 Peripheral arterial disease (PAD) – risk factors
- Standard 32 Peripheral arterial disease (PAD) – revascularisation
- Standard 33 Peripheral arterial disease (PAD) – vascular units
- Standard 34 Peripheral arterial disease (PAD) – critical limb ischaemia (CLI)

Standard 23

Abdominal aortic aneurysm (AAA)

All patients with an **AAA** measuring 5.5 centimetres or more should have round the clock access to a specialist **vascular** service.

How we know it's working

By March 2015 we will reduce the **mortality rate** in people who choose to have surgery for AAA to 3.5% or less. By March 2016 we will reduce it to 3.25% and to 3% or less by March 2017.

By March 2015 we will make sure the time between **diagnosis** and treatment is not greater than eight weeks for AAAs detected by screening. By March 2016 we will make sure the time between diagnosis and treatment is not greater than eight weeks for all AAAs and keep it that way for March 2017.

By March 2015 we will identify all vascular centres that meet the standards of the Vascular Society of Great Britain and Ireland.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **The Public Health Agency**

What are we trying to achieve?

We want to make sure everyone with an AAA measuring 5.5 centimetres or more gets the best treatment in a centre that meets the standards of the **Vascular Society of Great Britain and Ireland.**

Why is it important?

AAA is a potentially fatal condition that can lead to rupture of the main artery leading from the heart. If a swelling is greater than 5.5cm wide the chances of rupture are higher.

Standard 24

Carotid artery stenosis – rapid access

People with symptoms of a narrowing of the neck arteries or **carotid artery stenosis** should have fast access to ultrasound scans and surgery if needed to restore the blood supply to the brain.

How we know it's working

By March 2015 we will make sure at least 70% of people with severe narrowing of the neck arteries and stroke symptoms, who need surgery to restore the blood supply to the brain, have had an ultrasound scan within one week from when their stroke symptoms began. By March 2016 this will be at least 75% and at least 80% by March 2017.

By March 2015 we will make sure at least 80% of people with severe narrowing of the neck arteries and who have stroke symptoms have had surgery within a maximum of two weeks from the start of their symptoms. By March 2016 this will be at least 90% and at least 95% by March 2017.

By March 2015 we will make sure that less than 5% of those having surgery for severe narrowing of the neck arteries have a further stroke or mini stroke during their hospital stay. By March 2016 this will be less than 4.5% and less than 4% by March 2016.

By March 2015 we will make sure that less than 5% of those having surgery for severe narrowing of the neck arteries suffer damage to the nerves of the head or **cranial nerve injuries**. By March 2016 this will be less than 4% and less than 3% by March 2017.

By March 2015 we will make sure that not more than 5% of those having surgery for severe narrowing of the neck arteries have to be treated in theatre for bleeding either during or after their operation. By March 2016 this will be less than 4% and less than 3% by March 2017.

By March 2015 we will make sure that not more than 4% of those having surgery for severe narrowing of the neck arteries die during their hospital stay. By March 2016 this will be 3% and 2% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want everyone who has symptoms of a narrowing of the neck arteries to be able to get diagnosed and treated as fast as necessary for their stroke risk.

Why is it important?
Patients with narrowing of their neck arteries have a higher risk of stroke, but fast access to high quality treatment reduces this and gives better health outcomes.

Standard 25

Diabetic foot

All people with **diabetes** should have a plan to manage foot problems updated every year. Diabetic patients with severe foot problems should be treated by a team of health professionals.

How we know it's working

By March 2015 we will develop and put into practice a diabetic foot **care pathway** for Northern Ireland. By March 2016 we will make sure it is working in at least three Trusts. By March 2017 we will make sure it is working in all five Trusts.

By March 2015 we will find out how many people are admitted to hospital with diabetic foot disease. We will then set targets to reduce this.

By March 2015 we will find out how many people with diabetes have to have amputations. We will then set targets to reduce this.

By March 2015 we will make sure at least 60% of people with diabetes have a risk assessment for diabetic foot disease. By March 2016 this will be at least 80% and at least 90% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want to deliver of high quality diabetic foot services.

Why is it important?

Disease of the foot remains a major threat to people with diabetes. Early recognition of foot problems will reduces the need for amputations, improves quality of life for patients and reduces costs caused by diabetic foot complications.

Standard 26

Amputations

Anyone who needs to have a major leg amputation should be managed and treated by a specialist **multidisciplinary vascular team** to improve mobility and reduce the risk of death.

How we know it's working

By March 2015 we will find out how many patients who undergo their first leg amputation have a below the knee amputation. By March 2016 we will set a target to increase this. By March 2017 we will make sure that there are more below the knee than above the knee amputations.

By March 2015 we will find out how many leg amputees are to the **Regional Amputee Unit**. We will then set a target to improve this.

By March 2015 we will make sure that less than 7% of people die around the time of their leg amputation operations. By March 2016 this will be less than 6% and less than 5% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**
- **The Public Health Agency**

What are we trying to achieve?

We want all patients requiring major lower limb amputation to be treated in a way that is best for them and to be managed by a specialist multidisciplinary vascular team.

Why is it important?

Multidisciplinary management from specialists will ensure that each patient is cared for according to their individual need.

Standard 27

Lymphoedema

Everyone who has **lymphoedema** should have specialist treatment near to where they live and be offered the right treatment within nine weeks.

How we know it's working

By March 2015 we will make sure at least 90% of people with lymphoedema are offered the right treatment for their condition when they are assessed. By March 2016 this will at least 95% and at least 97.5% by March 2017.

By March 2015 we will make sure at least 35% of lymphoedema outpatients have their **BMI** recorded in the **Lymphdat** system. By March 2016 this will be at least 50% and at least 75% by March 2017.

By March 2015 we will make sure at least 80% of lymphoedema outpatients wait no longer than nine weeks for their first appointment. We will review this target in March 2016 and March 2017.

By March 2015 we will make sure that no lymphoedema outpatients wait longer than 18 weeks for their first appointment. By March 2016 we will make sure that no one waits longer than 15 weeks. We will review these targets in March 2017.

By March 2015 we will make sure that no lymphoedema outpatients wait more than nine weeks for their first **AHP** outpatient treatment. By March 2016 we will again make sure that no outpatients wait more than nine weeks for their first AHP outpatient treatment. We will review and reset these targets in March 2017.

Who is responsible for making sure it happens?

- **Lymphoedema Network for Northern Ireland**
- **HSC Board**
- **HSC Trusts**
- **Primary Care**

What are we trying to achieve?

We want everyone with lymphoedema to have fast and easy access to the best treatment.

Why is it important?

Easily accessible services will ensure early treatment, stop the condition from getting worse and increase patients' quality of life.

Standard 28

Varicose veins

A full range of treatment should be available to people with varicose veins that are causing complications and have not improved with non-surgical treatment.

How we know it's working

By March 2015 we will make sure that 50% of patients offered a full range of treatments have complicated varicose veins. By March 2016 this will at least 70% and at least 90% by March 2017.

By March 2015 we will make sure that at least 30% of people with varicose veins are treated under local anaesthetic in a treatment room rather than under general anaesthetic in a hospital. By March 2016 this will at least 50% and at least 70% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**

What are we trying to achieve?

We want to offer patients with varicose veins treatment in a treatment room under **local anaesthetic** rather than the traditional surgery under **general anaesthetic**.

Why is it important?

New treatments and therapies for varicose veins are available that offer better outcomes than traditional open surgery.

Standard 29

Leg ulcers

Everyone with leg ulcers should have their condition diagnosed and managed by appropriately trained staff in keeping with the **Map of Medicine care pathway**.

How we know it's working

By March 2015 we will find out how many people with leg ulcers have had an **ankle brachial pressure index test** performed in Primary Care before they are referred for hospital assessment and treatment. We will then set targets to improve this.

By March 2015 we will find out how many GP practices have access to a registered nurse who has completed a leg ulcer course. We will then set targets to improve this.

By March 2015 we will find out how many people with leg ulcers are referred for more specialist treatment within 16 weeks after not responding well to 12 weeks of treatment. We will then set targets to improve this.

By March 2015 we will find out how many people with healed leg ulcers are given **graduated compression hosiery**. We will then set targets to improve this.

By March 2015 we will make sure at least three Trusts have up-to-date policies for treating leg ulcers. By March 2016 this will be at least four Trusts and by 2017 five Trusts.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **Primary Care**

What are we trying to achieve?

We want to increase the number of patients with leg ulcers who are treated according to national guidelines.

Why is it important?

Leg ulcers can seriously worsen the quality of life in people who have them. Treatment based on good research will improve patients' quality of life and reduce the impact of the illness.

Standard 30

Blood vessel abnormalities

All patients with complex blood vessel abnormalities should be discussed at a **multidisciplinary meeting** before treatment takes place.

How we know it's working

By March 2015 we will find out how many people who are getting treatment for blood vessel abnormalities are discussed at multidisciplinary meetings. We will then set targets to improve this.

Who is responsible for making sure it happens?

- **HSC Trusts**

What are we trying to achieve?

We want to make sure that everyone with blood vessel abnormalities gets the treatment that is best for them.

Why is it important?

Blood vessel abnormalities are complicated and almost always need treatment. This is best managed by a **multidisciplinary team**.

Standard 31

Peripheral arterial disease (PAD) – risk factors

Anyone diagnosed with **PAD** should have their **cardiovascular risk** factors assessed and managed.

How we know it's working

By March 2015 we will make sure at least 50% of people with PAD have been prescribed aspirin or another blood thinning drug in the previous 15 months. By March 2016 this will be at least 70% and at least 90% by March 2017.

By March 2015 we will make sure at least 50% of people with PAD have had a blood pressure reading of 150/90 or less within the previous 15 months. By March 2016 this will be at least 70% and at least 90% by March 2017.

By March 2015 we will make sure at least 50% of people with PAD have a total cholesterol reading of 5.0mmol/l or less within the previous 15 months. By March 2016 this will at least 70% and at least 90% by March 2017.

By March 2015 we will make sure at least 50% of people with PAD and who have diabetes have had a foot assessment within the previous 15 months. By March 2016 this will at least 70% and at least 90% by March 2017.

Who is responsible for making sure it happens?

- **HSC Board**
- **Primary Care**

What are we trying to achieve?

We want to improve the management of cardiovascular risks in people who have PAD.

Why is it important?

PAD gives people leg pain when they are walking. It is common and increases the risk of death from heart disease and stroke. Early assessment and good treatment reduce the risks and improve the quality of life for patients.

Standard 32

Peripheral arterial disease (PAD) – revascularisation

All people who have **PAD** and who might need **revascularisation** should have the right **imaging** scans before surgery.

How we know it's working

By March 2015 we will make sure at least 90% of people with PAD symptoms have had scans before undergoing their treatment. By March 2016 this will at least 95% and at least 99% by March 2017.

Who is responsible for making sure it happens?

- **HSC Trusts**

What are we trying to achieve?

We want to make sure people with PAD have scans to help decide the best treatment for them.

Why is it important?

People with PAD need scans when their treatment is being decided. This helps to plan the right treatment and discuss other options.

Standard 33

Peripheral arterial disease (PAD) – vascular units

All people with leg pain caused by **PAD** and who have had surgery should be managed in a **vascular unit**.

How we know it's working

By March 2015 we will make sure that no more than 15% of people who have leg pain caused by PAD and are undergoing surgery are smokers. By March 2016 this will be no more than 10% and no more than 5% by 2017.

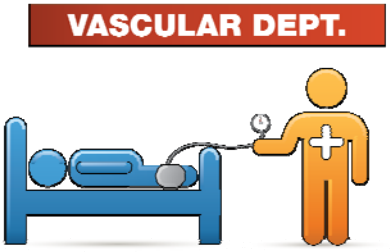
By March 2015 we will make sure at least 80% of people who have leg pain caused by PAD, and who have had surgery are prescribed blood thinning or clot-busting drugs. By March 2016 this will be at least 85% and at least 90% by 2017.

By March 2015 we will make sure at least 75% of these patients are prescribed **lipid-lowering medicines**. By March 2016 this will be at least 80% and at least 85% by 2017.

By March 2015 we will make sure at least 90% of these patients have no complications in the repaired blood vessels. By March 2016 this will be at least 93% and at least 95% by 2017.

By March 2015 we will make sure that less than 7% of these patients need amputations. By March 2016 this will be less than 6% and by March 2017 less than 5%.

By March 2015 we will make sure that at least 93%% of patients with PAD survive their hospital stay for surgery. By March 2016 this will be at least 95%, and at least 97% by March 2017.



Who is responsible for making sure it happens?

- **HSC Trusts**

What are we trying to achieve?

We want to make sure people with leg pain caused by PAD get the best treatment for their condition.

Why is it important?

Leg pain is one of the most common symptoms of PAD and can affect people's ability to walk. Treatment in a vascular unit helps to prevent the risk of heart attack and stroke, as well as relieve symptoms and improve walking distances.

Standard 34

Peripheral arterial disease (PAD) – critical limb ischaemia (CLI)

All people with **CLI** should be managed in a **vascular unit**.

How we know it's working

By March 2015 we will make sure no more than 35% of people who have had surgery for CLI are smokers. By March 2016 this will be no more than 30% and no more than 25% by 2017.

By March 2015 we will make sure at least 80% of people who have CLI, and who have had surgery, are prescribed blood thinning or clot-busting drugs. By March 2016 this will be at least 85% and at least 90% by 2017.

By March 2015 we will make sure at least 75% of these patients are prescribed **lipid-lowering medicines**. By March 2016 this will be at least 80% and at least 85% by 2017.

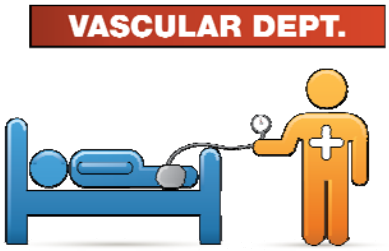
By March 2015 we will make sure no more than 36% of these patients are admitted as an emergency. By March 2016 this will be no more than 33% and no more than 30% by 2017.

By March 2015, we will make sure that no more than 36% of patients with CLI need amputations after having had surgical treatment. By March 2016, this will be less than 33% and by March 2017, less than 30%.

By March 2015 we will make sure at least 80% of patients with CLI survive their hospital stay for surgery. By March 2016 this will be at least 83% and at least 85% by March 2017.

Who is responsible for making sure it happens?

- **HSC Trusts**
- **Primary Care**



What are we trying to achieve?

We want people with CLI to get the best treatment for their condition.

Why is it important?

CLI is a severe symptom of **PAD** and there are also increased risks of heart attack and stroke.

Kidney conditions

The following standards are included in the kidney conditions section

- Standard 35 Chronic kidney disease (CKD) - diagnosis
- Standard 36 Dialysis care
- Standard 37 Kidney transplants
- Standard 38 Acute kidney injury (AKI)

Standard 35

Chronic kidney disease (CKD) – diagnosis

Everyone with **CKD** should receive fast **diagnosis** and effective treatment and follow-up.

How we know it's working

By March 2015 we will make sure at least 80% of people with CKD have a blood pressure reading of 140/85 or less within the previous 15 months. By March 2016 this will be at least 82%. By March 2017 this will be at least 85%.

By March 2015 we will make sure at least 95% of patients with **proteinuric CKD** and high blood pressure are treated with blood pressure lowering drugs. By March 2016 and March 2017 we will maintain this figure.

By March 2015 we will make sure that at least 82% of patients with CKD have had **proteinuria test** within the previous 15 months. By March 2016 and March 2017 this will be at least 85%.

Who is responsible for making sure it happens?

- **HSC Trusts**
- **Primary Care**

What are we trying to achieve?

We want everyone with CKD to have a fast diagnosis, effective treatment and follow-up.

Why is it important?

People with CKD have an increased risk of developing **cardiovascular diseases** such as heart disease, stroke, and peripheral vascular disease. Good control of blood pressure and effective treatment of CKD help reduce these risks. There is worldwide recognition on how important it is to detect CKD early.

Standard 36

Dialysis care

Everyone getting **dialysis** should receive a high standard of safe and effective care, provided by highly skilled teams and designed around their needs and age.

How we know it's working

By March 2015 we will make sure at least 70% of patients who have been on **haemodialysis** for more than 90 days and less than one year receive treatment through a **permanent vascular access**. By March 2016 this will be at least 75% and by March 2017 at least 80%.

Who is responsible for making sure it happens?

- **HSC Trusts**

What are we trying to achieve?

We want everyone getting dialysis to receive a high standard of safe and effective care, designed around their needs and age.

Why is it important?

Dialysis care delivered by highly skilled **multidisciplinary teams** improves the quality of patients' lives, reduces complications and makes best use of HSC dialysis services.

Standard 37

Kidney transplants

Anyone likely to benefit from a kidney transplant should receive a high standard of service to help them through the transplant process and achieve the best possible quality of life.

How we know it's working

By March 2015 we will make sure at least 70% of people who need a kidney transplant have received information about and discussed kidney transplants. By March 2016 this will be at least 75%. By March 2017 this will be at least 80%.

By March 2015 we will make sure at least 75% of patients on the transplant list have an annual review of their suitability for a transplant. By March 2016 this will be 80% and by March 2017, 85%.

By March 2015 we will make sure at least 80 kidney transplants happen. We will then set targets for March 2016 and March 2017.

By March 2015 we will set up a system to review all donated kidneys offered to patients in Northern Ireland and look for reasons why they should not have been refused.

Who is responsible for making sure it happens?

- **HSC Trusts**
- **Renal teams**
- **Multidisciplinary transplant teams**

What are we trying to achieve?

We want all who are likely to benefit from a kidney transplant to get a high standard of service to help them through the transplant process and achieve the best possible quality of life.

Why is it important?

Not everyone is suitable for a transplant and there are difficulties in supplying enough kidneys to meet demand. But a successful operation is a more effective treatment for kidney failure than **dialysis**. Quality services are needed to advise and support transplant patients.

Standard 38

Acute kidney injury (AKI)

Everyone at risk of **AKI** should be identified quickly and referred to a specialist **renal team** where necessary; preventing AKI should also be a priority.

How we know it's working

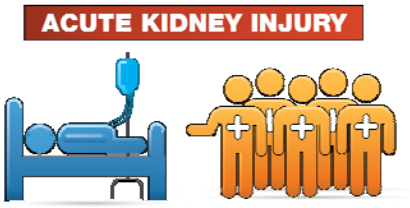
By March 2015 we will make sure at least 95% of junior doctors can get training on recognising AKI, in line with best practice guidelines. By March 2016 and March 2017 this will be at least 98%.

By March 2015 we will develop a system to identify patients who began long-term haemodialysis after suffering AKI. We will then set targets and create an action plan to reduce the number of people suffering AKI.

By June 2014 we will have investigated the possibility of developing a system to identify inpatients at risk of AKI who might require review and treatment to prevent AKI.

Who is responsible for making sure it happens?

- **HSC Trusts**



What are we trying to achieve?

We want to make sure we identify everyone at risk of AKI, focus on prevention, and deliver high quality services through specialist renal teams.

Why is it important?

Doctors may be able to prevent kidney illness by identifying people who are at high risk of AKI.

Medicines management

The following standards are included in the medicines management section

- Standard 39 Managing medicines
- Standard 40 Managing medicine reviews

Standard 39

Managing medicines

Everyone with **cardiovascular disease** should get medicines that help them to live as good and long a life as possible.

How we know it's working

From March 2015 onwards we will keep cardiovascular medicines prescribed in agreement with guidelines at 87%. We will review this target in March 2016 and 2017.

By March 2015 we will find out how many people with cardiovascular disease are using a medicines management support programme. We will then set targets to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **The Public Health Agency**
- **Local Commissioning Groups**
- **Primary Care including Community Pharmacists**

What are we trying to achieve?

We want to make sure that the medicines people with cardiovascular disease take are managed well so that the right person receives the right medicine in the right dose at the right time.

Why is it important?

Research shows that around 50% of medicines for long-term conditions are not taken as prescribed. Managed well and used appropriately, medicines can improve function, quality of life and use of limited resources.

Standard 40

Managing medicine reviews

People with **cardiovascular disease** should have a thorough review of all their medicines at various times during their treatment to make sure they are still the most appropriate and are being taken as prescribed.

How we know it's working

By March 2015 we will make sure that at least 80% of cardiovascular patients who take four or more medicines are offered a yearly medicines review. We will maintain this figure by March 2016 and March 2017.

By March 2015 we will find out how many cardiovascular patients have had their medicine list checked on admission to hospital to make sure it is correct. We will then set a target to improve this.

Who is responsible for making sure it happens?

- **HSC Board**
- **HSC Trusts**
- **The Public Health Agency**
- **Local Commissioning Groups**
- **Primary Care including Community Pharmacists**

What are we trying to achieve?

We want people with cardiovascular disease to have regular reviews of the medicines to make sure they are being managed properly.

Why is it important?

Medicine reviews can help patients to improve the management of their condition. They also help to reduce the wasting of unwanted or unused medicines.

End of Life care

The following standards are included in the End of Life care section

- Standard 41 End of life care

Standard 41

End of life care

People with terminal illnesses, together with their carers, should be supported to have a good death in the place they prefer.

How we know it's working

By March 2014 we will find out how many people died in their preferred place of care. We will then set a target to improve this.

By March 2014 we will find out how many people understand what advance care planning is. We will then set a target to improve this.

Who is responsible for making sure it happens?

- **HSC Trusts**
- **Primary Care**, including **Community Pharmacists**

What are we trying to achieve?

We want to improve the **palliative** and **end of life care** and support for patients, families and carers.

Why is it important?

It is important that people have the opportunity and the support they need to make decisions about their way they die. Research shows that quality of life is better and even longer when these needs are met.

Research

The following standards are included in the research section

- Standard 42 Promoting research

Standard 42

Promoting research

All HSC services should encourage, carry out and use research to improve people's health and wellbeing.

How we know it's working

By March 2015 we will find out how many research studies come under Northern Ireland's **cardiovascular**, primary care, kidney and stroke clinical research networks. We will then set targets to increase this for March 2016 and March 2017.

By March 2015 we will find out how many research studies into cardiovascular disease in Northern Ireland are funded by industry. We will then set appropriate targets.

By March 2015 we will find out how many patients might take part in research studies that come under Northern Ireland's cardiovascular, primary care, kidney and stroke clinical research networks. We will then set appropriate targets.

By March 2015 we will find out how many patients are invited to take part in research studies under Northern Ireland's cardiovascular, primary care, kidney and stroke clinical research networks. We will then set appropriate targets.

By March 2015 we will find out how many patients take part in research studies under Northern Ireland's cardiovascular, primary care, kidney and stroke clinical research networks. We will then set appropriate targets.

Who is responsible for making sure it happens?

- **HSC Trusts**
- **The Public Health Agency**
- **Northern Ireland Clinical Health Research Network**

What are we trying to achieve?

We want to use research to create the knowledge we need to improve people's health and wellbeing.

Why is it important?

Research helps our understanding of what works to prevent, diagnose and treat diseases. It is the basis for making decisions in HSC.

Glossary

A

AAA (abdominal aortic aneurysm) is a ballooning in the aorta located in the belly. The aorta is the large artery leading out of the left side of the heart supplying the body with blood. An aneurysm is the name for a bulge in the wall of an artery.

Abnormal heartbeat means your heart is beating very fast or very slowly or its electrical impulses are not working properly.

ACS (acute coronary syndrome) refers to any group of symptoms that may be blocking the arteries to the heart.

AHP means allied health professional.

AKI (acute kidney injury) is when the kidneys rapidly stop working due to damage.

Angina is chest pain or discomfort that happens when the heart is not getting enough oxygen because of reduced blood flow to the heart.

Angioplasty is the technique of mechanically widening narrowed or obstructed arteries in the heart.

Ankle brachial pressure index tests measure blood pressure at the ankle and in the arm while a person is at rest and then after five minutes of walking on a treadmill. They are used to find out how severe peripheral arterial disease is.

Atrial fibrillation is a type of abnormal heart rhythm in which the upper two chambers of the heart beat very rapidly. It can cause unpleasant palpitations and sometimes breathlessness.

B

Blood pressure is the force with which the heart pumps blood.

BMI means body mass index. It is a way to calculate a person's healthy weight range. Health professionals believe a BMI over 25 is unhealthy.

BNP (brain natriuretic peptide) is a blood test to help doctors to determine if you have heart failure, rather than another condition that may cause similar symptoms.

C

Care pathway – an outline of anticipated care, treatment and a timeframe of care for an illness.

Cardiac death is when the heart abruptly and without warning stops working.

Cardiac event is a phrase to describe the various types of heart conditions including angina and heart attacks.

Cardiac rehabilitation is a process to help patients get back to normal life and if possible improve their health after heart disease.

Cardiovascular means relating to the heart and blood vessels.

Cardiovascular disease is a group of conditions that includes stroke and heart disease.

Cardiovascular risk means the chances you have in developing diseases that involve the heart or blood vessels over a period of time.

Carotid artery stenosis is a narrowing of one or both of the large carotid arteries in the neck that provide most of the blood supply to the brain.

Cholesterol is a fat made by the body and is essential for good health. Having a healthy cholesterol level means you don't have too much overall. It also means you have the right balance between the two types of cholesterol.

Chronic heart failure means there is a long-term problem with the heart.

CKD (chronic kidney disease) is a long-term problem with the kidneys.

CLI (critical limb ischaemia) is a severe blockage in the arteries in the lower limbs.

Clot-busting drugs break up clots in the blood. Doctors use these drugs to dissolve the clot that cause strokes or heart attacks.

Community pharmacists provide treatment and advice on minor ailments to the communities they serve, most usually at the local or high street chemist shop.

CPR (cardiopulmonary resuscitation) is an emergency medical procedure for someone taking a heart attack. It involves CPR chest compressions and mouth-to-mouth breathing.

Cranial nerve injuries are damage caused to the nerves connected to the brain.

D

Diabetes means that your blood glucose (often called blood sugar) is too high. Blood always has some glucose in it; this is what provides energy to keep you going. But too much glucose in the blood isn't good for your health.

Diagnosis means finding out what a disease or condition is from its signs, symptoms and test results.

Dialysis is a medical process to remove toxins from a person's blood that the kidneys normally would flush out. It is generally used when a person's kidneys no longer work properly.

E

ECHO (echocardiogram) is a test that uses ultrasound waves to look at the structure of the heart.

End of life care means the care given to a patient who is dying. End of life care helps all those with advanced, progressive, incurable conditions to live as well as possible until they die.

F

FH (familial hypercholesterolaemia) is an inherited condition that gives people higher than normal levels of cholesterol in their blood from birth, putting them at high risk of early heart disease.

H

Haemodialysis is a medical procedure that uses a dialysis machine to filter waste products from the blood.

HSC Board (Health and Social Care Board) is the organisation responsible for commissioning, managing and improving health care services in Northern Ireland.

HSC Trusts (Health and Social Care Trusts) provide health and social services across Northern Ireland. There are five trusts. Each one manages its own staff and services and controls its own budget.

Hypertension is the medical name for high blood pressure.

G

Graduated compression hosiery is tights and stockings designed to improve circulation in the legs.

I

Independent advocacy is when a person or organisation speaks for people who need support to make choices because of disadvantages like frailty, disability or financial and social circumstances. It makes sure a person's individual needs and views are respected and acted on.

Imaging scans describe the various types of scans used to help diagnose illnesses.

Inpatients are people who are staying in hospital for treatment.

L

LDL (low-density lipoprotein) cholesterol is the harmful type of cholesterol.

Left ventricular failure is when the part of the heart that pumps blood around your body (the left ventricle) becomes weak.

Local Commissioning Groups are the organisations that commission health and social care services at a local level.

Lymphdat is a Northern Ireland database of information lymphoedema.

Lymphoedema is a painful chronic condition that causes swelling of the legs, arms and sometimes the body.

Lymphoedema Network for Northern Ireland is an organisation that looks after the development of lymphoedema services in all five HSC Trusts.
Lipid-lowering medicines reduce the concentration of lipid, such as cholesterol, in the blood as a measure against heart disease.

M

Map of Medicine is a collection of evidence-based, practice-informed care maps that connects all the knowledge and services around illnesses.

Mini stroke is when the blood flow to the brain is stopped for a few minutes or a few hours. Its symptoms are similar to a stroke, but last less than 24 hours.

Mortality rate is a measure of the number of deaths in general, or due to a specific cause in a population.

Multidisciplinary meeting is a meeting between health professionals and experts treating an illness or disease.

Multidisciplinary teams are groups of various health professionals and experts who work together.

Multidisciplinary transplant teams are groups of doctors, health and experts who carry out complex organ transplant operations.

Multidisciplinary vascular teams are groups of doctors, health professionals and experts on the blood vessels and veins.

N

Northern Ireland Clinical Research Network is an organisation that supports the clinical research community in Northern Ireland.

P

PAD (peripheral arterial disease) is narrowing of one or more arteries (blood vessels). It mainly affects arteries that take blood to the legs.

Palliative means soothing. The purpose of palliative care is to enable people with life limiting illness to live as well as possible until they die.

Patient and Client Council represents and speaks for patients, clients, carers, and communities on health and social care issues.

Permanent vascular access is a lasting site on the body where blood can be removed and returned during dialysis. Vascular access means a way of getting into the veins.

Phase 1 cardiac rehabilitation happens while the patient is in hospital and takes the form of counselling and advice with a simple programme of education and psychological support.

Phase 2 cardiac rehabilitation happens at home in the time immediately after leaving hospital. It takes the form of a supervised self-help programme and assessment of physical, psychological and social needs and advice on everyday activities with encouragement to take light exercise in the first few weeks.

Phase 3 cardiac rehabilitation is delivered in an outpatient setting and lasts typically for 6–8 weeks. It involves supervised exercise, education on preventing further heart problems and psychological approaches to recovery.
Phase 4 cardiac rehabilitation encourages maintenance of healthy behaviours, continued exercise and sticking with lifestyle changes.

Primary Care describes the first points of contact within the Health Service, such as GPs, district nurses, community pharmacists, dentists and opticians.

Proteinuric CKD is a sign of chronic kidney disease where there is too much protein in the urine.

Proteinuria test is a test to find out how much protein is present in the urine.

R

Regional Amputee Unit works with people from across Northern Ireland who have had amputation surgery, to provide, develop and maintain prosthetic limbs
.
Regulation and Quality Improvement Authority checks up and reports on the availability and quality of the care provided in the Health and Social Services.

Renal teams are groups of health professionals specialising in treating kidney disease and disorders.

Revascularisation is the term for a surgical procedure that provides new, additional, or improved blood supply to a body part.

S

Smoking cessation means stopping smoking.

Stage 1 hypertension is an early form of high blood pressure, and may require treatment with medicine, together with frequent monitoring, in order to avoid progression to Stage 2 hypertension.

Stage 2 hypertension is a serious form of high blood pressure, and requires immediate treatment.

Stroke is a brain attack that happens when the blood supply to part of the brain is cut off.

Stroke rehabilitation teams help stroke patients to recover health through therapies and treatments.

T

The Public Health Agency deals with protecting the health of the general public and promoting healthy lifestyles.

V

Vascular means to do with the blood vessels.

Vascular Society of Great Britain and Ireland promotes vascular health by supporting and furthering excellence in education, training and scientific research.

Vascular units are special places for treatment for the full range of vascular diseases.

Alternative formats

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