



Pregnancy and post-partum management for women with cardiovascular disease

NOTES

This document will use the term 'women'/'woman' throughout. It is important to highlight that it is not only those who identify as women who require access to women's health and reproductive services. For example, some transgender men, non-binary people, and intersex people or people with variations in sex characteristics may also experience pregnancy. All healthcare services should be respectful and responsive to individual needs.

This guidance is not intended to be construed or to serve as a standard of care. Standards of care are determined based on all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guidance recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

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This document has been prepared by Public Services Delivery Scotland (PSD Scotland) on behalf of the Scottish Obstetric Cardiology Network (SOCN). Accountable to Scottish Government, PSD Scotland works at the heart of the health service providing national strategic services to the rest of NHS Scotland and other public sector organisations to help them deliver their services more efficiently and effectively. SOCN is a collaboration of stakeholders involved in obstetric cardiology care, who are supported by a PSD Scotland Programme Team to drive improvement across the care pathway.

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Background



ESC:

It is recommended that high-risk patients are treated in specialized centres by a multidisciplinary pregnancy heart team

MBRRACE:

- Pregnant women with complex needs or a complex medical history should have timely antenatal multidisciplinary planning, and an experienced obstetric anaesthetist should contribute to the planning
- In pregnant or postpartum women with complex medical problems involving multiple specialties, the responsible consultant obstetrician or physician must show clear leadership and be responsible for coordinating care and liaising with anaesthetists, midwives, other physicians, and obstetricians and all other professionals who need to be involved in the care of these women
- Ensure the appropriate national Maternity Early Warning Score is used to monitor a pregnant woman wherever in the hospital she receives care

NICE:

- Be aware that some women with heart disease are at low risk of complications and their care should be in line with the NICE guideline on intrapartum care, whereas others need individualised specialist care.
- For women with heart disease, reassess intrapartum risk regularly during pregnancy and the intrapartum period using all of the following:
 - comprehensive clinical assessment, including history and physical examination
 - the modified WHO classification of risk
 - New York Heart Association (NYHA) functional class
- Offer the same investigations to pregnant women with heart disease as to women who are not pregnant. Review the results and act on them without delay.
- Develop an individualised birth plan with the woman with heart disease covering all 3 stages of labour following multidisciplinary discussion

*ESC: European Society of Cardiology

Antenatal care

Women with cardiovascular disease (CVD) will present to antenatal care through various routes including self-referral, via primary care or following booking appointment. It is important to recognise that some women with CVD may have been lost to follow-up and may not have an awareness of the relevance of their CVD on a pregnancy. Others may have a family history of CVD that increases their risk and requires further investigation. Therefore, embedding robust cardiac and family history at booking is essential to recognise women who require access to clinicians with expertise in cardiac obstetrics.

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General principles: communication, location, MEWS

As pregnancy is time-limited, timely, structured communication among healthcare professionals and the patient is essential to the co-ordination of care. A multi-disciplinary team with its members individualised to the woman, CVD and other factors ensures appropriate oversight of care provision. Multi-disciplinary team meetings should be accessible to referring clinicians, and outcomes communicated in a timely manner.

Location of antenatal care has been discussed and depends on several factors. Ongoing local antenatal care is important even when women are under review by the Pregnancy Heart Team* (PregHT). Antenatal assessment of co-morbidities or complications of pregnancy should be co-ordinated to optimise healthcare resources and reduce excess appointments for the patient.

The Maternity Early Warning Score (MEWS) should be used in pregnancy and up to 42 days postpartum to detect early signs of clinical change. Ensuring there is clear documentation about normal observations for each patient with CVD ensures MEWS is assessed in context.

* The European Society of Cardiology (ESC) introduced the term Pregnancy Heart Team (PregHT) to describe the core group of expert clinicians involved in the management of women with CVD in pregnancy. For more information on PregHT please refer to the SOCN guidance 'Introduction to pregnancy and CVD and service structure in Scotland' to the SOCN guidance 'Introduction to pregnancy and CVD and service structure in Scotland'.

Early pregnancy assessment

For pregnant women with CVD, early pregnancy assessment is necessary to determine the most appropriate antenatal care pathway, ensuring timely review and risk-based management.

- Low-risk pregnancies follow the standard antenatal pathway, with the addition of consultant review.
- Moderate to high-risk pregnancies require early assessment, which may involve local cardiology, obstetrics, or the PregHT depending on maternal risk. This assessment helps evaluate maternal and fetal risks, facilitate discussions regarding pregnancy continuation, and establish an individualised follow-up plan.

The booking visit is an opportunity to assess CVD symptoms and identify other issues that need addressed, such as use of medications, especially in women who did not get the opportunity for preconception risk assessment. It is also an opportunity to identify CVD risk factors in a woman without known CVD.

Medication management

Anticoagulation

Managing anticoagulation in pregnancy requires a balance between maternal thromboembolic risk and fetal safety. Mechanical heart valves (MHV) in pregnancy

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carry a significant risk of maternal and fetal morbidity and mortality¹. Meticulous monitoring of the anticoagulation regime and care led by the PregHT is essential. When women with a MHV presents in early pregnancy refer urgently to the PregHT. If a plan is not already in place from preconception counselling, a discussion with the patient should be arranged to discuss risks and benefits of anticoagulation options (warfarin v LMWH) emphasising the importance of no breaks in anticoagulation. When women with MHV are managed with LMWH, aspirin is recommended as either 75mg or 150mg if indicated for prevention of pre-eclampsia. The British Society for Haematology have published a guideline for the management of MHV in pregnancy².

Beta-blockers

Beta-blockers are generally safe for use in pregnancy, but selection should prioritise agents with the lowest risk of fetal growth restriction, while avoiding atenolol due to its stronger association with restricted fetal growth. If a woman did not receive preconception counselling and optimisation, beta-blocker therapy should be reviewed early in pregnancy to ensure appropriate selection and dosing. Certain conditions, including Long QT syndrome, mitral stenosis and aortopathy, require continuation of beta-blockade to prevent life-threatening complications, and abrupt withdrawal should be avoided. Any necessary adjustments should be made in consultation with the PreHT, ensuring maternal stability while minimising fetal risks. Although discussed later fetal monitoring, including serial growth scans and neonatal heart rate surveillance, is recommended to assess for potential effects of maternal beta-blocker use such as growth restriction or bradycardia.

Figure 1 provides a graphical summary of the use of drugs in pregnancy and breast feeding.



Figure 1: Overview of cardiac medication use in pregnancy and lactation

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Miscarriage

An individualised approach to miscarriage is required to minimise maternal risk while providing compassionate care. Assessment of haemodynamic stability, anticoagulation status and cardiac function is essential to determine management and location of care. Options for management of miscarriage include expectant, medical and surgical management. Medical management with misoprostol may be appropriate. However, in cases of incomplete miscarriage, infection or heavy bleeding, a surgical option may be indicated. In these cases, a multi-disciplinary team consisting of gynaecologist, cardiologist and anaesthetist with expertise in this area is required to ensure optimal outcomes. If a woman with a mechanical heart valve presents with a miscarriage, inform the PregHT and surgical management may be most appropriate². Women with moderate-severe CVD who miscarry at home should contact the early pregnancy unit and be admitted.

Understanding the emotional needs of the woman and her family will ensure access to appropriate support and counselling. Prior to discharge a discussion about contraception and future pregnancy planning would be appropriate.

Termination of pregnancy

Termination of pregnancy may be requested due to maternal choice or be indicated due to a risk to the life of the woman. Regardless of the indication, healthcare professionals should provide non-judgmental, patient centred counselling and respect the woman's decision. The woman should be fully informed of the procedure versus the risk of continuing with a high-risk pregnancy. Counselling should be provided by healthcare professionals with expertise in cardiac obstetrics and termination. The decision to medically or surgically terminate the pregnancy will be based on the woman's choice, gestation, CVD, clinical status of the mother and other factors. Swift access to termination services should be available.

Timing of review and investigations

Early referral to the PregHT is important to facilitate timely review and access to investigations. The frequency and location of maternal and fetal review during pregnancy depends on several factors including the nature of maternal CVD, co-morbidities, fetal well-being, development of pregnancy complications, geographical location. Women with low-risk CVD and no other concerning features may be reviewed once or twice during pregnancy by a consultant obstetrician in addition to routine antenatal care. Cardiology input can be requested as required.

Women with moderate or high-risk CVD will require more frequent monitoring perhaps once each trimester, monthly or fortnightly depending on maternal CV status.

Investigations should be tailored to the individual. Routine observations (heart rate, blood pressure, O₂ saturations, respiratory rate, and temperature) should be recorded along with clinical assessment and assessment of functional status. Serial assessment of cardiac function and symptoms will require timely access to echocardiogram, ECG, Holter monitoring and NT-proBNP. For patients with an

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aortopathy, assessment of the aorta by MRI is indicated, usually around 20 weeks gestation and at frequent intervals thereafter. Those responsible for reporting the investigation should be aware of the pregnancy and any specific time implications there are. Timely reporting is essential even for routine investigations and communication with the requesting clinician is important. Where there has been a change in the patient's cardiovascular status, escalate the report appropriately to ensure timely review and alteration to the follow-up plan.

Fetal monitoring

Maternal CVD and treatments have an impact on fetal wellbeing. Some are at higher risk of intrauterine growth restriction. Maternal cyanotic heart disease, Fontan physiology, mechanical heart valves and heart failure are associated with IUGR and other complications. The use of beta-blockers, while made on a balance of maternal and fetal well-being, require additional fetal growth scans at 28, 32 and 36 weeks.

Fetal echocardiography around 20 weeks is recommended for women and men with congenital heart disease and other inherited cardiac conditions where indicated. Close co-ordination between the Pregnancy Heart Team and fetal medicine specialists is important in optimising fetal wellbeing and planning for delivery.

New presentation of CVD in pregnancy

For acute presentations follow the guidance found on the SOCN website (www.socn.scot.nhs.uk). Cardiovascular disease should be suspected in pregnant and post-partum women presenting with breathlessness, orthopnoea, uncontrolled or new onset asthma, tachypnoea, palpitations especially if associated with chest pain or syncope, syncope and chest pain. The urgency of investigations will be determined by severity of the presentation. Women who do not present acutely with these symptoms should undergo history taking, clinical exam, observations, assessment of risk factors and diagnostics tests relevant to the presentation e.g. ECG, echo, NT-proBNP. For patients who remain in the outpatient setting, referral to the relevant cardiac obstetric service is essential to facilitate appropriate ongoing review and monitoring.

Delivery planning

For many women with CVD, the mode of delivery will be determined by obstetric indications and not cardiac. American and European guidelines recommend an elective induction of labour for pregnant women with cardiac disease who have not presented in spontaneous labour before 40 weeks of gestation^{3,4}. From a cardiovascular perspective, vaginal delivery is preferred as it reduces haemodynamic shifts which are greater with a caesarean section. However, there are some cardiovascular conditions where a caesarean section may be preferred and they are listed in Table 1.

The multi-disciplinary team should develop a delivery plan by 28 weeks (or earlier if CVD associated with premature delivery). Anaesthetic review facilitates anaesthetic and pain management plan and the opportunity for the patient to make informed

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decisions in the outpatient setting. The care plan should be accessible to healthcare professionals who may provide care for the woman. If an induction of labour or caesarean section is planned, a plan should also be developed for labour or other complication that may present acutely, especially for those with moderate-severe CVD.

Indications to consider caesarean section	
Obstetric	As per local guidance
Cardiac	Poor ventricular function Cyanotic heart disease or pulmonary hypertension Myocardial ischaemia Severe aortic or mitral valve stenosis Dilated aortic root Any cardiac condition where there is limited ability to increase cardiac output safely Emergency delivery due to decline in maternal CV status

Table 1: Indications for caesarean section

Post-natal contraception

In recent years there has been an increase in the number of pregnancies within 1 year of delivery. The Postnatal Contraception Network is working across Scotland to improve access to post-natal contraception. A conversation about contraception should begin during pregnancy to allow time for the woman to make an informed choice. The method of contraception chosen should be clearly documented in the electronic notes and on the multi-disciplinary care plan.

Escalation of care

Prompt recognition and escalation of care is essential if maternal cardiovascular condition deteriorates. Ideally an escalation plan will have been recorded in the patients notes. However, in an emergency scenario escalation to senior clinicians and communication with relevant members of the PregHT is essential. Consideration should be given to urgency of investigations and treatments, not withholding emergency imaging or treatments from the woman. If transfer to another centre is required for advanced monitoring or interventions, this must be agreed with the relevant obstetric teams, especially where urgent delivery will be indicated.

Intrapartum care

The intrapartum care of women with CVD should be individualised, with a detailed plan developed during the antenatal period. This plan should outline the preferred mode and timing of delivery, as well as contingency plans for potential complications. To support decision making, the NICE guidance on Intrapartum Care for Women

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with Existing Medical Conditions or Obstetric Complications provides general recommendations for CVD in pregnancy⁵.

Post-partum care – the ‘4th trimester’

Women with CVD remain at risk of decompensation in the post-partum phase, especially the first 6 weeks following delivery. Complications can include thromboembolism, arrhythmia, heart failure and aortic dissection. Multi-disciplinary care with appropriate expertise remains essential at this phase of transition.

Location of care and follow-up

The location of post-partum care depends on the underlying CVD and pregnancy outcomes. Most women with CVD can follow a routine post-partum pathway. Women at higher risk of cardiac complications should be cared for in a setting that can provide adequate monitoring and interventions if required. The multi-disciplinary care plan should clearly identify the location of post-natal care, monitoring required, clinician review and include decisions to re-start medication stopped during pregnancy in the interests of fetal wellbeing. The antenatal contraception plan should be implemented before discharge.

Where women are being cared for in a non-obstetric setting e.g. coronary care unit, cardiac ICU or HDU, support should be provided to facilitate breast feeding where possible and time with the baby.

Following discharge, a clear plan for obstetric and cardiology follow-up should be in place including additional support where required from cardiac rehabilitation, heart failure nurses and mental health professionals. GP and cardiologist should be copied in to discharge documentation.

New presentation of CVD in pregnancy/post-partum

Women who present with CVD for the first time in pregnancy or post-partum should be reviewed by a cardiologist before discharge. This will facilitate information on self-care and symptom monitoring and the initiation of appropriate pharmacological therapies. It may be appropriate to repeat echo, ECG and NT-proBNP prior to discharge or within a few weeks post-partum.

Where there is uncertainty as to the aetiology of the presentation, further assessment and investigations may be required. For example, a woman who presents with left ventricular dysfunction and decompensated heart failure in the absence of a reversible cause should have a 3-generation family history, a referral to a genetic counsellor and MRI scan to assist in determining the aetiology of ventricular dysfunction. Close follow-up will also facilitate optimisation of pharmacological therapies and an individualised assessment for the need for advanced heart failure assessment and device therapies.

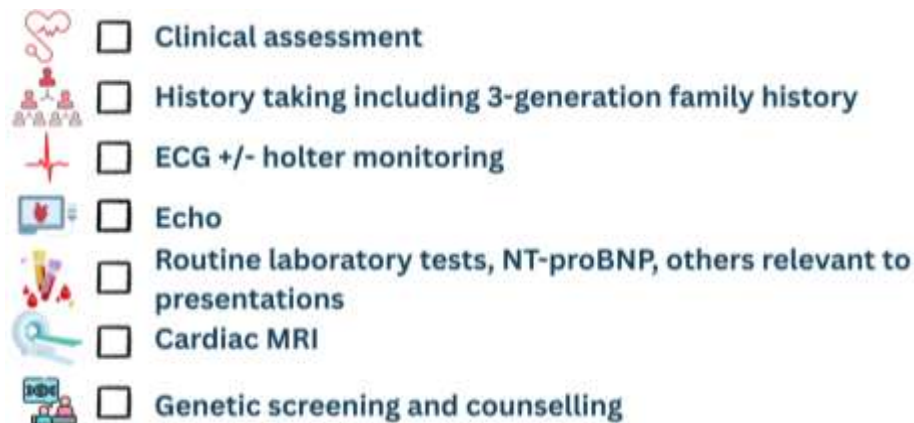


Figure 2: Investigations to consider for new cardiovascular presentations in pregnancy/postpartum

Patient Education & Symptom Recognition

Before discharge, women should receive information relevant to their CVD and pregnancy outcome. Many women will be suitable for routine follow-up and advised to contact their cardiology team if they are considering pregnancy in the future. Women with moderate – severe CVD or who experienced pregnancy complications should receive information specific to their clinical status and advised to make an appointment for preconception counselling if they are considering another pregnancy. All women should be advised not to discontinue cardiac therapies without discussion with a healthcare professional.

Women should also be provided with education on recognising early signs of cardiac decompensation including:

- **Increasing breathlessness or orthopnoea**
- **Chest pain or palpitations**
- **Swelling in the legs or sudden weight gain**
- **Severe fatigue or dizziness**
- **Signs of deep vein thrombosis (DVT) or pulmonary embolism (PE)** (e.g., unilateral leg swelling, pleuritic chest pain)

Written information in their native language should be provided, including **emergency contact numbers**, guidance on seeking urgent care, and **what to expect in the postpartum period**.

Resources

A range of guidance developed by SOCN is available at www.socn.scot.nhs.uk including:

- Introduction to pregnancy and CVD and service structure in Scotland
- Acute presentations in pregnancy
- Labour and delivery management plan for obstetric patients with cardiovascular disease

The MEWS chart and other resources can be accessed on Scottish Patient Safety Programme Perinatal Programmes website

<https://www.healthcareimprovementscotland.scot/improving-care/improvement-resources/scottish-patient-safety-programme-spsp/>

Royal College of Physicians Acute Care Toolkit 15: Managing acute medical problems in pregnancy.

<https://www.rcp.ac.uk/improving-care/resources/acute-care-toolkit-15-managing-acute-medical-problems-in-pregnancy/>

Transthoracic Echocardiographic Assessment of the Heart in Pregnancy—a position statement on behalf of the British Society of Echocardiography and the United Kingdom Maternal Cardiology Society

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www.nice.org.uk/guidance/ng121

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Appendix 1 - Document governance

Authors	This document was developed by the Known Pathways Subgroup on behalf of the SOCN Steering Group. Full membership of the group is available in Appendix 2.
Stakeholders involved	A wide range of health care professionals working in the area of obstetric cardiology were involved in the development of this document. This includes Obstetricians, Cardiologists, Anaesthetists, Pharmacists, Clinical Geneticists, Specialist Nurses, Midwives and Sexual Health consultants. Feedback from patients throughout the development of all of the SOCN materials was sought.
Methodology used	Evidence-based literature reviews and engagement with clinical experts within the field of obstetric cardiology across Scotland.
Rationale	Cardiac disease remains the leading indirect cause of death in pregnancy. The network was established to support and develop Obstetric Cardiology services throughout Scotland in improving standards of clinical care for pregnant women and their families affected by heart disease in pregnancy. The network supports the delivery of evidence based, patient centred care for both mother and baby through the development and implementation of clinical guidelines, care pathways, clinical standards and information resources.
Scope	The aim of this document is to support the delivery of services to improve outcomes for women with cardiac disease and support implementation of optimal care to any women with a cardiac condition who is contemplating a pregnancy or has a pregnancy in Scotland. .
Approval process	Members of the Scottish Perinatal Network and Network for Inherited Cardiac Conditions Scotland were able to review and provide feedback on the final draft of this document. The SOCN Steering Group endorsed this document on 31 March 2026. Full membership of the group is available in Appendix 2.

Network contact details

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Appendix 2 - Group membership

Known Pathways Subgroup Membership		
Name	Job Title	Organisation
Dr Julia Anderson	Consultant Haematologist	NHS Lothian
Dr Sonal Anderson	Consultant in Obstetrics & Gynaecology	NHS Ayrshire & Arran
Dr Katrina Bramley	Consultant Anaesthetist	NHS Lothian
Dr Adelle Dawson	Consultant Cardiologist	NHS Grampian
Dr Fiona Dennison	Consultant Obstetrician	NHS Ayrshire & Arran
Dr Richard Dobson	Cardiology Registrar	NHS Golden Jubilee
Jacqueline Dunlop	Principle Genetic Counsellor	NHS Tayside
Dr Stuart Hanna	Consultant Anaesthetist	NHS Forth Valley
Mary Hannaway	Senior Charge Midwife	NHS Greater Glasgow & Clyde
Dr Shahzya Huda	Consultant Obstetrician/Sub-group Chair	NHS Forth Valley
Dr Jayne McLaren	A&E Consultant	NHS Ayrshire & Arran
Dr Lucy Michie	Obstetrics & Gynaecology Registrar	NHS Ayrshire & Arran
Dr Giles Roditi	Consultant Radiologist	NHS Greater Glasgow & Clyde
Maggie Simpson	Lead Clinician	NHS Golden Jubilee
Dr Caroline White	Consultant Cardiologist	NHS Lanarkshire

SOCN Steering Group Membership (2025/2026)		
Name	Job Title	Organisation
Dr Ros Burns	Obstetric Anaesthetist	NHS Lothian
Dr Rachel Darling	Consultant Anaesthetist	NHS Greater Glasgow & Clyde
Richard Forsyth	Health Systems Insights Manager	British Heart Foundation
Dr Patrick Gibson	Consultant Cardiologist	NHS Lothian
Dr Anja Guttinger	Sexual & Reproductive Health Consultant	NHS Ayrshire & Arran
Dr Duncan Hogg	Consultant Cardiologist	NHS Grampian
Dr Shahzya Huda	Consultant Obstetrician	NHS Forth Valley
Dr Vera Lennie	Consultant Cardiologist	NHS Grampian
Dr Lynn Miller	Consultant Cardiologist	NHS Fife
Lynsey Moir	Pharmacist - Clinical Cardiology	NHS Greater Glasgow & Clyde
Dr Rebecca Northridge	Consultant Obstetrician	NHS Tayside
Dr Karolina Pesz	Consultant Geneticist	NHS Greater Glasgow & Clyde
Maggie Simpson	Advanced Specialist Nurse	NHS Greater Glasgow & Clyde
Dr Lorna Swan	Consultant Cardiologist	Golden Jubilee National Hospital
Dr Niki Walker	Consultant Cardiologist	Golden Jubilee National Hospital

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