Department of Health: delivering NSF targets ahead of time

Ten years ago, England had one of the worst death rates from circulatory diseases in Europe. Today, thanks to the expertise and hard work of thousands of NHS staff, major progress has been made in implementing the National Service Framework (NSF) for Coronary Heart Disease (CHD), and deaths from circulatory diseases are set to be reduced by 40%, three years ahead of the 10-year target set when the NSF was published in March 2000. As a result, we estimate that around 100,000 lives are being saved each year.

The NSF for CHD was one of the first Government National Service Frameworks and provided a blueprint for how CHD services were to be improved over the next 10 years. Despite the fast changing world of modern medicine, its key messages have stood the test of time. Its success has also been recognised outside the country and the Spanish Government has recently announced that it will be using our NSF for CHD as a template for implementing changes in their health services.

Many of the NSF's key targets have already been delivered; some ahead of schedule. These considerable achievements are summarised below:

- Patients commonly waited more than two years for a heart bypass operation in the mid 1990s. Today, no one waits for this procedure for more than nine months. The NHS is currently on track to ensure that this wait is reduced to no more than six months by the end of the year and no more than three months by 2005.
- The 'choice pilot' for heart operations was the first to go live in July 2002. So far, about 2,800 patients – about half of those eligible – have been treated more quickly elsewhere (i.e. outside their health authority) at a time and place of their choosing.
- 13 major NHS building projects at a cost of over £580 million have been announced to date by the Government in areas where need is greatest e.g. Wolverhampton, South Tees, Bristol, Blackpool, Manchester, Southampton, Sheffield, Leeds and Plymouth. The NHS has also purchased the Heart Hospital in London from the private sector.
- More systematic care of patients with heart disease in primary care has seen a very rapid growth in the prescription of the lipid-lowering agents (i.e. statins) and drugs for high blood pressure. The prescription of statins, alone, is rising by a third each year and currently stands at well over £600 million, saving potentially up to 6,000 lives each year and reducing the number and severity of heart attacks.
- The NHS has made rapid progress in ensuring that people having a heart attack receive thrombolysis quickly after they have called for professional help. The proportion of patients treated within the 'golden hour' has more than doubled over the past three years from about 25% to 50%, although further improvements are still needed in this area. More than 75% of eligible patients now receive thrombolysis within 30 minutes of arrival at hospital. The superb data now emerging from MINAP has helped local health communities concentrate on the most effective strategies that will help them achieve the challenging target of improving call-to-needle times by 10% each year. There will be other vital lessons to be learnt from this programme, probably the most comprehensive of its kind.
- The programme to place defibrillators in public places is already saving lives. With over 680 now installed, already 29 heart attack victims have been revived.
- Two major initiatives are targeting improved waiting times for the diagnosis of heart disease. Firstly over the past

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Roger Boyle 'Heart Tsar'

three years, the NHS has built up a national network of rapid access chest pain clinics, which aim to provide a one-stop diagnostic service to patients with new chest pain within two weeks of referral by their GP. About 80% of patients were seen within 14 days in the final quarter of 2002–03. Secondly, combined Department of Health and Lottery investment of over £80 million is ensuring a national network of state of the art angiography suites, enabling patients to have more rapid access to the second stage of CHD diagnosis which enables cardiologists to tell what sort of treatment is needed.

The current focus is, predominantly, the delivery rather than the formulation of policy. There are a few areas in which clinical and technological developments mean that we shall have to do more work over the next few years (e.g. hi-tech scanning and acute angioplasty as an alternative to thrombolysis for heart attack). But the main challenge now is to roll out existing good practice, particularly in primary care. There are three main thrusts.

1. *Improving services for people with heart failure:* Recent publication of a clinical guideline by the National Institute for Clinical Excellence (NICE) and our own tool-kit for delivery *Delivering services for heart failure* should help improve services for people with heart failure.

2. *Sustaining and consolidating shorter waiting times:* This is the first year that almost all our revenue resources have been devolved in general allocations and we need to guard against loss of momentum. Having weathered the introduction of rapid access chest pain clinics (RACPCs), we will have to be ready for further pressure as the new catheter laboratories come on stream.

3. *Improving the uptake of statin therapy and other risk reduction strategies:* We have agreed with NICE a package of guidelines and appraisals in the area of prevention, lipid management and statin prescribing, aimed at helping primary care roll out activity while, at the same time, getting best value from their rapidly rising prescribing budgets. We are already spending £10 million each week on statins and more is needed if the continuing fall in cardiovascular deaths and incidence of AMI is to be quickened.

Future challenges

Many further challenges lie ahead. CHD remains most prevalent amongst more deprived communities and in ethnic minorities; the epidemic of obesity may slow some of the encouraging trends in cardiovascular events.

There are very real pressures on the many staff engaged in the battle against CHD right across the patient pathway.

In primary care there is a need for more GPs with a special interest in CHD. The pioneers have shown just how much work can be devolved safely from secondary to primary care but there is a need to move to a more integrated approach so that patients can travel up and down the skills ladder much more easily. This requires a closer look at competencies and who does what, but will inevitably require more staff at all levels.

We have seen excellent development in the role of practice nurses as the NSF agenda has unfolded but there needs to be a greater clarity about career structures as well as vital issues, such as cross-practice and cross-boundary working.

It is hoped that the new GP contract will facilitate the current dramatic trend in improvement in CHD management in primary care as well as provide the necessary financial environment to match the staffing issues that remain.

In hospitals, there is a clear need for more cardiologists. An increasingly knowledgeable public demand that cardiac care is provided by specialists. Nowhere is this more important than in the treatment of all types of acute coronary syndrome. Add to this the increasing workload (the service has already absorbed a 40–50% increase in angioplasty in just three years), the need for closer assessment of patients with heart failure, the demands of rehabilitation programmes, the need for more pacing, implantable cardioverter defibrillators and cardiac electrophysiology, as well as the European Working Time Directive, it can be seen that there needs to be a huge increase in the numbers of consultants available. Then there is primary angioplasty!

A joint working party of the British Cardiac Society and the Department of Health concluded that there needed to be a three-fold increase in the number of consultant posts. The challenge is to find ways of bridging the gap until increasing numbers in training come through the system to fill these major gaps. There needs to be more thinking about the ways cardiologists will work as the new role of acute physicians, which were recommended by the Royal Colleges, come into being.

In parallel, work has been in progress to improve training opportunities for those aspiring to become cardiac physiologists and to look at novel ways of recruiting into this vital area.

British cardiology has come a long way since the first edition of this journal was published 10 years ago. The NSF has contributed to the many improvements that are now benefiting patients. There is still a great deal to be done but thanks are due to all those staff who have helped deliver such a great deal so far.

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