The Coronary Heart Disease Collaborative

This month *The British Journal of Cardiology* begins a series of articles exploring the work of the Coronary Heart Disease Collaborative. This editorial gives a brief introduction to its origins, aims and philosophy for readers not yet involved in its activities.

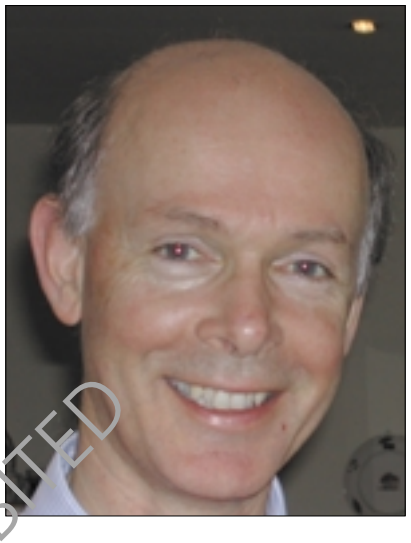
The Coronary Heart Disease Collaborative (CHDC) was set up by the NHS Modernisation Agency with the overall goal of improving the experiences and outcomes for patients with suspected or diagnosed coronary heart disease by optimising the care delivery systems across the whole integrated pathway of cardiac care. It started work in August 2000 with a pilot group of 10 local programmes and, in April 2002, its network expanded by a further 20 programmes, achieving one programme in every Strategic Health Authority in England.

The aim of the Collaborative is to improve the quality of care of patients with coronary heart disease from both the patients' and carers' experiences, and the delivery of evidence-based treatments (and ultimately quality of life and survival). The Collaborative supports the aims of the *National Service Framework for Coronary Heart Disease* by providing service deliverers with the means to achieve its goals. It also challenges service deliverers to develop targets based on their own and their patients' assessments of what constitutes excellent care.

Each Collaborative programme has six project areas: acute myocardial infarction, stable angina, heart failure, revascularisation, rehabilitation and secondary prevention. In each of these, the project scope encompasses the whole patient pathway. This means that almost all healthcare organisations are involved, from ambulance staff and primary care through to tertiary units and community rehabilitation schemes. There is a strong emphasis on breaking down barriers between organisations, particularly primary and secondary care, where many of the worst delays occur.

Methodology

Each programme works by getting together local clinical and managerial teams to work with highly trained CHDC managers to look in detail at the processes delivering a particular element of the service. The fairly structured methodology we employ is based on the work of the Institute of Healthcare Improvement in the USA – this comprises detailed analysis of



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clinical processes followed by initiation of small changes, analysis of their effects and then further change (so-called plan, do, study, act [PDSA] cycles). This iterative approach allows improvement to be demonstrated with relatively little upheaval and, if the experiment is a failure, it can be easily reversed. Because such change is 'non-threatening', there is a high degree of clinician buy-in. These clinicians are often the best advocates of the process once they are convinced that real and substantial change is possible. Even at the early 'process mapping' stage, clinicians are often amazed to find out what really happens in their departments or practices and this is an important starting point.

The scope of the programme is very broad and challenging: it aims to cover the whole of England by 2005 and to become firmly embedded as a 'usual way of working' within the emerging clinical cardiac networks.

There is also a strong emphasis on measurement of change. Each local programme reports monthly progress to the national team on a range of measures. The local teams can then plot their progress as well as benchmarking their achievements against the national results. Comparative data also enable the national team to provide greater support if progress is slow in a particular area. New measures to test that improvements are sustainable have also recently been introduced.

Progress

So does it work? Over the course of the last two years we have seen some remarkable examples of improvements. These have often been achieved with little or no additional cost – the articles that follow in the coming months should give some idea of the potential. Other examples can be seen in the service improvement guides and further material can be accessed through our web site (www.modern.nhs.uk/chd), which also gives details about who is involved in each local programme and lists events that you might like to attend. These meetings are excellent ways to spread ideas for improvement.

Even if you are not involved at present, the CHD Collaborative will be coming to you between now and 2005. Readers interested in this series of articles and wanting to start similar work, please contact the CHD Collaborative (Administrator, CHD Collaborative, NHS Modernisation Agency, 4th Floor, St John's House, East Street, Leicester, LE1 6NB. Tel: 0116 222 5100).

The first article in the series looking at how local programmes have looked at acute myocardial infarction – one of the six project areas – can be found on pages 101–04. Articles covering each of the remaining project areas – stable angina, heart failure, revascularisation, rehabilitation and secondary prevention – will be published throughout 2003.

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