News

NHS Improvement: what is the future for heart and stroke services?

On the eve of his retirement, the outgoing National Director for Heart Disease and Stroke, Professor Sir Roger Boyle, has cautioned against reckless change in the new NHS, describing this as a threat to the continuous improvement that has been made over the past past decade.

Speaking to the *BJC* he said: "My criticism of this government is that they have been so busy condemning what's happened before, when (actually) the NHS has improved more than it's ever done".

Sir Roger commented on current changes in the NHS at an event held by NHS improvement (NHSI) 'Celebrating Clinical Leadership in Heart and Stroke – the Improvement Story so far'.

"To say that we are an over-managed health service is complete baloney," he added, highlighting the NHS' low transaction costs among developed nations. "We've done smaller commissioning in the past and we've tried bigger commissioning - we've settled for something in between and that seems to have been the best compromise".

He warned that in any major reorganisation, authority has to be re-earned in order for anything to change. "I'm very wary about where we're going to over the next couple of years because corporate memory is lost," he said.

Later in a panel discussion at the meeting with NHS Medical Director Professor Sir Bruce Keogh and National Clinical Director for Cancer Care Professor Mike Richards, Sir Roger said that his opposition to major NHS reorganisation was amongst the reasons for his retirement in July. "I'm partly leaving because I'm opposed to substantial reorganisation of this service I love deeply, and which is regarded across the world as one of the best".

Asked about the future role of clinical networks, Sir Roger criticised the abolition of strategic health authorities and primary care trusts (PCTs). "What we need at the moment is stability, not more change. Where we know we have tried things and they have worked, great. But we have also tried things that haven't worked and we need to learn from that as well, otherwise…we just re-learn the same lessons time and time again".

He also emphasised the importance of national clinical audits in monitoring the performance of new strategies, to ensure continued improvement, warning against the complacency of a "task and finish" approach: "If you go back and look at the National Service Framework…we started writing it in 1998, and there's not a lot we'd want to change. But I think we are in a different decade, and we really ought to be revitalising our approach. We need to get further upstream, get better at prevention, as maintaining the excellence of improved care…we have to keep monitoring to ensure we are improving".

Sir Roger paid tribute to the improvements that have been made. "Over the last decade we have seen a transformation in heart services across England. The National Service Framework outlined what needed to be done and the NHS has delivered almost every aspect laid out in March 2000. Service improvement does not happen spontaneously. It requires organisation, leadership, and a great deal of hard work. This is what NHS Improvement has provided in spades over the years. Their industry and commitment have been consistent levers for change over the years working with the local delivery mechanisms and the 28 cardiac networks".

Future improvements

Ongoing improvements were also showcased at the NHSI event. These included the reduction of strokes attributable to atrial fibrillation (AF) through use of the Guidance on Risk Assessment for Stroke Prevention in Atrial Fibrillation (GRASP-AF) risk management tool. Used by GP practices to identify patients registered for AF, it highlights patients with a $CHADS_2$ score of 2 or more not currently receiving anticoagulant treatment. Identified patients can be reviewed for suitability for anticoagulation, to reduce overall stroke mortality. NHSI is committed to increasing GRASP-AF use from 830 to 2,000 GP practices by April 2012.

The national implementation of primary percutaneous coronary intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) has increased access to primary PCI from 27% of the population in 2008 to 88% by February 2011. The work, spearheaded by the Cardiac Networks, has been a success due to its adaptation to different regions. NHSI aims to make primary PCI available to 100% of eligible STEMI patients by December 2011.

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A further ambition announced is to increase widespread uptake of the serum natriuretic peptide (NP) blood test to quickly rule out heart failure, reducing the need for further investigations by 30-40%. The NHSI projects that adoption of the serum NP test by PCTs not yet using it would yield national savings of £13.7 million, as well as enabling more rapid referral of genuine heart failure patients.

NHSI has collaborated with the National Institute for Health and Clinical Excellence (NICE) on a recently published quality standard for chronic heart failure, presenting an improved pathway for total heart failure care.

Palliative care is also the target of NHSI reforms of end of life care for patients with heart failure. The recently implemented National End of Life Care Strategy examines the problems of inappropriate intervention and avoidable admission as heart disease reaches terminal stages

Janet Williamson, National Director of NHSI, said that the challenge now was to continue to make improvements and spread good practice within heart and stroke as well as other clinical areas. She said the government had pledged to retain and strengthen clinical networks in any reform. They would cover more areas of specialist care, as well as having a stronger role in commissioning.

NICE guidance on stable angina

The National Institute for Health and Clinical Excellence (NICE) has published a new clinical guideline for the management of stable angina (NICE clinical guideline 126). The guideline partially updates the NICE technology appraisal guidance 73.

Key priorities for implementation include:

- exploring and addressing issues according to each person's needs including self management skills, concerns about stress, anxiety or depression on angina; and advice about physical exertion including sexual activity
- optimal drug treatment for the initial management of stable angina with revascularisation for people whose symptoms are not satisfactorily controlled with optimal medical treatment
- when revascularisation is appropriate, the potential survival advantage of coronary artery bypass grafting over percutaneous coronary intervention, and also the risks and benefits of the procedure
- regular multidisciplinary team meetings to discuss the risks and benefits of continuing drug treatment or a revascularisation strategy.

The full guidance is available at http://guidance.nice.org.uk/CG126.

A future supplement to the BJC will also review implications of this guidance for primary and secondary care.

E-learning tool for warfarin self-monitoring

A new online training tool (CoaguChek® Academy, Roche) has been made available for patients receiving long-term anticoagulation therapy that will provide them with information about self-monitoring in advance of a face-to-face appointment with a healthcare professional.

The e-learning tool covers topics including an introduction to anticoagulation and International Normalised Ratio (INR) testing and the use of specific self-monitoring devices. On successful completion of the online tool test, patients receive a certificate to show that they have understood the information.

It is estimated that up to 50% of patients taking long-term warfarin therapy would be eligible to self-minotor. Recent research from the Atrial Fibrillation Association (AFA), AntiCoagulation Europe (ACE) and Roche as part of their *Personal Touch* campaign, revealed that 94% of patients on warfarin want to be more involved or consulted in their care decisions. Findings also showed that currently less than 2% of patients in the UK benefit from self-monitoring.

"The Department of Health recently highlighted self-monitoring for warfarin users as a prime example of the modern NHS coping with the millions of people with chronic conditions, yet too often we hear that our members are not able to get access to self-monitoring," said Eve Knight, Chief Executive of ACE.

Steve Davidson, Chairman of the Clinical Leaders of Thrombosis (CLOT) said: "Self-testing is a win-win situation for the patient, the healthcare professional, and the NHS. Self-testing has been shown to improve compliance and outcomes, giving patients control over their therapy and lives, and reducing clinic waiting and travelling times. The results of this new survey show that there is a missed opportunity for patients and the NHS, who could benefit more from self-testing."

Helen Williams joins BJC editorial board

We are pleased to welcome to our editorial board Helen Williams, a Consultant Pharmacist for Cardiovascular Disease for the South London sector. Helen works across a number of PCTs, acute trusts and the South London Cardiac and Stroke Network. She is involved in a wide range of activities including developing pharmacist-led clinics in primary care to manage hypertension and vascular risk, supporting community heart failure services and contributing to the NHS Health Checks roll-out. She has also worked worked on various NICE clinical guidelines as well as supporting the development of a Commissioning Guide for Cardiac Rehabilitation.