

The background of the cover is a collage of four images, each with a semi-transparent red overlay. The top-left image shows a person's profile looking down. The top-right image shows medical equipment with various tubes and wires. The bottom-left image shows a person's hands holding a clear plastic container. The bottom-right image shows a close-up of a person's face, possibly wearing a mask or oxygen. The text is overlaid on these images.

The Coronary Heart Disease National Service Framework

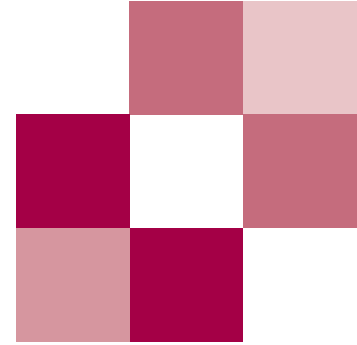
*Building on excellence,
maintaining progress*

Progress report for 2008

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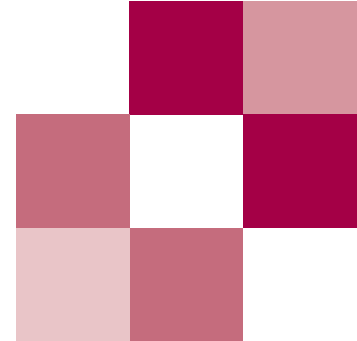
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Foreword

by the Secretary of State for Health



This is the eighth annual progress report for the Coronary Heart Disease National Service Framework (CHD NSF), highlighting the achievements made in 2008. Over the last nine years, the CHD NSF and related initiatives have led to some remarkable improvements in the services patients receive and the prevention of illness. Death rates from heart disease are falling while smoking prevalence, a major cause of heart disease, still follows a downward trend. The number of people receiving cholesterol- and blood pressure-lowering drugs is increasing steeply, which will ensure that mortality rates continue to fall in future years.



The target set out in *Saving Lives: Our Healthier Nation* to reduce deaths from cardiovascular disease (coronary heart disease, stroke and related diseases) by 40% in people under 75 by 2010 was met five years early. The mortality rate has now fallen by 44% when compared with the 1995–97 baseline. No one is waiting more than three months for heart bypass surgery – this is a great improvement from 2000, when more than 1,000 patients waited over a year for surgery, and from 1996 when some patients waited over two years.

Now, over 70% of people with heart attack symptoms are treated with thrombolytics ('clot-busting' drugs) within 60 minutes of calling for help, compared with approximately 24% before the CHD NSF's launch.

A £735 million capital programme is nearing completion and is providing the nation with world-class, state-of-the-art facilities and equipment for treating patients with coronary heart disease and other heart diseases. Since 1999, the number of cardiologists has increased by 61% (to 752 in total – which exceeds the target of 685), and there are 46% more cardiothoracic surgeons.

Around 4 million people are now receiving statins (cholesterol-lowering drugs), saving an estimated 10,000 lives every year. These drugs are now also available over the counter rather than solely by prescription, enabling more people to benefit.

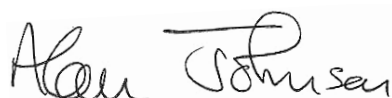
Equalities are being tackled – the gap in the death rate from coronary heart disease between the most deprived areas and the national average has narrowed by 32%. We are on track to meet the 2010 target of at least a 40% reduction in the gap.

The CHD NSF reaches its tenth anniversary next year, yet its approach continues to stand the test of time. One important feature designed in from the start is the capacity for the NSF to develop and keep pace with changes in the field. This has been witnessed with changing guidelines from the

National Institute for Health and Clinical Excellence, a new chapter having been written (on arrhythmias and sudden cardiac death), a policy statement on the development of adult congenital heart disease services, and, in 2008, the addition of an important element, the publication of the outcomes of the National Infarct Angioplasty Project. This document sets out the new national strategy to treat heart attacks using primary angioplasty, which represents a major breakthrough in terms of reducing mortality, speed of rehabilitation and readmission rates. The ongoing research into this area will offer very clear benefits to the people of this country.

The development of services for patients with heart disease will not end when the ten-year horizon mentioned in the NSF's foreword is reached. We must not lose the momentum and enthusiasm that the CHD NSF has created for continuous improvement in heart services and patient outcomes. Having a clear focus on heart disease has delivered great improvements in the service. However, to ensure that these improvements are sustained, and so we can build on what we have learnt over the last nine years, we need to look at the treatment and management of heart disease and incorporate these into the wider context of vascular diseases: this will ensure co-operative and comprehensive service delivery. The new National Quality Board will provide expertise and leadership in shaping the priorities for the NHS for the future, and the work we are doing now to evolve services across vascular disease will ensure that they are best placed to drive continuous quality development in all of the relevant clinical areas.

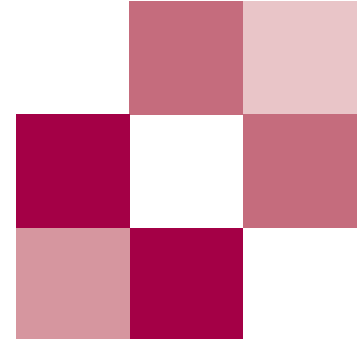
The achievements realised so far through the CHD NSF are testament to the hard work and commitment of the NHS. We will continue to strive for excellence in cardiac care and the prevention of illness and avoidable deaths. My thanks to all those who have contributed to delivering these incredible improvements.



Alan Johnson
Secretary of State for Health

Introduction

by the National Director for Heart Disease and Stroke



The Coronary Heart Disease National Service Framework (CHD NSF) is a commitment made in 2000 to improve the quality of cardiac care across the country. This report demonstrates how 2008 was by no means an exception in providing the improvements that have made the CHD NSF such a success.



There have been achievements in many areas of cardiac care and, combined with the close working relationship the Department of Health has with NHS Improvement, the focus of 2008 was achieving consistent quality of care that we will be able to continue taking forward.

I have been privileged to oversee implementation of the CHD NSF over the last nine years. As well as seeing the service meet and exceed the major milestones to reduce deaths and cut waiting times, I have witnessed the ongoing development of strong local leadership and 'gold standard' professionalism in the provision of cardiac services. Cardiology is held up as an excellent example of how health services should be provided not just in this country: it is also now a service that the rest of the world looks on with envy.

Front-line clinicians and other staff continue to champion the development of cardiac services, bringing innovation and excellence to service development and delivery as practices and technologies evolve and advance.

Over the years I have become more and more convinced that the best improvements are made with accurate and thorough data collection and analysis. We have continued to improve our audit data collection: the number of trusts registered in the audits has increased, two new audits have been launched, and existing audits have been adapted to ensure accurate coverage of primary angioplasty.

Much of the content of the CHD NSF is as relevant now as it was in 2000, and will probably still be relevant in 2020. We must ensure that progress continues and the enormous achievements that have already been realised are built upon. We will review how well the implementation of the CHD NSF is progressing and look at how patient expectation and need, technology and working practices in cardiology are changing to enable us to feed into the discussions of the new National Quality Board, which has been set up to oversee the setting of priorities for the service in the future.

By working with the National Quality Board, we will maintain our strong focus on opportunities for improvement and health gain in heart disease. Lord Darzi's report *High Quality Care For All* provided welcome reaffirmation

Introduction

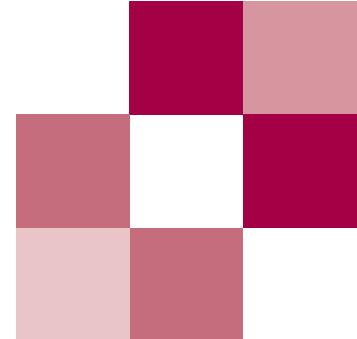
of the importance of putting quality at the centre of what we do and the need to look across the whole patient pathway. Increasingly, we are also looking for opportunities to work with other specialties, particularly stroke, diabetes and kidney care, which have many concerns in common. The vascular risk assessment programme is a concrete example of how a cross-vascular approach can be constructed. I will work with the National Clinical Directors for Diabetes and Kidney Care to identify opportunities for joint working.

I look forward to working with you all in the future.

A handwritten signature in black ink that reads "Roger Boyle". The signature is written in a cursive style with a large initial 'R' and 'B'.

Professor Roger Boyle
National Director for Heart Disease and Stroke

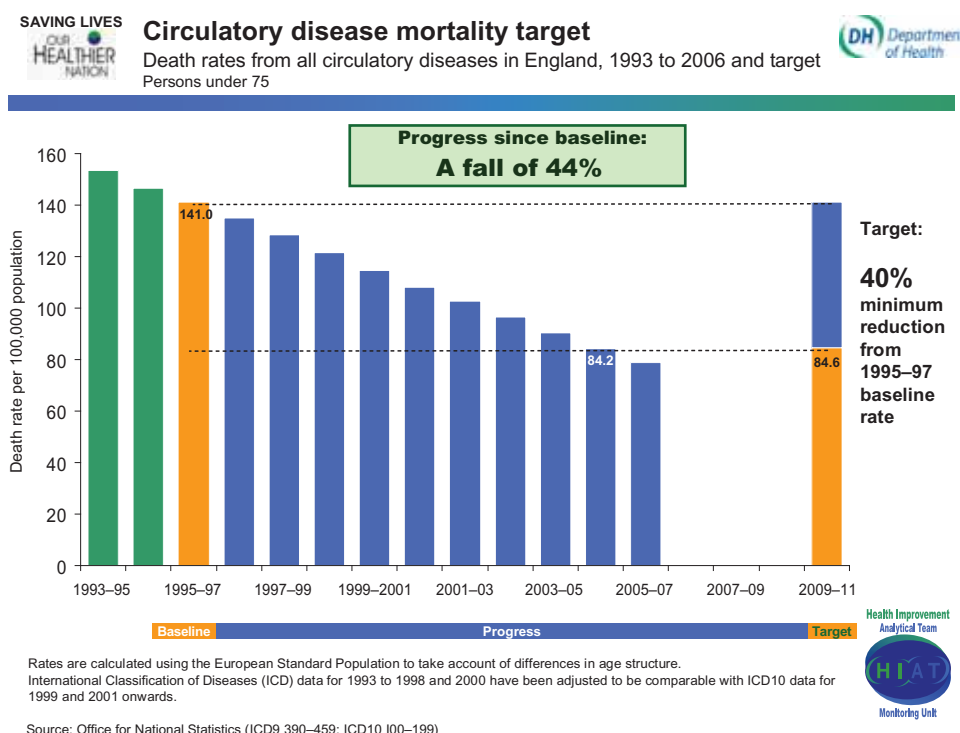
Chapter 1: Progress and successes in 2008



Saving lives

Our Public Service Agreement mortality target – to reduce mortality from heart disease and stroke and related circulatory diseases in people under 75 by at least 40% by 2010 – was set in the public health White Paper *Saving Lives: Our Healthier Nation* in 1999. It was based on the trend data available at the time, including international comparisons, and was seen as a significant challenge.

Since then, steady progress has been made and the target has been met, five years ahead of schedule. This major achievement is the result of the shared efforts of people working in many parts of the healthcare system.



People suffering a heart attack are receiving either:

- thrombolysis, more quickly than before; or
- new primary angioplasty services that have been, and will be, implemented for people suffering a heart attack.

Progress and successes in 2008

Waiting times for heart surgery have dropped dramatically since the publication of the Coronary Heart Disease National Service Framework (CHD NSF) and outcomes have improved. In April 2002, there were 7,558 people waiting for a coronary artery bypass graft and 4,364 of them had been waiting three months or more; by December 2008 this had fallen to 1,670 people waiting and only six people had been waiting longer than three months.

In primary care, secondary prevention has improved thanks to the additional incentive of the Quality and Outcomes Framework, a performance management system for GPs that is supervised by primary care trusts (PCTs).

The prescription rate for cholesterol-reducing statins has more than doubled over the last three years, cutting mortality from coronary heart disease and the number of heart attacks each year.

Smoking cessation has also made a major contribution. Smoking prevalence among adults dropped from 28% in 1998 to 21% in 2007. This is particularly encouraging since the decline in smoking prevalence has been consistent over the last decade.

Capital schemes

The revascularisation capital programme started in 2001 and is due for completion in 2009. The programme had over 30 individual schemes and in April 2008 the last six schemes had all started and were under construction or nearing completion. By the end of 2008 three of these developments were open for patients.

South Manchester – Wythenshawe Hospital (£22 million) – opened May 2008

This is a major extension and expansion of existing facilities – providing outpatient and testing facilities and critical care.

Northampton General Hospital (£6 million) – opened June 2008

A new extension includes a state-of-the-art catheter laboratory and a pacing theatre.

Maidstone Hospital (£3.6 million) – opened November 2008

A new catheter laboratory and day beds are now open. The facility is enabling angiography, angioplasty and other cardiac interventions to be undertaken in Maidstone for the very first time.



Maidstone – staff in the new catheter laboratory

Since the end of 2008:

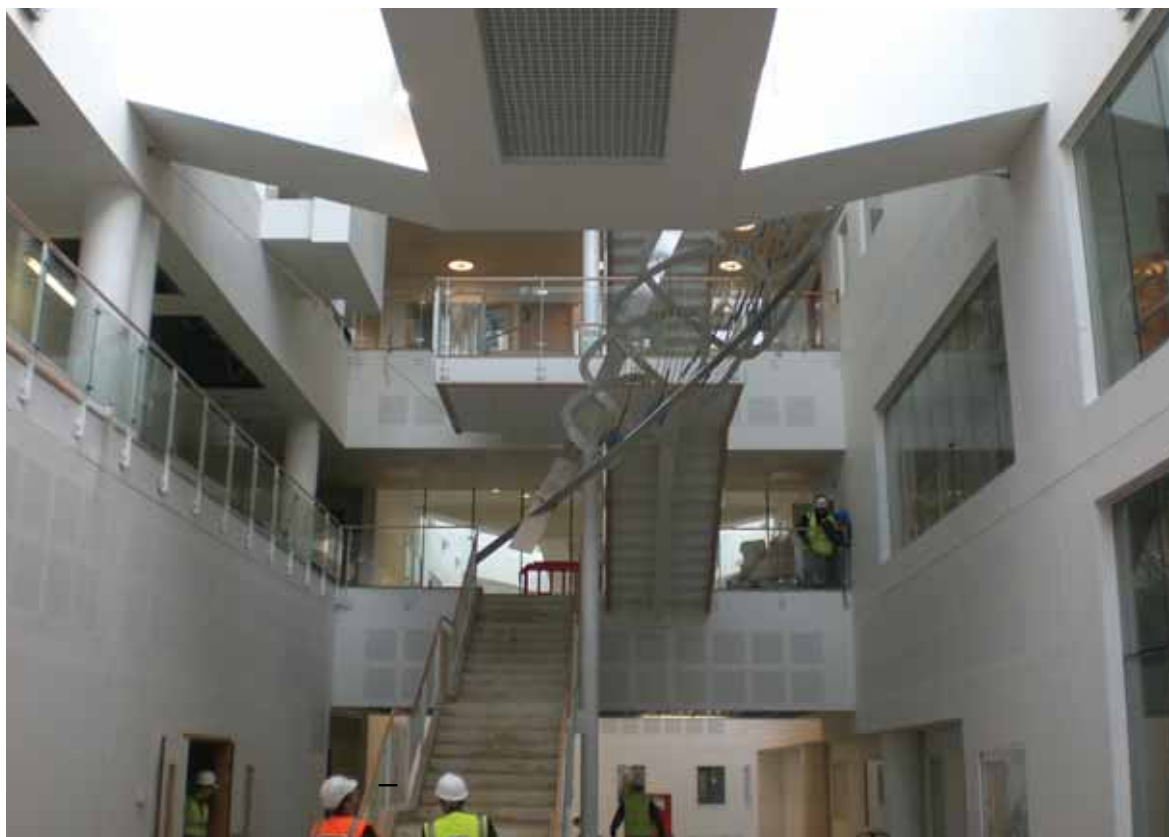
Hull – Castle Hill Hospital (£31.4 million) – opened March 2009

The scheme is a major replacement and expansion of existing facilities. The development includes a cardiac outpatient and non-invasive testing department, four catheter laboratories, five operating theatres and 12 critical care beds.

The two remaining schemes on site at the end of 2008 are listed overleaf.

Bristol Royal Infirmary (£57.3 million) – opening May 2009

The new regional adult cardiothoracic centre is a major extension and expansion of services. The development includes new cardiac intensive care facilities, a coronary care unit, three catheter laboratories and supporting day beds, inpatient beds and an outpatients department.



Bristol Royal Infirmary – atrium in the new adult cardiothoracic centre

Oxford Radcliffe Hospitals (£29.1 million) – opening summer 2009

The new five-storey build is an extension to the existing cardiac block at the John Radcliffe Hospital. It will provide four catheter laboratories, a day and recovery unit, cardiac critical care, an echo suite and a physiotherapy gym.

Treatment of heart attack

National Infarct Angioplasty Project (NIAP)

Primary angioplasty is the treatment of heart attacks using an angioplasty procedure carried out in a catheter laboratory. A tube is inserted via the arm or groin to the blocked heart artery and a balloon attached to the tube is then inflated and removed. A stent is left in the artery to squash the fatty deposit causing the blockage and allow blood flow to restore itself.

The Department of Health has been working with the British Cardiovascular Society and the British Cardiovascular Intervention Society on NIAP to test the feasibility of offering primary angioplasty services on a countrywide basis. This study was completed during 2008. An interim report was published in February 2008 and final conclusions from the study were included in *Treatment of Heart Attack National Guidance*, which was published in October 2008 together with an independent evaluation of patient experience, staffing and costs of a primary angioplasty service.

Key conclusions were as follows:

- National roll-out of primary angioplasty is feasible and likely to be cost effective but may be logistically challenging in some parts of the country. A 97% population coverage over three years is considered feasible.
- Where a primary angioplasty service cannot be established, it is preferable for thrombolysis (clot-busting drug treatment) to be given pre-hospital and for patients to be referred for angiography.

However, implementation of a primary angioplasty programme will depend on local priorities.

Thrombolysis

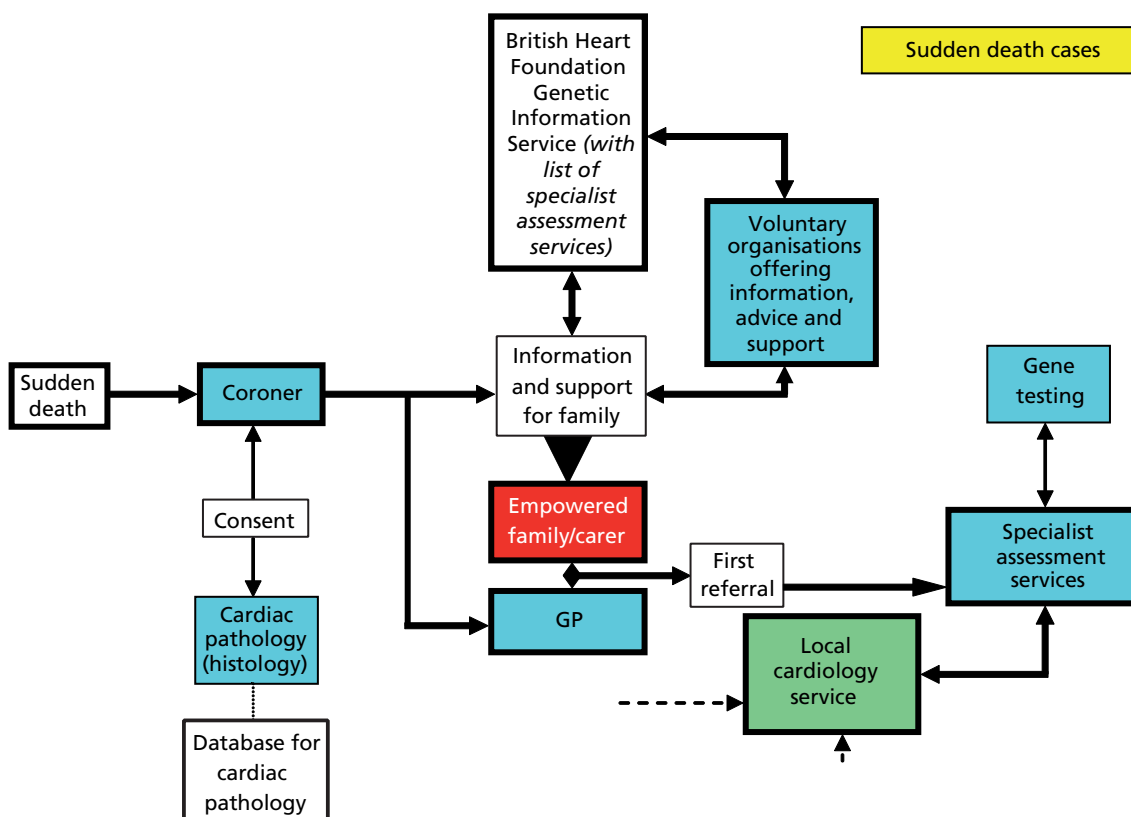
The proportion of people treated with thrombolysis within the NSF standard of 60 minutes from call for professional help exceeded the national target level of 68% during 2008. The number of people treated with thrombolysis has reduced during 2008 as primary angioplasty services have been developing.

Sudden cardiac death and inherited cardiac conditions

2008 saw considerable progress made towards putting in place a national structure for ensuring that, following a sudden cardiac death:

- as much as possible is done to determine whether that death was the result of an inherited heart condition;
- the risk to other family members is assessed and communicated; and
- family members at risk are referred as quickly as possible to a specialist heart service dealing with these conditions.

The service to which we aspire nationally is illustrated in the following diagram.



UK Cardiac Pathology Network (UKCPN)

UKCPN is developing well. The Department of Health funded the setting up of a database to enable cardiac pathologists to record information on sudden cardiac death cases referred to them by coroners. The database was launched in November 2008.

British Heart Foundation (BHF) Genetic Information Service (GIS)

2008 saw BHF and the Department of Health collaborating on an information service that the BHF will fund and operate from April 2009. The GIS will take calls from relatives of sudden cardiac death victims who have been referred by the coroner. The GIS will then ensure that those perceived to be at risk are given information on the service to which they should be referred; they can then take this information to their GP. This should mean that more people will access specialist inherited cardiac conditions services.

For the future

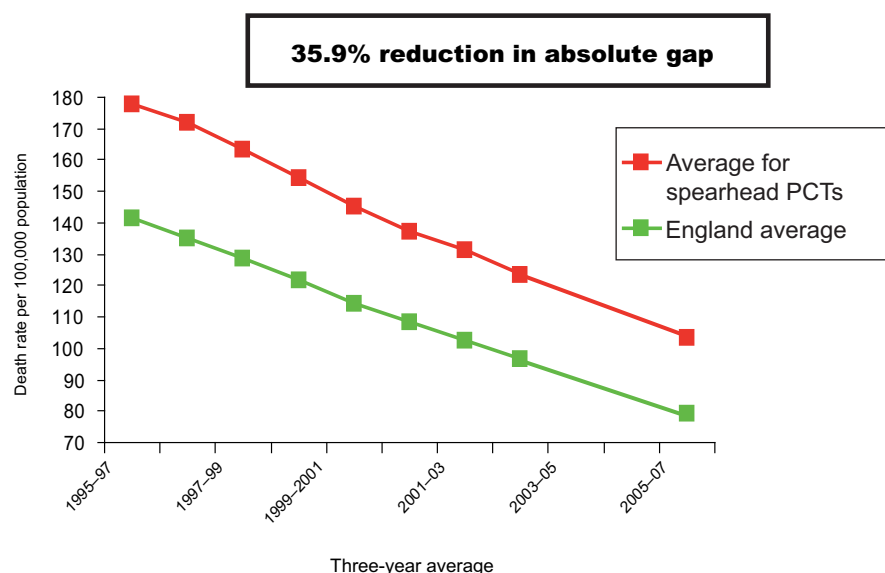
The Department of Health will be working with a number of organisations to look at the quality requirements and standards that we would expect each of the specialist inherited cardiac conditions assessment services to meet. We will pursue with specialist commissioning colleagues the designation of centres that will do this work. We also need to look specifically at how engagement with, and education of, coroners might be improved, how we can get a fair costing and reimbursement service for these specialist services, and how we ensure that genetic testing services are fully integrated in the provision of assessment services.

Mending the gap

Inequalities in the death rate from heart disease, stroke and related disease among the under-75s have been narrowing throughout the NSF years. This is taking us towards our target of a 40% reduction in the gap by 2010.

Measuring the difference between the worst fifth of areas in the country for health and deprivation (the spearhead PCTs) and the national average has shown that the absolute gap has reduced by 35.9% between 1996 and 2007.

Deaths from circulatory disease in people under 75 years of age
England, 1996–2006

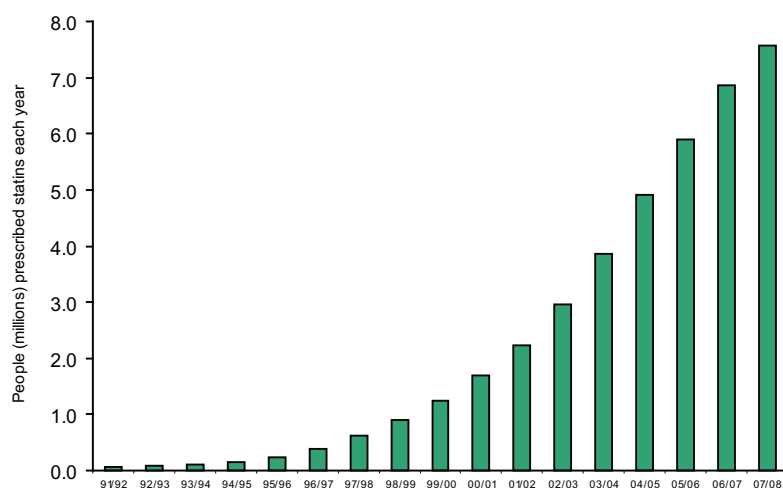


Source: Office for National Statistics

Statins

The measurement and control of cholesterol is included in the Quality and Outcomes Framework in the GP contract. High levels of achievement have been shown, with increasing numbers of patients being prescribed statins (cholesterol-lowering drugs). The use of low-cost generic statins instead of higher-cost branded drugs was recommended in the 'better care, better value' indicator launched in 2006; this has led to great savings while there has been no compromise to treatment. The number of patients on statins has increased consistently since 2006.

Estimated number of people (millions) prescribed statins each year, 1991/92 to 2007/08



Calculation of number of people based on six prescribed items per year.

New technologies

Lord Darzi's final report *High Quality Care For All* included a commitment to ensure that: "clinically and cost-effective innovation in medical technologies is adopted".

In June 2008, the National Institute for Health and Clinical Excellence issued guidance on the use of transcatheter aortic valve implantation for treatment of aortic stenosis in patients who would be considered too high risk for conventional cardiac surgery. This is one of a number of emerging minimally invasive surgical techniques. Another example is percutaneous mitral valve leaflet repair or 'mitral clips'. The Department of Health has been working with relevant professional societies and NHS specialist services commissioners to ensure that new techniques are introduced safely into the NHS and that eligible patients can benefit.

Audit

During 2008, audits have continued to develop and to increase their coverage. The heart attack and angioplasty audits have both been adapted to support the auditing of primary angioplasty and will be more closely linked in the future.

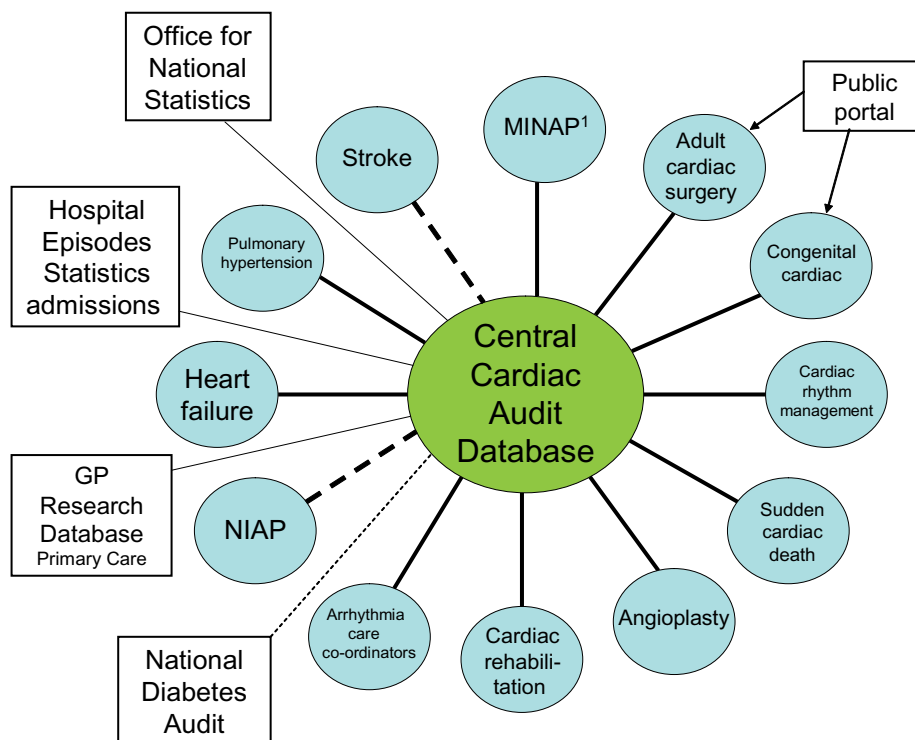
The heart failure audit now has over 80% of trusts registered, and 74% of the cardiac rehabilitation programmes are now registered with the cardiac rehabilitation and quality of life audit.

Two new audits have commenced: the sudden cardiac death database was launched in November 2008 and the national audit of pulmonary hypertension was launched in December 2008.

Updated figures were published for the cardiac surgery audit public portal in the summer of 2008.

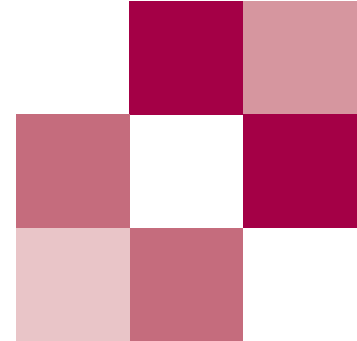
Lord Darzi's final report on the NHS Next Stage Review, *High Quality Care For All*, published in June 2008, confirms the importance of the measurement of clinical effectiveness. The audits will be key to the implementation of such measures and to the production of NHS trust quality accounts.

The following diagram illustrates the cardiac audits that are currently included within the Central Cardiac Audit Database.



¹ Myocardial Ischaemia National Audit Project

Chapter 2: Working with NHS Improvement



NHS Improvement

NHS Improvement covers a number of clinical specialties, including heart, stroke, cancer and diagnostics.

NHS Improvement works closely with the Department of Health, 28 cardiac networks, charities and leading organisations in the field, to make sustainable improvements along the whole pathway of cardiac care. The programme uses a number of different approaches; these include working with priority project sites that focus on testing and spreading improvements, working with networks to support the implementation of national policy, and supporting the development of new policy areas.

A number of important programmes of work commenced in 2008.

The role of cardiac networks

Cardiac networks support and facilitate the delivery of integrated care across primary, secondary and tertiary service organisations. Working with relevant organisations within their healthcare communities, clinicians, managers, commissioners and patients are all involved in improving cardiac services across their locality.

Cardiac networks continue to play a vital role in delivering improvements across cardiac care. In the past year several have merged or changed their boundaries in line with local organisational changes.

By April 2009, cardiac networks will have embraced the stroke agenda and extended their role and expertise to support stroke, while retaining a focus on the cardiac agenda, to ensure their continuing contribution to improving cardiac services.

A further development for networks has seen them increasingly involved in commissioning. Networks are a source of advice and support to commissioners and are well placed to promote the shift of emphasis towards prevention and the public health agenda, programme budgets and whole pathway commissioning. Additionally, networks have excellent clinical engagement and can offer access to expert advice on clinical innovations and specialist service provision. Networks have an important role in helping primary care trusts (PCTs) deliver on their priority outcomes and World-Class Commissioning competencies, and this role is growing.

“Cardiac networks have encouraged clinicians to think about service development and delivery in terms of the whole health economy rather than their own individual trusts or practices. This has brought new legitimacy and authority to the clinical advice available to commissioners.”

Dr Mark Dancy, National Clinical Chair, NHS Improvement

Cardiac rehabilitation

NHS Improvement is working with 13 sites across England on a series of projects aimed at increasing the access, equity and uptake of cardiac rehabilitation (CR) services by supporting the implementation of commissioning guidance from the National Institute for Health and Clinical Excellence.

The work is focused on improving the commissioning of CR (with special reference to reducing inequalities in access, e.g. through projects in a multi-cultural inner city area or an area with a predominantly agricultural transient ethnic population). Close working with the Department of Health and the British Association of Cardiac Rehabilitation and use of the National Audit of Cardiac Rehabilitation ensure an integrated approach.

Service specifications, flexible pathways, redesigned service models, improved referral systems, innovative locations and robust costing and funding arrangements are some of the projected outputs from the projects.

The learning from these projects will be spread widely and shared through cardiac networks, national workshops and the NHS Improvement website.

Heart failure

The focus of quality improvement activity extends across the heart failure pathway and is achieved using a variety of approaches. NHS Improvement has been working in partnership with 14 lead organisations, including cardiac networks, PCTs, secondary and tertiary care providers and social care, across England since September 2008 in order to improve care.

This pathway project covers aspects ranging from improving screening and access to heart failure services right through to supportive and palliative care. Projects include the use of brain-type natriuretic peptide (BNP) testing in emergency admissions to speed up the diagnosis of heart failure, the use of telemonitoring in the community to support home management of chronic heart failure, and improving access to supportive and palliative care services.

Local teams are supported to meet the aims of their individual projects through attendance at peer support meetings, access to online resources, ongoing site visits with NHS Improvement and clinical support through strong national clinical leaders.

The underpinning mechanism to demonstrate and sustain improvement is the bespoke NHS Improvement system, which can be used to log progress, collect and analyse data and disseminate useful resources.

Heart rhythm management devices

Following a review by NHS Improvement of cardiac network plans in August 2008, 25 networks were identified as delivering ongoing arrhythmia service improvement work. The two key challenges were 18-week wait access targets and improving device implantation rates. The Network Devices Survey team, NHS Improvement, the Department of Health, patient organisations and Heart Rhythm UK, under the guidance of the Department of Health Chapter 8 Sub-programme Board Group, are working in collaboration to support devices work across England. NHS Improvement hosted a devices event for this group in December, raising the profile of device implantation underperformance and inequity.

As well as the ongoing programme of work to provide the cardiac networks with the appropriate data on implantation rates in their area, NHS Improvement and the Department of Health are working with a number of other organisations to provide further support in the form of expert analysis and peer review of current performance. Cardiac networks will then be able to investigate the local root cause of underperformance and the effectiveness of improvements, such as identifying unmet need and redressing this through clinical education. Effectiveness is measured in terms of overall rate, equity of access and service quality. NHS Improvement will co-ordinate and share the local work, providing a communication route and regional events.

Atrial fibrillation

Atrial fibrillation (AF) is both under-recognised and under-treated despite evidence demonstrating that systematic screening increases the detection of new cases by approximately 60%. AF is an important risk factor for stroke: it has been estimated that optimal treatment of AF in the population would reduce the overall stroke risk by 10%. Sixteen cardiac and stroke networks are currently working with PCTs to target cohorts of practices. They are working to address the identification and management of AF in primary care and the identification of new cases of AF, to ensure appropriate treatment, and to review provision of arrhythmia clinics, pathways and services.

Results to date have been encouraging. The networks have worked with 22 PCTs and more than 139 general practices across England. A major achievement of this work has been the opportunistic screening of over 1,500 patients in a target population; 25 new cases of AF were identified and subsequently treated. Practices have developed in-house anticoagulation services and pathways of care have improved between primary and secondary care. To support wider development, a number of resources and tools have been developed. These include case studies of effective AF screening from which to learn, and innovative searching technology to enable any practice to identify and risk-score AF patients quickly and accurately.

The Department of Health and NHS Improvement have also been working with the Quality and Outcomes Framework Cardiac Services Working Group to ensure that the risk of stroke is identified during the management and treatment of patients with AF in the primary care setting.

Heart attacks

Following on from the publication of *Treatment of Heart Attack National Guidance* (see Chapter 1), NHS Improvement set up a small team to facilitate the roll-out of primary angioplasty services. This involved appointing a National Improvement Lead on Reperfusion (full time) and a National Clinical Lead (part time). Given that patients may require angioplasty for heart attack at any time of the day or night, the treatment needs to be available within a specified time limit to ensure maximum benefit, and clinicians need an adequate caseload to maintain skills and carry out training. It will not be appropriate for this service to be provided in all acute hospitals.

At a National Clinical Consensus Meeting in September 2008, it was agreed that the cardiac networks were the appropriate building blocks for developing this service. Individual networks are establishing their own plans to deliver the service according to their local priorities and geography. The key is to provide rapid and safe treatment to all heart attack patients. For primary angioplasty, patients may be taken directly to larger cardiac centres in some areas; in other areas, local hospitals will provide daytime emergency angioplasty, with patients presenting at night being taken directly to the nearest major cardiac centre. A successful angioplasty programme, therefore, will involve co-operation between neighbouring hospital trusts and collaborative working with the local ambulance trust.

The work of the Heart Improvement Programme includes:

- publication of a document on the commissioning of primary percutaneous coronary intervention (PCI);
- development of a web-based toolkit to assist individual hospitals, networks and commissioners in developing this new service;
- hosting national meetings to discuss relevant issues;
- collating data from the Myocardial Ischaemia National Audit Project to monitor the national change in practice from thrombolysis to angioplasty as the standard treatment for heart attack; and
- providing bespoke advice to cardiac networks with specific difficulties in implementing this new service.

Early results are encouraging, with over 40% of the population already living in areas with a 24/7 primary PCI service for heart attack. This proportion is expected to grow to more than 95% within two years.

Implementation of primary angioplasty services will depend on local priorities and geography.

Cardiac surgery

The cardiac surgery project, an extension of last year's 'sustaining cardiac pathways' national priority, incorporates a broad focus on adult elective and non-elective work and aims to improve local cardiac surgery services and develop solutions to deliver 18-week pathways. The project also supports organisations to review and implement the recommendations outlined in the National Confidential Inquiry into Patient Outcome and Death (*The heart of the matter*, June 2008).

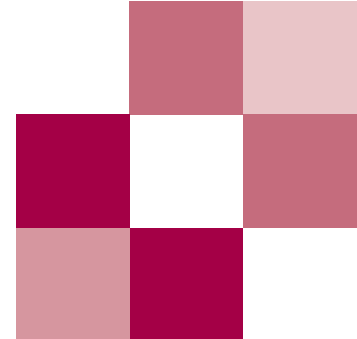
Working in partnership with eight organisations, including NHS trusts and networks, the focus of activity includes:

- management of surgical referrals;
- pre-assessment and preparatory tests and stabilisation before surgery;
- theatre scheduling; and
- discharge planning.

Organisations participating in the project are supported by a national team through a series of interactive peer support workshops and site visits.

The development of the cardiac data 'dashboard' by NHS Improvement provides organisations with publicly available data on performance in cardiac service delivery against the national 18-week and diagnostic targets. This enables comparisons and benchmarking at a number of levels: cardiac network, strategic health authority, provider and commissioner. This tool is accessible via the NHS Improvement website.

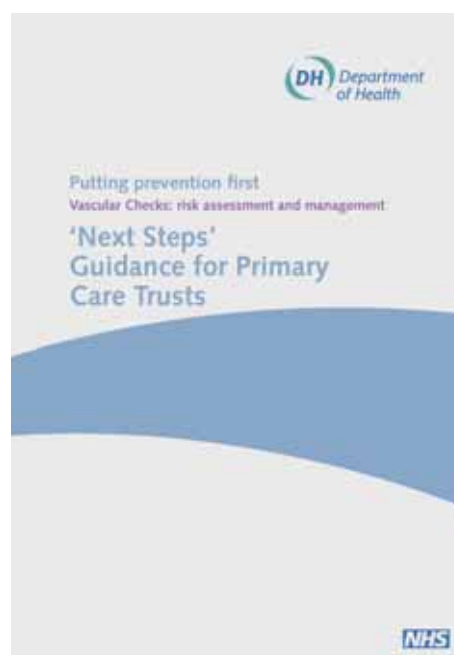
Chapter 3: Vascular Checks Programme



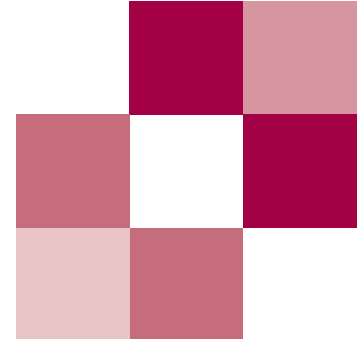
In January 2008, the Prime Minister announced the Government's intention to shift the focus of the NHS towards empowering patients and preventing illness. As part of this, he set out his ambitions to dramatically extend the availability of 'predict and prevent' checks to give people information about their health, support lifestyle changes and, in some cases, offer earlier interventions.

The introduction of systematic checks for all people aged between 40 and 74 to assess and reduce individuals' risk of diabetes, heart disease, stroke and kidney disease is a significant opportunity to reduce mortality and morbidity and close the gap in health inequalities. *Putting prevention first* was published on 1 April 2008, setting out the basis of this new programme and the evidence supporting its introduction.

We are working with stakeholders to help develop the programme. A learning network has been established with colleagues at NHS Improvement to promote sharing and learning among primary care trusts (PCTs) on activity such as vascular checks. The *'Next Steps' Guidance* for PCTs was published on 13 November 2008 to inform and support implementation of the programme and help PCTs commission services. Phased implementation of the programme will begin in April 2009.



Chapter 4: 2010 and beyond ...



The Coronary Heart Disease National Service Framework (CHD NSF) has initiated improvements in most areas of cardiology. We must continue to build on the success we have realised so far but also consider where we might need to do better.

Now is a good time to reflect on how big an effect the standards and markers of good practice set out in the CHD NSF have had so far, and why; and also why the development of services for those with heart failure and cardiac rehabilitation, for instance, have not been embraced by the NHS as much as we would have hoped.

In response, we are commissioning an external review of the CHD NSF's implementation.

Many things have changed since 2000 and it is timely to look at how the needs, requirements and expectations of patients have altered, how the burden of disease has changed, what technological changes have taken place and what all these changes mean in terms of future service needs. We will also, therefore, be conducting a piece of work to consider what the profile of cardiology services might look like in the future and what forms of resources and support services may need.

This reservoir of information will enable us to inform the new National Quality Board about how cardiac services have developed over the last nine years, and help in deciding what the priorities in this area might be for the future. But while continuing to ensure that treatment for all the vascular conditions improves, we must also take this opportunity to widen our understanding of how vascular diseases link together and how we should continue to develop a cross-vascular programme of work. Areas that will need to be focused on are:

- preventing vascular disease and not just treating it;
- removing inequalities of access; and
- ensuring that those with chronic vascular conditions, who require long-term and end-of-life care, get the same level and quality of services that those with acute conditions are now getting.

We have already embarked on this programme of work.

The vascular programme National Directors will work together to identify gaps in service provision and then will work with the National Quality Board to consider what work should be focused on in the future and who is best placed to ensure that those gaps are filled. This might be the Department of Health, but could equally be another national organisation.



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