The Coronary Heart Disease National Service Framework

Shaping the future

Progress report for 2006
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This report is published to celebrate six years of improvement since the launch of the Coronary Heart Disease National Service Framework (CHD NSF). It highlights the progress that continues to be made by the NHS in the prevention, diagnosis and treatment of heart disease. This is an area where services are now over half way through a ten-year programme of transformation.

The fantastic commitment of NHS professionals continues to yield improvements in services and health outcomes. The premature death rate from cardiovascular disease (heart disease, stroke and related diseases) among people under 75 continues to fall. The latest mortality figures show that deaths have reduced by 35.9% since 1996. It builds on previous downward trends and indicates that we are on track to achieve our Public Service Agreement target of at least a 40% reduction by 2010.

This is good news, and there is still much to do. This report also provides a chance to consider where we are in relation to achieving a whole range of commitments. All twelve of the NSF standards need to be met by 2010 and there is the new direction for health services set out in the White Paper Our Health, Our Care, Our Say. More new cardiothoracic centres and catheter laboratories have opened around the country – already helping provide more care closer to home, which is an important theme. In addition, work is needed to prepare to reduce patient waiting times – from referral to treatment – to 18 weeks in 2008. We also have to keep our focus on the inequalities agenda to make sure that improvements in CHD services benefit all parts of the community.

While the Department of Health continues to maintain a strong focus on CHD we are working on a vascular programme. This will look at how we can improve the management of shared risk factors for CHD, stroke, diabetes and kidney disease. People often live with more than one of these diseases, so there are good reasons to integrate preventative strategies and early interventions. Over time I believe we will see this increasingly reflected in the way services are delivered by the NHS.
As expertise, treatment techniques and new service models develop, the CHD agenda continues to expand beyond the original limits of the NSF. In 2005 we published a new chapter covering cardiac arrhythmias, and in June 2006 commissioning guidelines were launched for adults with congenital heart disease.

The diagnosis and treatment of heart disease continues to break new ground, and is an area about which we can all feel justly proud.

Patricia Hewitt
Secretary of State for Health
The purpose of this document is to provide a summary of the excellent work that is going on all over the country. It highlights the main areas of activity since we published our last progress report, *Leading the Way*, in March 2005. This report also explains where further work is needed. It has been written for people who work in the field of CHD and for everyone who has an interest.

In the six years since we published the CHD NSF the rate of progress and change continues. There’s no sign that the pace is slowing down. In fact quite the reverse, and through all this the standards set out in the NSF are as relevant and robust today as they were back then.

This is important in a health service where decision-making and financial power are increasingly devolved. I believe the NSF continues to provide a meaningful set of development standards. These standards offer a common bedrock of clinical quality to anchor local service planning in the evidence base. They will assist commissioners to ensure that services meet the needs of their local populations.

A recent article published in the *European Heart Journal* shows that we are among the highest spending countries in the region on cardiovascular diseases. These figures also show that while we continue to have high incidence, our rates are declining as quickly as any other country. Having the fastest improving services in the region means we have achieved high rates of success in tackling heart disease. This clearly shows the Government’s continued commitment to tackling the disease.

I would like to pay a particular tribute to the work of the NHS Heart Improvement Programme (HIP) and the cardiac networks. The HIP has provided a vital link in the road from policy development to implementation. The cardiac networks, which have grown in strength and experience over the past couple of years, have delivered the management and clinical engagement we need to make a reality of the NSF’s ambitions. I believe that the principles and benefits that they have demonstrated will be just as useful in the future.
I would also like to send my personal thanks to the thousands of people who are involved in the prevention, diagnosis and treatment of heart disease.

Professor Roger Boyle
National Director for Heart Disease and Stroke
The CHD NSF continues to deliver improvements in CHD services

<table>
<thead>
<tr>
<th></th>
<th>Then</th>
<th>Now</th>
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<tbody>
<tr>
<td>Adult smoking prevalence</td>
<td>28%</td>
<td>24% (2004)</td>
</tr>
<tr>
<td>Number of children receiving free fruit at school</td>
<td>zero (2000)</td>
<td>nearly 2 million</td>
</tr>
<tr>
<td>Estimated number of lives saved with statins</td>
<td>2,900 (2000)</td>
<td>9,700 (2005)</td>
</tr>
<tr>
<td>Number of patients waiting over 12 months for heart surgery</td>
<td>1,093 (Mar 2000)</td>
<td>zero (Dec 2002)</td>
</tr>
<tr>
<td>Number of patients waiting over 9 months for heart surgery</td>
<td>2,694 (Mar 2000)</td>
<td>zero (Mar 2003)</td>
</tr>
<tr>
<td>Number of patients waiting over 6 months for heart surgery</td>
<td>2,766 (Apr 2002)</td>
<td>zero (Mar 2004)</td>
</tr>
<tr>
<td>Number of patients waiting over 3 months for heart surgery</td>
<td>5,663 (Apr 2002)</td>
<td>zero (Mar 2005)</td>
</tr>
<tr>
<td>Percentage of heart attack victims given thrombolysis within 30 minutes of arrival at hospital</td>
<td>38% (2000)</td>
<td>83% (between Apr 2005 and Mar 2006)</td>
</tr>
<tr>
<td>Consultant cardiologists</td>
<td>467 (1999)</td>
<td>725 (Sept 2005)</td>
</tr>
<tr>
<td>Heart surgeons</td>
<td>182 (1999)</td>
<td>238 (Sept 2005)</td>
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Reducing mortality

We continue to make good progress towards our Public Service Agreement mortality target for cardiovascular disease (CVD) with a 35.9% reduction, against a target of 40% by 2010.

The latest figures (2003 to 2005) shown below build on previous downward trends and indicate that we are on track to achieve the target ahead of schedule.

Some of this improvement results from changes affecting people’s risk, such as the decline in smoking. Other contributing factors include health interventions put in place as a result of the CHD NSF. These include improving emergency care, reducing waiting times and ensuring that people are prescribed the correct drugs, like statins.

Circulatory Disease Mortality Target
Death rates from All Circulatory Disease in England 1993–2005 and target
Persons under 75

Death rate per 100,000 population

Progress since baseline:
a fall of 35.9%

Rates are calculated using population estimates on 2001 census, subsequent to amendments resulting from the Local Authority Population Study (LAPS).
Rates are calculated using the European Standard Population to take account of differences in age structure.
ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.
Source: ONS (ICD9 390–459; ICD10 I00–I99).
Mending the gap

Inequalities in the death rate from heart disease, stroke and related diseases among the under 75s have been narrowing for the past eight years, and we are on track to meet a 40% reduction target in the gap by 2010.

Over the last eight years, the gap between the worst-hit areas in the country and the rest of the country has been narrowing, from 36.7 excess deaths per 100,000 population in 1995 to 1997, to 26.4 in 2003 to 2005. This translates as a 28% reduction in the absolute gap as shown in the graph below.

Deaths from circulatory disease in people under 75 years of age
England 1996–2005

Age standardised rates per 100,000 population

Three-year average

- Average spearhead group of local authorities
- England average

28% reduction in the gap

36.7
26.4


Three-year average
Developing new models of emergency care

People who need urgent admission to hospital receive the best care when they are taken direct to the right specialist facilities. Patients with a heart attack, for example, could be taken straight to a hospital with cardiac catheterisation laboratories rather than the nearest A&E.

Prompt and accurate diagnosis by paramedics is crucial so that patients receive the best care at the most critical time, and in the most appropriate setting.

The two front-line treatments for heart attack described below are being delivered to more people faster than ever before.

Thrombolytic drugs

Known as clot busting drugs, they open the blocked coronary artery and return blood supply to the affected part of the heart. Thrombolysis is most effective when administered within three hours of a heart attack.

Primary angioplasty

Angioplasty is a procedure for unblocking arteries. A tube is inserted via the arm or groin and guided to the blocked heart artery. A balloon attached to the tube is then inflated and removed, leaving in place a stent – a rigid support which squashes the fatty deposit blocking the artery, restoring blood flow. Primary angioplasty is the use of angioplasty as the first treatment for heart attack and is most effective when performed within three hours of onset of symptoms.

Primary angioplasty is successful in restoring blood flow for more people than thrombolysis and research suggests that outcomes for patients are better. Primary angioplasty also offers some benefit for patients who present to services late after onset of their symptoms.
Case study: South East London Primary Angioplasty Service

Ambulance paramedics decide on patient’s suitability for primary angioplasty based on an electrocardiogram (ECG) reading and transport the patient directly to the Primary Angioplasty Centre at King’s College Hospital. Where there is uncertainty, they may take the patient to the nearest hospital for diagnosis and then, if appropriate, on to the Primary Angioplasty Centre. After receiving an angioplasty, patients stay for up to three days in the centre and are then discharged home (about 90% go home) or to a more local hospital for further recovery. Some patients spend less than a day in the centre and then move to their local district general hospital (DGH).

King’s College Hospital (Primary Angioplasty Centre)
Three cath labs, one dedicated to primary angioplasty
Five interventional cardiologists

41% of patients via DGHs
The Department of Health has been working with the British Cardiovascular Society to test the feasibility of offering primary angioplasty services on a country-wide basis. The National Infarct Angioplasty Project (NIAP) has established seven pilot sites involving ten primary angioplasty centres each offering a different service model or geography.

Early findings from the study suggest that the most effective model of delivery for emergency time-critical services include several key features:

- These begin with an initial diagnosis by ambulance paramedics based on an ECG reading.
- If necessary direct transfer to the catheter laboratory of the primary angioplasty centre.
- In some cases, this will involve bypassing emergency departments in district general hospitals (DGHs), and going directly to more specialist services.
- Where there is uncertainty, patients may need to be taken to the nearest hospital first for diagnosis and then on to the primary angioplasty centre.

An interim report on the findings of the study will be published by the NIAP Steering Group in 2007.

**Inter-hospital transfers**

As well as getting the initial treatment destination right, patients may need to move between hospitals to benefit from highly specialised diagnostic tests and treatments. The NHS is making progress so that this happens faster and more efficiently.

Working with cardiac networks, the NHS Heart Improvement Programme published a set of solutions to some common issues that were causing delays in inter-hospital transfers.

A group of clinicians identified delays in transferring patients with acute cardiac conditions between secondary and tertiary hospitals for diagnosis and treatment. A voluntary audit of nearly 230 hospitals was conducted in April 2004. This examined waiting times for patients who needed a hospital transfer for either angiography/angioplasty and heart surgery.

Evidence from a repeat audit shows significant progress in reducing these delays and improving the quality of care provided to urgent cardiac patients. Recent work by the NHS Heart Improvement Programme showed that the mean wait between first hospital admission and the time of procedure for all patients reduced from 11.7 to 6.4 days between April 2004 and October 2005. This has saved thousands of bed days.

The research shows how the patient pathway can be improved when all parts of the local health economy work together. Cardiac networks work across the traditional administrative boundaries of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and are well placed to lead this type of service improvement.
The National Defibrillator Programme

The successful completion of a six-year programme to install defibrillators in public places is now in sight. Already, evidence to date suggests that since July 2000 at least 93 lives have been saved as a result of the first phase of the National Defibrillator Programme.

The government-funded Defibrillators in Public Places initiative was introduced in early 2000. Then, in October 2003, the Big Lottery Fund made the British Heart Foundation the award partner for Phase 2 of the National Defibrillator Programme in England.

In February 2005 responsibility for the programme passed to the NHS. Community Defibrillation Officers (CDOs) have been recruited to each ambulance trust, and they are key to establishing the programme at a regional level and within communities.

Examples of the programme’s reach now include Dorset, where the CDO has installed an Automated External Defibrillator (AED) on Brownsea Island. The island has over 110,000 visitors annually and no access to ambulances. In the West Midlands there are 24 AED-trained community responders for the rural south Solihull areas. They provide coverage to high cardiac risk areas where ambulance provision is challenging.

CDOs continue to make links within the community and ensure that they are working with ethnic groups. West Yorkshire has developed partnerships with local ethnic minority groups and business, bringing together a Bradford-based community resuscitation scheme to train in a local Asian restaurant. Volunteers are provided with free hospitality and the use of the on-site conference facilities to complete their training.
Case study: National Defibrillator Scheme, Reading

Local businessman Abdul Loyes is manager at the Sardar Palace Indian restaurant. He signed up for training after reading about the scheme in the local paper. He said: “I was aware that ethnic origin was one factor that can increase the likelihood of suffering from heart-related illness. I am very grateful to the National Defibrillator Programme partners for their work to help people in need, both here in east Reading and other communities.”

Abdul Loyes (right) and colleague
2 World class facilities and more capacity

The CHD NSF has already seen over £700 million of investment. This has provided new and refurbished buildings, equipment and technology, including cardiothoracic centres and catheter laboratories. It has been managed through two capital development programmes, described below, and the NHS continues to make good progress with these.

The Cardiothoracic Centre Programme £580 million

The NHS has put together the central funding provided by the Department of Health with contributions from its regular capital allocations to develop a major capital building programme. We are now well past the halfway stage, which will result in a total of 31 new or improved centres for the diagnosis and treatment of patients.

The following sites have opened in 2006/early 2007:

Sheffield £13.3 million

The South Yorkshire Cardiothoracic Centre is located at the Northern General Hospital. Building work began in September 2005 and was completed in the summer of 2006. The centre provides care to the population of Sheffield and the surrounding North Trent area including Barnsley, Chesterfield, Doncaster, Bassetlaw and Rotherham.

The new and improved centre now includes five operating theatres, five angiography suites, and a cardiac intensive care and high dependency unit. The centre also has rapidly expanding services for cardiac electrophysiology, adult congenital heart disease, clinical genetics and cardiac failure. Approximately 600 staff are based at the site.
Plymouth £31.4 million

The new Southwest Cardiothoracic Centre in Plymouth is located in two separate, but linked, locations within Derriford Hospital. Building work commenced in December 2003 and two cardiac theatres opened in February 2006.

The adjacent new building includes four wards, an intensive/critical care unit, a library, research and development facilities, seminar rooms and administration offices. This is now in the final stages of development and on target to open in spring 2007.
Blackpool £45 million

Work began at the Victoria Hospital on the new cardiac centre in November 2003, and the first patients were admitted in May 2006.

Facilities include 14 critical care beds, three operating theatres and three cardiac catheter laboratories (both with capacity to expand to five), 67 inpatient and 16 short-stay beds, x-ray facilities and an outpatient department. It also houses an education centre featuring a lecture theatre, seminar rooms, a research laboratory and library.

The unit currently performs approximately 1,000 open-heart procedures, 1,000 angioplasties and 2,000 angiograms each year, and has the capacity to expand the number and range of treatments.
Patricia Hewitt, Secretary of State for Health, opened the North Wing extension to Southampton General Hospital on 23 November 2006. This includes a twelve bed cardiac intensive care unit where critically ill patients are cared for before and after major surgery, and in the event of major life-threatening heart complications. Around 1,000 patients will receive care in this unit each year.

The Secretary of State for Health also saw cardiologists working in state-of-the-art catheter labs where cardiac defects are detected and treated with angioplasty. This service will be provided to 3,000 patients annually.
This year has also seen the following schemes approved for development:

Bristol £60 million
Hull £30.6 million
Newcastle £4.7 million
South Manchester £19.6 million
Taunton £6.2 million

The cardiothoracic centre building programme is on track to complete in 2008.

The Catheter Laboratory Programme £125 million

This programme, jointly funded by the Department of Health and the Big Lottery Fund, has provided 90 new or replacement cardiac angiography laboratories to improve diagnostic facilities across the country. As a result, the capacity of catheter laboratories will have increased by over 50% since 2002. The programme has created new capacity in parts of the country where it is needed. For example:

- Birmingham and the Black Country have had four new and one replacement catheter laboratories.
- Greater Manchester has had four new and one replacement catheter laboratories.
- Trent has had four new catheter laboratories at Chesterfield, Nottingham City, Sherwood Forest and Lincolnshire.

The services provided in all these centres are developing to enable people to have diagnostic angiography, pacemakers installed and – in some cases – angioplasty, in more local settings for the very first time.

All these new facilities are helping to improve the early detection of people with heart disease and enable them to receive specialist treatment quicker than ever before. More of the population now has access to specialist diagnosis and treatment closer to home. It also means that services are delivered in bright and modern settings with up-to-date equipment, which benefits both patients and clinicians.

This extra capacity has also enabled patients to be offered a choice of four to five hospitals for treatment. As a result no-one waits more than three months for heart bypass and coronary angioplasty operations. CHD policy will continue to be developed in this area and it will be key to achieving the 18-week target for all CHD patients in 2008.
Improving specialist treatment within the NHS

Adult congenital heart disease

May 2006 saw the publication of new commissioning guidelines for congenital heart disease. By definition the original CHD NSF concentrated on disease in the arteries and was never intended to cover all heart conditions.

The new guidance, developed with patients, patient groups and experts, highlights the importance of access to specialist treatment for young people and adults with congenital heart disease, also known as Grown Ups with Congenital Heart Disease or GUCH. Designed for NHS commissioners and patients, the guide will be a powerful driver of service improvement.

Thanks to improvements in techniques and new treatments in the 1980s and 1990s, the survival rate of children with congenital heart conditions into adulthood has improved significantly. There are now more adults with the condition than children – some 135,000 in England, of whom about 17,000 have complex conditions. Despite this, they can expect to lead full lives with the right support.

The guidance provides advice and support for commissioners and defines what patients and their families can expect from the NHS. It aims to:

- ensure that patients are seen and treated by staff with appropriate levels of expertise;
- help the NHS improve the transition between children’s and adult services;
- increase levels of awareness of congenital heart conditions in the NHS; and
- improve the way services are co-ordinated for patients.

Congenital heart disease is a life-long condition, and patients want a more cohesive service with co-operative and joint working across providers. The guidelines clearly show how services will be developed within the NHS. There are specialised services that clearly benefit from being concentrated to sustain and develop expertise, while other services must be provided more locally under shared care arrangements between providers.
Patients will also be better supported in their self-care, for example by providing home testing kits instead of a patient needing to attend an anticoagulation clinic. Patients also want better information and care plans and this is reflected in the quality indicators in the guide – all entrants to adult services need a detailed written care plan.

Rosie Winterton, Minister of State for Health Services launched the guidelines at the National Heart Hospital on 11 May

Update on Chapter 8 of the CHD NSF

In March 2005, the NSF was extended with a new chapter that provides models of care and markers of quality for arrhythmias and sudden cardiac death. It has three quality requirements for delivery:

• people with arrhythmias to receive timely and high-quality support and information, based on an assessment of their needs;

• people presenting with arrhythmias, in both emergency and elective settings, to receive timely assessment by an appropriate clinician to ensure accurate diagnosis and effective treatment and rehabilitation; and

• when sudden cardiac death occurs, NHS services have systems in place to identify family members at risk and provide personally tailored, sensitive and expert support, diagnosis, treatment, information and advice to close relatives.

Since its publication, the Department of Health has worked with the NHS Heart Improvement Programme to support cardiac networks with the delivery of Chapter 8. A series of national events have helped to share knowledge and promote good practice.
Work is currently taking place on developing regional services available throughout the NHS. Priorities include ensuring that arrhythmia patients receive heart rhythm management devices (such as pacemakers) wherever this is appropriate, and ensuring that bereavement and other services and support are available for those who have experienced the sudden cardiac death of a loved one.

Case study: Syncope Clinic at Chelsea and Westminster Hospital

This clinic was established in February 2006 with the strong support of the hospital’s management team. There is a busy tilt-testing service, where a tilting table is used to determine if patients have a tendency to faint (syncope) and why, which is investigating 750 patients a year. A close working relationship with the hospital’s A&E department has been established, and many referrals come from there. The demand for the service is still growing and options for meeting this are being considered.

Case study: United Bristol Hospital Trust (UBHT) arrhythmia clinics

Diagnostic clinics for new GP referrals were introduced for palpitation patients in 2003. This service has been welcomed by patients and local GPs, and has been very successful in reducing outpatient clinic waiting times. UBHT has also been successful in providing physiologist-led rapid access chest pain clinics since 2004. It is currently introducing syncope clinics to this professional group and intends to develop a diagnostic clinic for all heart patients (covering palpitations and other arrhythmias, syncope, chest pain and heart murmur).

Work in progress

Audits

Underpinning all our progress is the provision of information for people who work in the health service. It is essential to have reliable data on which to base the right interventions.

The development of audit has been a key element in implementing the NSF. The term ‘audit’ refers to the systematic collection and provision of information about different aspects of heart disease and its treatment.
The diagram below shows the different elements of the overarching audit strategy, and how data is linked between the various projects.

National audits and registries for adult patients

Heart Valve Registry  Cardiac rehabilitation  Cardiac Surgery
Implantable cardioverter defibrillators  Central Cardiac Database
Electrophysiology  Ambulance Care  Heart Attack
Heart Failure

Information available to the public*

* The outcome of this audit is available on the Healthcare Commission website. This gives the public information about heart surgery outcomes in individual hospitals.

Heart failure, rehabilitation and end-of-life care

These will be the areas of focus in the next stages of the NSF.

When the Healthcare Commission published an assessment of CHD NSF implementation, they highlighted rehabilitation and heart failure as specific areas needing more work. Since then the Department of Health and the British Heart Foundation have established an audit database for these areas which will provide the evidence base for service improvements.

The Healthcare Commission is due to publish an improvement review of heart failure in 2007.

In June 2006, ministers charged the National Cancer Director Mike Richards, with support from all other national clinical directors, to develop an end-of-life care strategy. The strategy will deliver increased choice to all patients about where they live and die and, within available resources, provide them with support to make this possible.

The strategy will set out in more detail the direction heralded in the White Paper *Our Health, Our Care, Our Say* and will be the means whereby the commitments in the election manifesto are delivered. The strategy will be published in late 2007.
A targeted approach to risk assessment

Vascular disease is the main cause of death and disability in England. It accounts for 38% of deaths each year and costs an estimated £25.8 billion to the economy.1

People of South Asian and African Caribbean origin are most at risk of vascular disease. There is also a social class gradient, with the lowest socio-economic groups most at risk. Tackling vascular disease is key to achieving the national 2010 health inequalities target relating to life expectancy.

Recent developments designed to identify and reduce the risk factors at an earlier stage for vascular diseases include the following.

Health Trainers and NHS Life Check

2006 has seen the implementation of Health Trainers in Spearhead areas with a positive response from users. 2007 will see Life Check launched and evaluated in selected Spearhead areas with a wider roll-out in 2008. Like NHS Stop Smoking Services, they are a good example of how the NHS is increasingly helping people to lead healthier lives, and protecting people’s health.

Life Check is being developed to identify general risk factors at an early stage. Both schemes will signpost people to local services already available in the community to support their healthier choices, and reduce their current and long-term risk of ill health.

Statin therapy

Control of cholesterol is a key factor in the primary and secondary prevention of vascular conditions. The growth in the prescription of statins to lower cholesterol (in people with CHD) has been rising steadily by 30% year on year, and the Quality and Outcomes Framework (QOF) figures show how effective this has been for patients with CHD.

In January 2006 the National Institute for Health and Clinical Excellence (NICE) published its Health Technology Appraisal (HTA) of statins which found that they were both clinically and cost effective for patients at a

20% ten-year risk of developing cardiovascular disease. This updates the NSF chapter on primary prevention and encourages GPs to identify and treat people at moderate risk, with the potential for cutting the incidence of cardiovascular disease (CVD) in their local populations. NICE estimates that the HTA will make a further 3.3 million people eligible for statin treatment on the NHS.

In December 2005 the Joint British Societies published updated *Guidelines on Prevention of Cardiovascular Disease in Clinical Practice*. They too have moved to a cardiovascular approach and recommend risk management at a 20% ten-year risk. They also recommend lower treatment targets for cholesterol than those in the NSF and the QOF. NICE is working on a guideline on lipid management, due out in 2007, and while we await their recommendation, the NSF targets remain national policy.

Although statin prescribing has continued to rise, the drop in price means that the costs in 2005/06 were less than in 2004/05. There is also the potential to reduce overall costs even further by more use of generic statins. In September 2006 the NHS Institute for Innovation and Improvement published a productivity metric showing the potential savings from more generic prescribing, which SHAs and PCTs will be able to use to maximise efficiency at local level.

**Tobacco policy**

Figures for the NHS Stop Smoking Services for the period April 2003 to March 2006 show that 832,900 people had successfully quit at the four week stage, exceeding the Department of Health’s three-year target of 800,000 successful quitters.

Exposure to second-hand smoke can have serious effects on health, including contributing to the risk of heart disease and lung cancer in non-smokers. Through legislation, virtually all enclosed public places and workplaces, including public transport and certain work vehicles, will become smoke-free. Health ministers have undertaken a commitment that smoke-free legislation will come into force on 1 July 2007.

As a result of the department’s education work, TV-led advertising campaigns have become the biggest single prompt for smokers to try to quit.

In summer 2006, internet tobacco advertising was banned. The Department of Health has also recently completed consultations on proposals to include graphical warnings on tobacco packs, as well as raising the age of sale of tobacco products in England from 16 to 18 years.

The Department of Health has also announced that from 1 October 2007, the legal minimum age for the purchase of tobacco products will be raised from 16 to 18 years.
The vascular programme

CHD, diabetes, kidney disease and stroke are all forms of circulatory disease that relate to some extent to blood vessels, or vascular disease. In 2006 the Department of Health brought together national clinical directors and their policy plans for these areas, to support implementation of the NSFs for diabetes, CHD and renal disease, and the development of a new national strategy for stroke.

The Department of Health and national clinical directors are working together to address a set of shared issues such as prevention, early detection and risk management. Various aspects of their treatment are similar too, and for those people affected there are benefits to be gained by a more integrated approach.

Many patients have more than one of these conditions, so a co-ordinated policy approach will look at improving the patient journey to ensure services and support are less fragmented.
More information

The following documents can be downloaded from the Department of Health’s website:

* Mending hearts and brains by Professor Roger Boyle
* Emergency care by Professor Sir George Alberti
* Improving stroke services: a guide for commissioners and a toolkit (ASSET2)
* Development of the national Stroke Strategy
* Adult Congenital Heart Disease (GUCH)
* Leading the way – CHD NSF progress report 2005
* CHD NSF Chapter 8: Arrhythmias and sudden cardiac death
* Our health, Our care, Our say White Paper
* The Coronary Heart Disease National Service Framework
* The Diabetes National Service Framework
* The Renal Services National Service Framework
# Annex

**CHD NSF – Standards**

<table>
<thead>
<tr>
<th>Standards 1 and 2: Reducing heart disease in the population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <em>The NHS and partner agencies should</em> develop, implement and monitor policies that reduce the prevalence of coronary risk factors in the population, and reduce inequalities in risks of developing heart disease.</td>
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<tr>
<td>2. <em>The NHS and partner agencies should</em> contribute to a reduction in the prevalence of smoking in the local population.</td>
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<thead>
<tr>
<th>Standards 3 and 4: Preventing CHD in high risk patients</th>
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<tbody>
<tr>
<td>3. <em>General practitioners and primary care teams should</em> identify all people with established cardiovascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.</td>
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<tr>
<td>4. <em>General practitioners and primary health care teams should</em> identify all people at significant risk of cardiovascular disease but who have not developed symptoms and offer them appropriate advice and treatment to reduce their risks.</td>
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<tr>
<th>Standards 5, 6 and 7: Heart attack and other acute coronary syndromes</th>
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<tr>
<td>5. <em>People with symptoms of a possible heart attack should</em> receive help from an individual equipped with and appropriately trained in the use of a defibrillator within 8 minutes of calling for help, to maximise the benefits of resuscitation should it be necessary.</td>
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<td>6. <em>People thought to be suffering from a heart attack should</em> be assessed professionally and, if indicated, receive aspirin. Thrombolysis should be given within 60 minutes of calling for professional help.</td>
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<tr>
<td>7. <em>NHS Trusts should</em> put in place agreed protocols/systems of care so that people admitted to hospital with proven heart attack are appropriately assessed and offered treatments of proven clinical and cost effectiveness to reduce their risk of disability and death.</td>
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<tr>
<th>Standard 8: Stable angina</th>
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<tr>
<td>8. <em>People with symptoms of angina or suspected angina should</em> receive appropriate investigation and treatment to relieve their pain and reduce their risk of coronary events.</td>
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Standards 9 and 10: Revascularisation

9. People with angina that is increasing in frequency or severity should be referred to a cardiologist urgently or, for those at greatest risk, as an emergency.

10. NHS Trusts should put in place hospital-wide systems of care so that patients with suspected or confirmed coronary heart disease receive timely and appropriate investigation and treatment to relieve their symptoms and reduce their risk of subsequent coronary events.

Standard 11: Heart failure

11. Doctors should arrange for people with suspected heart failure to be offered appropriate investigations (eg electrocardiography, echocardiography) that will confirm or refute the diagnosis. For those in whom heart failure is confirmed, its cause should be identified – treatments most likely to both relieve their symptoms and reduce their risk of death should be offered.

12. NHS Trusts should put in place agreed protocols/systems of care so that, prior to leaving hospital, people admitted to hospital suffering from coronary heart disease have been invited to participate in a multi-disciplinary programme of secondary prevention and cardiac rehabilitation. The aim of the programme will be to reduce their risk of subsequent cardiac problems and to promote their return to a full and normal life.