Date: 4 July 2001

Venue: Committee Room 3, National Assembly for Wales

Title: Coronary Heart Disease - National Service Framework Implementation Plan Results of Consultation

Purpose

1. To inform H&SSC members of the outcome of the consultation on the draft Coronary Heart Disease (CHD) National Service Framework (NSF) Implementation Plan.

Summary

2. This paper is a follow up to one presented to HSSC on 25 October 2000 (HSS-18-00(p.3)) which invited members' comments on the draft of the CHD NSF Implementation prior to it going out for consultation. Following the consultation an analysis of the responses was completed in collaboration with Dr Gillian Todd, Chair of the Coronary Heart Disease Implementation Steering Group and Director of Specialised Health Services Commission for Wales (SHSCW). A report on the results to consultation is shown at Annex 1. Copies of the responses are available in the Members' Library.

3. As a result of the consultation and a meeting held with the BMA General Practitioners Committee (GPC) amendments were made to the Implementation Plan.

Timing

4. This paper follows on from the HSSC on 25 October at which it was agreed to inform members of the outcome of consultation.

5. A formal launch of the CHD NSF Implementation Plan is scheduled for 3 July in the Assembly building.

Background

6. Implementation of the National Service Framework in Wales - The Coronary Heart Disease National Service Framework Implementation Plan for Wales provides a systematic approach to drawing up standards to improve quality across coronary care sectors.

7. The plan was produced by a steering group, led by Dr Gillian Todd, Director of the Specialised Health Services Commission for Wales (SHSCW). In order to ensure involvement and ownership throughout Wales, the plan was sent out for consultation in November. The National Assembly for Wales carried out an analysis of the responses.

Outcome of consultation

8. The consultation was very successful with a large volume of responses (69). Resource implications appeared to raise the most concern; in particular respondents were concerned about the financial, staffing, time and physical resource implications.

9. Officials also met with the General Practitioners Committee (GPC) to discuss their concerns. In addition, Dr Todd has kept the CHD Steering Board involved with the results of consultation.

10. Some of the targets have been revised to represent financial years and not calendar years, and a number of technical revisions have been made. A report on the results to consultation is shown at Annex 1.

11. **Key Action 23** - At the HSSC meeting on 25 October members commented specifically on targets contained in Key Action 23 of the Implementation Plan. It should be noted that as a result of consultation the waiting times for Coronary Artery Bypass Grafting (CABG) and angioplasty now read as financial years; ‘should be twelve months by 2001/2 instead of 2002, six months by 2003/4 instead of 2003 and three months by 2006/7 instead of 2005’. These dates are within the target dates specified by the English NSF (six months by 2005 and 3 months by 2008).

JANE HUTT
Minister for Health & Social Services

Contact: Clinical Quality Improvement Branch, NHS Quality Division

Annex 1

RESULTS TO CONSULTATION EXERCISE ON IMPLEMENTATION PLAN FOR

CORONARY HEART DISEASE NATIONAL SERVICE FRAMEWORK (WALES)

A total of 69 responses were received to the consultation exercise on Coronary Heart Disease. There was a wide cross section of responses ranging from NHS organisations, national committees and colleges to external agencies.

List of Respondents

Bron Derw Surgery
Fforestfach Medical Centre
Bristol-Myers Pharmaceuticals
United Kingdom Central Council for Nursing, Midwifery and health Visitors
Alyn Family Doctors
Gwent Healthcare NHS Trust - Cardiology Department
Gwent Healthcare NHS Trust - Pathology/Biochemistry
The Royal college of Physicians of Edinburgh
Glan Clwyd Hospital
Singleton Hospital
University of Glamorgan
Royal College of General Practitioners Wales
Department of Cardiac Rehabilitation
Royal College of Nursing
Cardiff Local Health Group
Gwent Community Health Council
Carmarthenshire Local Health Group
Bridgend Local Health Group
Iechyd Morgannwg Health Authority
Cardiff and Vale NHS Trust - Chief Executive
Cardiac Rehabilitation Service
Llandaff North Medical Centre
Cardiff and Vale NHS Trust - Pharmacy Department
Primary Care Discussion Group
Department of Postgraduate Education for General Practice
Oldcastle Surgery
Dyfed Powys Health Authority - Health Policy & Public Health
North Glamorgan NHS Trust
Cardiff and Vale NHS Trust - Clinical Pharmacy All Wales Specialist
Diabetes UK Cymru
Health Psychology Department
Neath Port Talbot Local Health Group
Carmarthenshire NHS Trust
Welsh Affairs Committee
Morgannwg Local Medical Committee

Gwent Health Authority
Public Health & Policy Directorate
The Chartered Society of Physiotherapy
Gwent Healthcare NHS Trust
Cardiff County Council
Conwy Federation of Community Health Councils
Bro Morgannwg NHS Trust - Director of Planning
Salop House
The Royal Pharmaceutical Society
Cardiac Services Directorate
North Wales Cardiology Network
Cardiff and Vale NHS Trust
Bro Taf Health Authority - Primary Care Medical Advice
Powys Local Health Group
Conwy Local Health Group
Rumney Medical Practice
Swansea Local Health Group
SHSCW
Age Care
Fitness Wales
CHD NSF Implementation Plan Steering Board
Bro Morgannwg NHS Trust - Consultant Cardiologist
Ceredigion Local Health Group
Welsh Health Authorities Corporate Support Unit
Bro Taf Primary Care Audit Group

The majority of respondents welcomed the plan in principle:

'Practical, readable, inclusive and evidenced'

'The framework articulates and recognises the overriding importance of coronary artery disease as the prime cause of morbidity and mortality in Wales'

However respondents offered their reservations as constructive criticism. The small handful of establishments, who were less supportive, tended to prefer the English version of the plan (see below for more detail).

The establishments collectively remarked upon certain issues surrounding the CHD document, which are covered in more detail in the following paragraphs.

GENERAL COMMENTS

Empowering the Patient

Patient empowerment is a concept that was widely supported. Cardiff and Vale NHS Trust suggested that it is included as a bullet point on the front page. The proposal for the development of patient pathways was welcomed by a number of the respondents.

Eight positive comments were received on the CHD patient held record. Respondents anticipated that the development of this system will encourage patients to take on responsibility for their health and consequently have a positive effect on the management of their health. Ceredigion Local Health Group was concerned that the introduction of patient held records might add to the administrative burden. They did however recognise the significance of information technology to help control the extra workload.

Diabetes Cymru recommended that patients are involved in the designing of the pathways and the record, to ensure compliance and understanding of their care plan.

Dyfed Powys Health Authority held that a lack of transferability of GP computer system records when patient changes practice is a major barrier to driving up quality and improving efficiency.

Intervention

Three respondents welcomed the consistent approach to assessment and treatment across primary, secondary and tertiary care as it will minimise confusion and in turn risks to patients.

Respondents were pleased to see an emphasis on prevention and health promotion. Lifestyle changes are seen as significant to tackling the onset of Coronary Heart Disease.

'Well designed prevention programmes with qualified staff is important, present programme is insufficient and patients receive poor advice.'

One respondent said that people find it difficult to achieve a change in lifestyle and may require drug therapy as a way of achieving the desired results. Another respondent was concerned that failure to change patients' behaviour through lack of appropriate interventions may increase anxiety of patients and have a detrimental effect to their health. A possible solution would be for patient-doctor consultations to be more prescriptive than merely a voluntary effort by patients.

Iechyd Morgannwg were concerned that the plan only benefits people with access to primary care and may increase inequality. However they believe a community nurse may be able to encourage access. Cardiff County Council added *'Challenge cannot be understated, the need for positive support to those at risk is essential. Many of those at risk will be the most difficult to reach, particularly amongst the elderly and the ethnic minorities…Difficult to influence lifestyle changes especially to those of ethnic minority; their cultural backgrounds provide barriers to change, which will have to be tackled sensitively by experienced workers'*.

One respondent held that issues of thrombolysis and secondary care dominated the plan for patients with Acute Coronary Syndromes. It was suggested that the plan requires more emphasis on other pre hospital care interventions ie pain relief or aspirin therapy.

A number of respondents commented on the need to include the level of risk that constitutes a high-risk patient. High risk is defined as 30% chance of developing the disease over 10 years in the English version of the plan. Information such as this would be useful for Doctors to know when to start treatment and should be included in the plan and/or the toolkit.

Nine respondents referred to the development of risk assessment tools. For consistency and continuity in the assistance of patients, eight suggested that the tools be standardised throughout Wales.

Clinical Orientation of the CHD Plan

Eight respondents commented on the CHD plan's heavy clinical orientation. There are many underlying social and economic issues that could have been reflected in the implementation. Multi disciplinary involvement from other agencies would benefit implementation. Gwent Community Health Council believed that agencies should help tackle root cause and disease prevention in addition to offering health education.

The Royal College of Nursing referred to *'(the document's) lack of reference to the determinants of health e.g. poverty, housing, deprivation etc, to deliver the aims of the document, it is essential to ensure partnership working between health and social policies'.*

Iechyd Morgannwg suggested the provision of an agency register so patients can seek assistance from a range of agencies:

'The plan could have incorporated a method of ensuring all patients' needs both health and social, are being met during their illness',

'Agencies other than health have a part to play in improving diet, increasing exercise and reducing smoking' Dyfed Powys Health Authority.

The University of Glamorgan emphasised the need for a significant input from exercise scientists to assist in primary prevention programmes and treatment of CHD patients. Rehabilitation in sport/exercise environment would help relieve pressures of space in hospitals.

A representative of Llandaff North Medical Centre suggested Public Health plays a part in encouraging a non-medical approach to primary prevention.

Standards and Performance Targets

Seven representatives commented upon the performance targets that have been set within the standards. One respondent said that the standards were a good way of ensuring that the aims of the document are met. However six respondents said that targets were weak and cannot be measured. (One respondent used key actions 5, 15, 20 and 26 to illustrate this point). They believed that more specific performance targets are required to set out actions for monitoring implementation.

'Inconsistency in performance target requirements identified, with a number of targets focusing on process rather than progress. Furthermore there is inconsistency in respect of the identification of milestones for achievement'. Cardiff Local Health Group.

One respondent, while fully appreciative of the framework that is provided, suggested each action requires more clarity and should draw lines of responsibility for district versus tertiary. A similar point is raised with comparisons to the English plan.

English Version of the CHD Plan

We received six responses about the English version of the CHD Implementation Plan. Four respondents appeared to prefer the English version.

Three establishments referred to the clarity of the English version, they thought it was easier to read. One GP commented that the standards in the Welsh version should relate to specific fields like the English, for ease of reference. In the English version the reader is able to refer to a specific subject of interest. Two of these respondents also said that it was not clear who was responsible for the implementation of some standards.

The Chartered Society of Physiotherapy were concerned that Wales will have a sub standard service in comparison to England, they referred to the plans' neglect of smoking cessation clinics, developing green transport plans, developing a National CHD register or using measurable outcomes to assess the impact of cardiac rehabilitation.

One respondent questioned the need for two different documents:

'Why have different documents, when England, Scotland and Wales are all suffering the same problem?

Dr Brynley Davies commented that *'the read across the Welsh standard to the English should be more explicit. The extra Welsh standard should be clearly stated and robustly linked to the evidence'*.

Steering Implementation Group

Seven comments were made about the membership of the steering group. Four respondents thought that primary care was under represented. The Pharmacy Directorate of UHW noted that although their

Principal Pharmacist was a member of the Steering Group, he is unsure of the process by which a single patient pathway is being developed. They detailed areas of the plan where pharmaceutical input would prove beneficial. One respondent said that the Steering Group had limited user involvement, no social care input or representative from the nursing education sector within the board. Conwy Federation of Community Health Councils noted that only two of the 35 members were from North Wales and The Chartered Society of Physiotherapy were also disappointed that the board did not include a physiotherapist.

RESOURCE IMPLICATIONS

Of the 69 responses received, 54 made some reference to the resource implications for the implementation of the Coronary Heart Disease plan. Although the majority of respondents were in support of the plan, they did not think that such a plan could be delivered without additional resources, manpower, equipment, facilities and drug funding.

'Can be done but not within the existing resources' Primary Care Discussion Group.

A wide range of resources were referred to throughout, which can be divided into:

funding of professional time;

equipment and facilities (particular references to coronary care units, cardiac beds, defibrillators and ECG machines);

drugs;

investigations (eg Tropinin T, exercise testing and echocardiography);

human resources.

Financial Implications of CHD Plan

At least five of the bodies that responded said that the financial framework of the plan should have been made more explicit. They were not clear on whether extra resources would be provided or whether funding is expected to come from the existing budget:

'Is there necessary financial support or will it mean taking from other pots of money' Conwy Federation of Community Health Councils.

Swansea LHG raised concerns for the financial consequences of providing treatment for patients who have not previously been identified as at risk.

The Cardiology Network Group states *'concern lies with reality of service, in that lack of both human and financial resources will undermine good intentions'*

It is hoped by the respondents that resources will be secured early so the plan can be delivered. *'Aims of NSF ambitious, laudable and important to achieve but will require a substantial increase in cardiac services, specialised nurses, the training of Physiological Measurement Technicians, equipment, dedicated bed availability, audit facilities, drug costs etc. It is imperative that investment is early and proposals are funded'* Cardiac Services Directorate of Cardiff and Vale NHS Trust.

There is also concern that the money allocated will not be invested wisely, in areas where it is most required. Ceredigion Local Health Group raised the issue of inequality and the difficulty of achieving targets in rural areas of Wales, they would be less likely to achieve the targets set for response to cardiac arrest and acute chest pain. This area would require additional resources in the form of ambulances and paramedics.

Dyfed Powys Health Authority were concerned that the substantial CHD resource requirement against a background of other national high priority areas (i.e. NICE guidelines, other NSF's) will lead to competition for investment.

Human Resources

There were 13 specific references to human resources. The plan would requires an increase in the number of cardiologists, specialised nurses, trained PMT's, pharmacists, radiology and pathology support staff, physiotherapists, psychologists, palliative care staff and dieticians.

The Cardiologists and Cardiology groups who responded to the consultation exercise refer to the practicalities of the plan given the current pressures they are facing without extra staff. A cardiologist from Singleton hospital stated that '*the present waiting time to see a cardiologist is four months, the idea that all patients of angina will have a diagnosis and treatment within three months is impractical'*.

Implications for General Practitioners

Eight of the respondents referred to the work load implications for General Practitioners. They were concerned that their *'fundamental role will suffer as the incorporation of the standards and communication of the risks to patients of CHD will take time'*. They stress that the plan cannot be implemented without the investment of time and significant resources in primary and secondary care. A number of the respondents suggested that each practice is brought up to an agreed standard in relations to IT investment and is given the necessary software and information in advance to be able to deliver the plan.

'Implementation of primary prevention has massive resource implications for GPs. Without allocation of

extra resources in the form of time, IT, postage, stationery etc the plan is undeliverable. Many practitioners struggling to provide general medical services and the significant increase in preventative work…leaves little spare capacity to deliver CHD'. Morgannwg Local Medical Committee.

Neath Port Talbot LHG suggested that pressures on prescribing budgets be addressed by The National Assembly.

Gwent Healthcare and Bro Morgannwg NHS Trust referred to the resource implications of all patients with a Cardiac diagnosis being seen by a cardiologist within 24 hours.

'Priorities need to be set up with realistic timetables set in the context of local needs. Needs an Investment plan balanced against local priorities.' *Neath Port Talbot Local Health Group*

Timing Issues

The implementation of the plan will present a challenge in the form of timing. Six respondents addressed the timing issue. It is essential that adequate time is allocated for delivery to be realistic. There is concern amongst GP's that timing is unrealistic given the huge workload implications to primary care, the Public Health and Policy Directorate of Bro Taf Health held that:

'Timing is not unrealistic but…need differing bases from which professionals will start'

The United Kingdom Central Council for Nursing, Midwifery and Health Visitors recognised the significance of resources but are assured that adequate resources will be provided. *'The maintenance and improvement of quality services is largely dependent on securing appropriate knowledge and skills development. Therefore we were reassured to know that the implementation plan is to be supported by a robust resource plan'*.

General Practitioners Committee (GPC)

We responded to a request for a face to face meeting with the GPC to discuss their concerns about the Implementation Plan. In particular they were concerned about the financial, staffing, time and physical resource implications. The meeting was useful and resulted in agreement between all parties. In addition Gill Todd has kept the CHD Steering Board involved with this part of the process.

Conclusions

As a result of the consultation some of the targets have been changed to represent financial years and not calendar years. Some technical revisions have also been made. Policy colleagues have put a lot of effort into identifying where there may be shortfalls and how to deal with these.

CHAPTER 1

Comments and Suggestions

(Made in reference to specific paragraphs of the plan)

Para 1.1

2 respondents commented upon the importance of addressing inequality in the CHD plan.

Para 1.3

2 respondents refer to lack of detail, one in relation to pharmaceutical aspects of care and the other in relation to funding the resource plan.

Para 1.6

'All areas at risk need to be targeted.' Cardiff County Council

Para 1.7

'Separate risk assessment tools should be made for those with and without established CHD as many of the tools are based on patients that don't have CHD.' Cardiff and Vale NHS Trust

Para 1.10

Rehabilitation needs to include references to a risk assessment tool and reference to outcome measures such as fitness tests etc. The plan recommends that a specialised nurse be appointed in each LHG, the Chartered Society of Physiotherapy disagree; *'a nurse need not exclusively carry out this role'*.

Para 1.11

Three respondents made additions to the individuals and organisations listed in the plan they include:

The food industry
Prisons
Care homes
Leisure centres
Exercise practitioners.

Cardiff County Council would be pleased to help progress the plan with channels with which they are directly involved with.

Technical Amendments

Para 1.6

'Cholesterol is a lipid and would more correctly read Hyperlipidaemia, (high blood cholesterol and/or triglyceride)'. Cardiff and Vale NHS Trust

CHAPTER 2

Comments and Suggestions

Para 2.1

One respondent draws attention to the deficit in health care i.e. in 1997 there were over 5000 admissions in Wales of patients with MI but only a fifth of these received bypass surgery in 1998-9.

Para 2.3

'Being at risk doesn't necessarily mean one has the disease' Llandaff North Medical Centre.

Para 2.7

'Chronological age is an appalling benchmark to judge biological functions' University of Glamorgan.

Para 2.9

Three respondents suggested that 'racial differences' be renamed 'ethnic minorities' and give more detail on the very high prevalence of diabetes in older people of Asian and African origin (which is 3 or 4 times that of Europeans).

Another respondent wanted to ensure that the document would be translated to incorporate racial differences.

Technical Amendments

Para 2.5

Two changes have been suggested: One respondent said that *'Positive support will be required to modify'* should be deleted, another said that the fourth bullet should read: *'compliance with the agreed medicine specimen'*.

CHAPTER 3

The content of Chapter three did not raise many concerns. On the whole the introduction of the framework for local interpretation is welcomed, the diversification of areas is acknowledged to require a flexible approach. The plan will allow Cardiff County Council to target areas where CHD incidences are greatest.

Chapter 4

Standard 1

13 respondents commented on Standard 1.

Comments and Suggestions

Two respondents felt that health promotion should be included in schools' national curriculum to encourage health attitudes from an early age.

Two respondents referred to health promotion schemes already in operation.

Other comments included:

- the availability and accessibility of affordable nutritious food and leisure facilities;
- difficulties of imposing healthy options on a population which fails to perceive a health risk or choose to ignore advice;
- voluntary organisations could ensure that diet and exercise strategies are appropriate;
- promotion programmes should support HIPs but avoid duplication;
- an agreed data-set for primary care should be developed.

Key Action Points

Four of the 15 respondents commented specifically on the Key Action Points.

Key action 1 (2 responses)

One respondent welcomed the baseline review of health promotion programmes. Another respondent reiterated that the review should be completed by 2002.

Key action 2 (2 responses)

One respondent felt that the HA should take the lead in agreeing priorities for investment. Another felt the resultant plan would lead to joint working between the health organisations.

Key action 3 (3 responses)

One respondent welcomed the survey. Another respondent felt that the survey should measure the changes, which occur from health promotion programmes. It was also noted that the sample size should be high for precise information.

Key action 4 (2 responses)

One respondent queried the provision of smoking cessation programmes and wondered whether they would be in the form of clinics as in England. The programmes could just be in the form of a telephone helpline. Cardiff County Council felt that support from the NAW would progress its own objectives for its smoking policy.

Key action 5 (1 response)

Commented that although the CHD NSF required the development of smoking cessation clinics by 2001 this was not reflected in the implementation plan.

CHAPTER 5

Standard 2

28 respondents commented on Standard 2.

Comments and Suggestions

Three respondents commented on the increased workload for GPs and the need for additional funding. *'I hope that the Assembly …are prepared to openly acknowledge the resource implications and to support this activity with appropriate funding' Postgraduate Education for General Practice, UWCM.*

Three respondents felt that not enough attention had been paid to CHD in diabetics. *'Whilst we welcome the majority of this section we believe that too little attention has been paid to diabetes…The recommended BP (blood pressure) target is at variance with our own and does not appear to be evidence based.'* Diabetes UK Cymru

Two respondents felt that additional training would be necessary. *'There must be greater emphasis on training particularly in primary care…. GPs and their practice nursing staff will need improved training in CVD risk factor management with care pathways established to resister and monitor their patients.'*

North Glamorgan NHS Trust

Two respondents referred to the need for a common coding system *'We believe that these systems must be based on a common coding system - Really Useful Read is being adopted locally…'* Neath Port Talbot Local Health Group

Two respondents noted that there is a difference between Standard 2 in Wales and the English NSF. *'…Standard 2 in Wales, unlike the English NSF, combines primary and secondary prevention'* Conwy LHG

'The English standards includes patients with evidence of "occlusive arterial disease"…' Llandaff North Medical Centre

Other comments included:

- incentives and additional resources must be in the action plan;
- the inclusion of medicines management by community pharmacists is forward thinking;
- the risk levels at which active treatment should be instigated should be specified in the standard;
- the concept of Coronary Heart Disease Resource Centres appears to be peculiar to the Implementation Plan;
- it is time consuming to extract information in a useable way, even where appropriate IT is in place;
- patients who already have been diagnosed as having CHD should receive higher priority than those at risk;

Key Action Points

23 of the 28 respondents commented on the key action points

Key Action 6 (4 responses – 1 from member of Steering Board not included here)

'..Will require systematic coordination of IT development within Primary Care' Gwent Health Authority;

'…patients with existing CHD and Diabetes are by far the highest risk ..' Rumney Medical Practice

'..does not address the fact that successful prevention relies heavily on compliance with treatment and modification of lifestyle.' Neath Port Talbot Local Health Group

Key Action 7 (4 responses)

Two respondents welcomed the proposal to establish resource centres but had concerns regarding

location and the availability of resources.

One respondent felt *'the development of resource centres, separate to provision of CHD services at GP surgeries… to be impractical, resource intensive and inconsistent with the development of comprehensive CHD services within a Primary Care setting.'* Gwent Health Authority

One respondent felt that resource centres may lead to unnecessary duplication.

Key Action 8 (4 responses)

One respondent felt '*the development of CHD management systems within Primary Care could be linked with the development of Diabetes Management databases.*' Gwent Health Authority.

One respondent expressed confusion as to *'exactly what a CHD management system is.'* Chartered Society of Physiotherapy.

One respondent *'..felt that the term "clinically likely angina" .. was not sufficiently specific..'* Powys Local Health Group.

One respondent expressed concern that providing highly structured care to those at risk *'..will need a great dealt of organisation and GP time unless it is to detract from the highest risk groups'* Rumney Medical practice

Key Action 9 (15 responses)

Six respondents felt that the cholesterol targets need clarification *'Clarification of cholesterol targets is required…. Clearer guidelines on reducing cholesterol by 2mmol/L should be given, particularly when very high. No target for HDL is given.'* Neath Port Talbot Local Health Group.

'We would place greater emphasis on achieving cholesterol levels of <5mmol/l than on reducing cholesterol levels by 2mmol/l…. Unless the total cholesterol is >5.0 mmol/l, there is little benefit is (sic) measuring HDL cholesterol..' Gwent Healthcare NHS Trust

'..There is no mention of raising HDL to the appropriate level.' All Wales Specialist - Clinical Pharmacy, UHW

Three respondents commented on the blood pressure target for diabetics:

'The blood pressure target for diabetics differs from that in the British Hypertension Society Guideline which states 140/80 and may give rise to confusion.' Bristol Myers Squibb Pharmaceuticals

'…We recommend a BP<140/80 resulting from the UKPDS (UK Prospective Diabetes Study)' Diabetes UK Cymru

Two respondents commented on the use of statins *'…the increased use of statins will have major impact on an already over stretched primary care budget.'* Carmarthenshire LHG

'The need to consider the use of fibrate drugs instead of or in addition to statins in patients with marked hypertriglyceridaemia' Gwent Healthcare NHS Trust

Two respondents felt that the performance targets are unclear *'does "60% achieved by 2002" refer to % register in place, % patients offered risk assessment or % patients where clinical signs are in line with aims?'* Conwy Local Health Group

'… although there are Performance Targets, there is no clear indication of evaluation, in terms of outcome measures of improved health (or reduced illness).' Postgraduate Education for General Practitioners, UWCM.

One respondent felt there was confusion between the treatment plan and personally held record 'We assume.. that the intention of this statement is to include the treatment plan in the personally held record' It was also felt that it should be made explicit 'that the personally held treatment plan will include the patient's medicine record..' Royal Pharmaceutical Society of Great Britain

The Chartered Society of Physiotherapy felt that access to physiotherapy should be included in this action point.

The Cardiac Rehabilitation Department at UHW felt it important the appointment of a specialised nurse in each LHG should be part of the local based rehabilitation service.

Other Comments included:

- *'..does not make it clear whether patients should receive both a beta blocker and an ACE inhibitor..'* All Wales Specialist-Clinical Pharmacy, UHW
- *'The WHO definition of diabetes should be included '* Welsh Cardiac Group, UHW
- *'..Some patients may not require dietary intervention. There should be '..a minimum referral criteria eg BMI above a certain level..'* Cardiac Rehabilitation Programme, West Wales General Hospital.
- *'..key action 9 has too many action points. The risk is that the most important actions will be missed..'* Rumney Medical Practice

Key Action 10 (3 responses)

One respondent commented on the three month timescale for a patient with stable angina to start

treatment. *'..most would probably not wish to wait three months before the start of treatment. There is no need for the start of treatment to be delayed...'* Royal College of Physicians of Edinburgh

Another respondent felt the timescales to be challenging *'These targets will have major implications on the supporting infrastructure necessary to achieve this action point.'* North Glamorgan NHS Trust

'Primary Care Teams must be included for Patient pathways development'. Bron Derw Surgery

Key Action 11 (4 responses)

Three respondents commented on the medicine management systems, one felt more information was required.

Another suggested *'The development of a "standard prescription formulae" should be specified as part of the "medicine management system"* '. Gwent CHC.

The Royal Pharmaceutical Society of Great Britain noted that *'the language used slips into that which implies professional domination… rather than promoting a partnership approach (with the patient)'*

Two respondents felt they did not understand certain points 'the last point regarding "cost of current patterns.." There are a number of interpretations..' All Wales specialist - Clinical Pharmacy, UHW

The performance target "Improved compliance with treatment as measured by audit" was queried. *'Compliance by GP with protocols or patient with prescribed medication?'* Llandaff North Medical Centre

Key Action 12 (1 response)

North Glamorgan Trust does not feel that these targets can be met '..requires a final target of 5,000 angiograms/million population. … In order to achieve the numbers of angiographic investigations required there is a desperate need for an increase in the number of dedicated, ring fenced cardiac beds within the regional cardiac centres…'

Technical amendments

Para 5.0

'While individuals with heterozygous familial hypercholesterolaemia (FH) are at high risk of developing coronary heart disease (CHD) at an early age, it is a relatively uncommon disorder with an estimate prevalence of 1 in 500 of the population. We believe that population screening for FH would not be cost-effective and that the most appropriate way to identify individuals with the disorder is by testing first-

degree relatives (parents, siblings and children) of known cases.' *Cardiology Dept, Nevill Hall Hospital.*

Para 5.1

'..Needs to recognise the role of raised triglycerides as well as cholesterol. Particularly important to type 2 diabetics.' All Wales Specialist - Clinical Pharmacy, UHW

Key Action 9

Blood pressure targets

'We note under key action 9 the proposal to aim for BP (blood pressure) of <130/80 whereas we recommend a BP<140/80 resulting from the UKPDS (UK Prospective Diabetes Study). We also note the proposal to undertake a random blood sugar to exclude diabetes. This recommendation is at odds with a recent report from the World Health Organisation.… We enclose a statement that sets out the main changes and suggest that this text be used.' Diabetes UK Cymru.

'There is a little confusion here between thresholds…. And targets…The blood pressure recommendation of 130/80 or below…is presumably a target for treated diabetics hypertensives, not a threshold (except for Type 1 Diabetics)…' Llandaff North Medical Centre

Cholesterol targets

'We would place greater emphasis on achieving cholesterol levels of <5mmol/l than on reducing cholesterol levels by 2mmol/l…. Unless the total cholesterol is >5.0 mmol/l, there is little benefit is *(sic)* measuring HDL cholesterol..' *Gwent Healthcare NHS Trust*

CHAPTER 6

Standard 3

24 respondents commented on Standard 3.

Comments and Suggestions

Para 6.0

Three respondents commented on Troponin assays:

'We question the clinical benefit and cost-effectiveness of repeat Troponin assays..' Royal Gwent Hospital

‘We agree that Troponin assays should be available daily in every DGH..’ Royal Gwent Hospital

‘Troponin assays are clearly required. Funding provision needs to be made for this.’ Dept Medical Biochemistry, UHW

Para 6.4

‘Given the rurality of Powys there is concern about pain to needle time’ Powys LHG

Para 6.6

Four respondents commented on thrombolysis:

‘Concerned about the timescales to reach a consensus on community thrombolysis’ Carmarthenshire *LHG*

‘*who will take the final responsibility for a paramedic administering a thrombolytic on their own initiative..?’* All Wales Specialist - Clinical Pharmacy, UHW

‘6.6 is however materially inaccurate in that some of our patients have received thrombolysis at home, in our surgery and in an ambulance.’ Dr Carl Langley, GP

‘*..only 21% (of community hospitals) administer Thrombolycis.’* Conwy East CHC

Para 6.9

‘*greater clarity of definition is needed between a casualty department and a minor injuries unit in Community Hospitals...’* Dyfed Powys HA

Para 6.11

’..15-20% of patients with AMI entering a CCU will have diabetes…consider recommending standard management as a key action in the care of patient with diabetes and CHD having AMI or cardiac arrest.’ Diabetes UK Cymru

Para 6.12

‘There is a lack of understanding of the terms "electrophysiological measurement department" and "electrophysiological tests". Royal College of Physicians of Edinburgh

Para 6.14

(Three respondents)

'should emphasise that although the lead is taken by a cardiac rehab nurse, it is a (sic) delivered by a multidisciplinary team. The full reference to the BACR guidelines and standards would also be helpful.' All Wales Specialist - Clinical Pharmacy, UHW

'..would prefer to see this section worded in such a way that other professions, such as physiotherapy, are not excluded …' The Chartered Society of Physiotherapy

'refer also to CSP Guidelines, "standards for the exercise component of phase III cardiac rehabilitation." June 1999

Para 6.19

'suggest that standard 3 should include record keeping and audit of diabetes versus non diabetes patients uptake of intervention…and monitoring of gender differences in uptake of re-vascularisation procedures.' Diabetes UK Cymru

Para 6.20

'second paragraph of this section seems to include targets, which do not appear elsewhere in the document.' The Chartered Society of Physiotherapy

Three respondents commented about drugs:

'The evidence for the use of statins..is strong enough to require that all patients leaving hospital after a MI should be taking one of these drugs and an appropriate performance target set.' Bristol Squibb Pharmaceuticals

'A large proportion of the population cannot tolerate aspirin. An alternative to aspirin should be offered eg clopidogrel ..' Bristol Squibb Pharmaceuticals

'45% of community hospitals do not have an Aspirin policy..' Conwy East CHC

Two respondents commented about the ambulance service:

'*a rapid response by the ambulance service depends on finding and on the distance from the ambulance station.'* Conwy East CHC

'…some of the Key Actions.. have big funding implications for the Ambulance Service in a rural area like Powys' Powys LHG

Three respondents commented about resources:

'..to include all unstable angina patients in a comprehensive rehabilitation programme is probably unnecessary and will require an expansion of the existing service. …The proposal to develop community based resuscitation training and response facilities is welcome, but will need to be resourced..' North Glamorgan NHS Trust

One respondent commented on the additional resources required by;

- the ambulance service for the inclusion of all chest pain calls within the 999 response;
- the drugs budgets for the increased use of statins;
- and to ensure compliance with the guidance. *Gwent CHC*

'*..it will prove impossible to achieve these objectives without a significant increase in the number of DGH Consultant Cardiologists….a substantial increase in the number of junior doctors, trained PMTs and provision of addition equipment.'* Welsh Cardiac Group. UHW

Other comments included:

- *The inclusion of the primary care CHD management system and patient held record in the discharge policy is welcomed.* Bristol Squibb Pharmaceuticals
- *'we would like more information on the specialised nurses and who is to employ them.'* Powys LHG
- One respondent felt one of the main concerns in the achievement of the proposed standards and action points in the short term to be staff recruitment and training. This would also be a factor in the development of local care pathways.

Key Action 13 (1 respondent)

'A GP initiated call for ACS is classed by the Ambulance service as an "Emergency call not "urgent". This could make the difference in achieving the targets' Bron Derw Surgery

Key Action 17 (3 respondents)

Two respondents commented on the practicality of patients being seen by a cardiologist within 24 hours:

'….Even the Royal Gwent Hospital, one of the largest DGHs in Wales, only has two Consultant Cardiologists!' Royal Gwent Hospital

One respondent queried whether the requirements for DGHs would apply to Community Hospitals. *'.. acute coronary conditions are treated in some Powys Community Hospitals.'* Powys Local Health Group

Key Action 18 (1 respondent)

The All Wales Specialist - Clinical Pharmacy commented that the appropriate levels of suitably trained support staff are essential.

Key Action 19 (2 respondents)

'there will need to be an increase in the number of junior doctors, trained technical staff.. and additional exercise tolerance testing (ETT) facilities.' North Glamorgan NHS Trust.

'..this patient held record must include the agreed medicine record…' Royal Pharmaceutical Society of Great Britain.

Key Action 20 (5 respondents)

Two respondents commented on the role of the specialist nurse in each LHG, *'(will) every NSF result in the direction that specialist nurses will be required across every LHG?*' Gwent Health Authority.

The Chartered Society of Physiotherapy noted that no mention is made of a state registered physiotherapist in this key action. The society also feels the performance target should offer a rehabilitation programme that is individually tailored to each patient.

Another comment about the rehabilitation programmes is that they '*should be integrated with secondary risk factor management programmes with appropriate identification of medical, dietetic and other health professional staff time and resources as well as nursing.*' Dept Medical Biochemistry, UHW

Key Action 21 (2 respondents)

'Increases in access to angiography will have resource implications'. Gwent Health Authority.

'are there minimum numbers of procedures/annum that accredited cardiac catheter operators need to carry out.' Also noted that there should be a timescale for the implementation of no waiting time for those with ACS. All Wales Specialist - Clinical Pharmacy, UHW

Key Action 23 (2 respondents)

'Target rates of revascularisation need to be clarified…the short to medium term objectives provide plans that on the face of it seem to be inferior to the service proposed in England.' Welsh Cardiac

Group, UHW

One respondent disagreed with the recommendation that *"angioplasty must only be undertaken in a tertiary centre with surgical services on site"*. It is felt the recommendation is outdated and outside the current British Cardiovascular Intervention Society guideline - *Royal College of Physicians of Edinburgh.*

Technical Comments

Para 6.11

Should the second paragraph read ‘low molecular weight heparin NOT low dose heparin'? *All Wales Specialist – Clinical Pharmacy, UHW*

‘This could be potential (sic) misleading and should be amended to "treatment with either low molecular weight heparin or therapeutic doses of unfractionated heparin."’ *Welsh Cardiac Group, UHW*

CHAPTER 7

Standard 4

General Comments

15 respondents responded to several aspects featured in Chapter 7.

Two respondents are disappointed that the value of pharmacists is so understated in the plan.

Eight respondents referred to echocardiography and plasma BNP in the context of the three options given:

Option 1 - Rapid Access Heart Failure Clinics

Option 2 - Open Access Echocardiography Clinics

One respondent disagrees that open access echocardiography is not cost effective.

Option 3 - Plasma BNP and Specialised Heart Failure Clinics

Five respondents hold that the use of plasma BNP assays needs to be investigated. They therefore question the practicality of providing routine BNP assays in the near future.

Another respondent said the information received on each of these options was insufficient and would require a research study not a pilot site.

Key Action 27

One respondent believes that there should be a separate bullet point for the development of strategy for palliative management of end stage of heart failure.

Resource implications again raised here. The plan is impossible to implement without investment in echocardiogram facilities and GP training. The development of appropriate blood tests to support effective targeting of echo screening may be some time away and should be reflected realistically in the programme.

Technical Amendments

Para 7.6

Change word ‘drugs’ to ‘medicines.’

CHAPTER 8

Standard 5

Comments and Suggestions

Four comments on Atrial Fibrillation were received:

Two respondents refer to the clarity of the standard and suggest it be revised. One respondents has been led to believe that population screening is being proposed and is concerned for the implications.

Two respondents agree that the optimal management of atrial fibrillation is complex and requires close collaboration between primary and secondary care. Both respondents however suggest that the paragraph be redrafted.

An enquiry was made for updated professional guidance on standards for anticoagulation in relation to INR.

1 respondent says that PCHT’s must be included for patient pathways development.

Two respondents raise resource implications for primary and secondary care in identifying and monitoring atrial fibrillation.

Technical Amendments

Para 8.5

Line 5, paragraph 1, change the word ‘drugs’ to ‘medicines’