The cost of national service frameworks

A bleak view of the programme of the Government's national service frameworks (NSFs) might suggest that they create a great deal of hard work for clinicians and divert resources away from one's own particular interest. Another view suggests that, together with the Cancer Plan, they have been a major lever in bringing about real improvements in the care of many patients being treated by the NHS.

My recollections of the NHS in the 1990s are of an organization that had lost its way. Round after round of cost improvement programmes had pared the beast to the bone and the internal market had driven deep and damaging divisions between primary and secondary care.

Spending in real terms had stood still or fallen back and many organizations maintained financial balance only by converting capital to revenue so that essential maintenance was delayed, giving rise to inevitable deterioration in the building stock and the clinical environment.

Too often the valid aspirations of clinicians in terms of clinical developments withered on the vine as the media repeatedly reminded us of the growing differential between ourselves and our European neighbours.

Bristol, Shipman and a range of other clinical disasters fuelled the flames so that it was no wonder that morale among doctors, nurses and other health professionals was as low as could be.

Against this background, it was with some trepidation that, in the year 2000, I took on the role of implementing the *National Service Framework for Coronary Heart Disease* (Department of Health, 2000a). Despite very clear steers from ministers and officials at the Department of Health that real investment would be provided there had been many false dawns. It was vital that clinicians bought into the process or the NSF would become yet another policy document destined to gather dust on many an official shelf. Would the wide range of health professionals that deal with coronary heart disease (CHD) believe and join in?

Published as a series of booklets in a rather ghastly pink box, the launch by the Prime Minister in March 2000 did not start well as the press conference was overshadowed by other major news stories but I need not have worried. Long before I had finished a series of visits right across the country with members of my team, it became clear that the CHD community were actually champing at the bit. Not only did they wish to implement what the NSF required they wanted to do more, a lot more, and right away.

Reflecting over the last 3 years of NSF implementation, the most remarkable thing has been that a relatively bland document such as the NSF for CHD should help to rekindle the clinical spirit. The results are now there for all to see (Department of Health, 2000b):

- Advertising of cigarettes has been banned
- 250 000 smokers have been helped to quit
- The National School Fruit scheme is providing 500 000 children in 3500 schools with a free piece of fruit each school day
- In primary care, the number of prescriptions for statins has risen by 30% each year so that the annual spend is now in excess of £0.5 billion
- Prescribing of cardiovascular drugs in general in primary care has risen by 54% since the NSF was published now costing some £460 million each quarter
- The Public Access Defibrillation scheme has seen 680 advisory external defibrillators deployed across 100 sites with 29 people revived and able to leave hospital
- In emergency care, there have been steady improvements in ambulance response times and improvements in delivery of thrombolysis
- Myocardial Infarction National Audit Project, the biggest and most comprehensive audit of acute myocardial infarction anywhere, now holds details of over 150 000 episodes of care and demonstrates improvement in almost every single quality measure over each quarter of each year
- More than 75% of eligible patients now receive treatment within 30 minutes of arrival at hospital and over 85% are discharged on the effective secondary prevention drugs
- Almost all accident and emergency departments now give thrombolysis whereas only 30% were able to do so in 1999
- The targets to reduce waiting times for heart surgery have long been eclipsed. Patients frequently had to wait up to 2 years for coronary bypass surgery whereas now the NHS is on target to reach a maximum wait of 6 months by the year end and 3 months by 2005 at the latest
- CHD began the first pilot of *Extending Choice for Patients* (Department of Health, 2002). Of 8000 eligible patients, nearly 6000 were deemed clinically eligible and, of these, some 2800 have opted for treatment elsewhere
- To date the Government has announced 13 major NHS building projects at a projected cost of over £580 million in areas where need is greatest, such as Wolverhampton, South Tees, Bristol, Blackpool, Manchester, Southampton, Sheffield, Leeds and Plymouth. The NHS has also purchased the Heart Hospital in London from the private sector
- Two major initiatives are bearing down on waiting times for diagnosis of heart disease:

- Over the past 3 years, the NHS has built up a national network of rapid access chest pain clinics, which aim to provide a one-stop diagnostic service to patients with new chest pain within 2 weeks of referral by their GP. About 80% of patients were seen within 14 days in the final quarter of 2002–03.
- Combined Department of Health and Lottery investment of over £125 million is ensuring a national network of state-of-the-art angiography suites, enabling patients to have more rapid access to the second stage of CHD diagnosis which enables cardiologists to tell what sort of treatment is needed.
- The headline target identified in *Our Healthier Nation* looks set to be achieved 2–3 years earlier than planned. The aim was to reduce cardiovascular deaths by 40% in people under 75 years of age by 2010, reaching a target of 83.8 per 100 000 population.

WHAT IS THE COST?

To date the NHS has spent some £800 million in support of the NSF for CHD. This large sum includes elements of capital, non-recurring revenue and recurring revenue. Fully accurate breakdown is made more difficult by the fact that in the new devolved NHS we have moved away from large, centrally controlled budgets and there are no longer earmarked budgets at local level. It is also clear that some of the spend, both capital and non-recurrent revenue, reflects an element of catch-up rather than longer term need although there are clear exceptions.

The Wanless Report confirmed the need for continued growth in expenditure on statins to at least double the current level of expenditure (HM Treasury, 2002).

There is still a need for further growth in angioplasty activity before we can really be regarded as on a par with our European neighbours. The 50% increase seen over the last 3 years has been largely absorbed by the cardiology staff as an efficiency gain. Further expansion will require more cardiologists and supporting staff particularly as we begin to take on the acute management of heart attack patients using percutaneous coronary intervention rather than thrombolysis.

STAFFING ISSUES

The need for more cardiology input to acute medicine, fuelled by the European Working Time Directive, will require more consultants too. The growth in cardiology numbers over recent years is an encouraging start on that front and the Government continues to explore ways of creating further expansion.

Equally important will be the development of primary care teams to take on even more of the systematic care necessary for CHD patients, as will be the need to move to more integrated systems of care so that patients can move up and down the skills ladder more readily. The pioneering work of GPs with special interests has shown that much of the care of CHD patients can transfer from secondary to primary care quite safely and there is much to be done in helping patients become managers of their own disease more effectively and confidently.

The recent publication of the guideline on heart failure by the National Instiute for Clinical Excellence will put more pressure on professionals right along the patient pathway (Department of Health, 2003; National Instiute for Clinical Excellence, 2003).

It is clear that much has been achieved and that there is still much to be done. Could all this money have been better spent? The chest physician or the gastroenterologist might answer yes but the evidence from the public and certainly the patients indicates that the improvements in CHD care have been spotted and warmly welcomed.

The NSF agenda has demonstrated beyond any doubt that the NHS was not terminally ill. It can modernize. It can improve. It can thrive. Perhaps the best testimony to the process has been the long list of specialities that have knocked on ministers' doors in endeavours to obtain NSF status. The evidence suggests that focussed work on specific topics delivers results and that clinicians remain as committed and vigorous as ever when given the resources to do the job. With historic levels of investment now going in to the NHS there are real opportunities for continued progress and better patient care. **HM**

Roger Boyle
National Director for Heart Disease
Department of Health
London SE1 8UG

Department of Health (2000a) *National Service Framework for Coronary Heart Disease.* Department of Health, London (www.doh.gov.uk/heart)
Department of Health (2000b) *Delivering Better Heart Services.* Department of Health, London(www.doh.gov.uk/heart/progress2003)
Department of Health (2002) *Extending Choice for Patients: A Discussion.* Department of Health, London
Department of Health (2003) *Developing services for heart failure.* Department of Health, London (http://www.doh.gov.uk/heart/heart-failure/developingservices.htm)
HM Treasury (2002) *Securing Our Future Health: Taking a Long-Term View.* HM Treasury, London (www.hm-treasury.gov.uk/Consultations_and_Legislation/wanless/consult_wanless_final.cfm)
National Institute for Clinical Excellence (NICE) (2003) *Clinical Guideline No. 5: The Management of Chronic Heart Failure in primary and secondary care.* National Institute for Clinical Excellence, London (www.nice.org.uk/Docref.asp?d=80259)

KEY POINTS

- The NHS in the 1990s suffered from poor resourcing and poor morale.
- There has been remarkable progress in delivering the National Service Framework for Coronary Heart Disease.
- Investment of some £800 million has been accompanied by major reform.
- The major improvements have been achieved by the hard work and buy-in of thousands of NHS staff.
- The National Service Frameworks have been keys to success.