THE SCOTTISH OFFICE

Department of Health

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NHS MEL(1996)2

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

16 January 1996

Dear Colleague

CORONARY HEART DISEASE IN SCOTLAND

Summary

1. This letter brings to your attention the publication on 18 January 1996 of the policy review report, 'Coronary Heart Disease in Scotland', a copy of which is attached. Please treat this as confidential until the date of publication.

2. The attached Annex provides a brief summary of the background to this report and its main recommendations. The main points of the report are also contained in a stand-alone Executive Summary which will be distributed to all GPs in Scotland. Copies have been supplied to Boards' Primary Care Departments for this purpose.

Action

3. Health Boards, NHS Trusts, directly managed units and GPs are invited to take account of the recommendations of the report. The recommendations are commended as key initiatives designed to help achieve the CHD targets in the Policy Statement *Scotland's Health: A Challenge To Us All.*

Robert Kendell

R E KENDELL
Chief Medical Officer

KEVIN J WOODS
Director of Purchasing

Addressees

For action:
General Managers, Health Boards

Chief Executives, NHS Trusts

For information:

Directors of Public Health

General Manager, Common Services Agency

General Manager, Health Education Board for Scotland

General Manager, State Hospitals Board for Scotland

Executive Director, SCPMDE

This MEL was prepared by SODoH-PHPU1-3

Enquiries to:
Mr J S Aldridge
ME Purchasing Strategy Division
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 1772
Fax: 0131-244 2051

ANNEX

CORONARY HEART DISEASE IN SCOTLAND: IMPROVING HEALTH

Background

1. The Department has now completed a wide-ranging policy review of coronary heart disease (CHD) in Scotland. A copy of the Main Report and the stand-alone Executive Summary are attached. Additional copies of the Main Report can be obtained from HMSO Bookshops, price £18.00.

2. A copy of the draft report was circulated to Board Chairmen, General Managers, providers and a range of other consultees in the autumn of 1994. Its general tenor was welcomed. Its text has been amended in the light of all the comments received. This MEL sets out the report's main conclusions and recommendations, and draws to Boards' attention the action which they as purchasers should now put in hand to assist in the achievement of the *Scotland's Health* targets for reductions in CHD mortality and to reduce Scotland's overall CHD burden. This MEL should be read in conjunction with MEL(1995)51, *Priorities and Planning Guidance for the NHS in Scotland 1996/97*, in which cardio/cerebro vascular disease is identified as one of three national priorities.

Main Conclusions and Recommendations

3. Our main aim is to obtain the greatest possible improvement in health in relation to CHD. The key task of the review has therefore been to consider the balance of the current investment in CHD prevention and treatment. Accordingly, we looked at the evidence on clinical effectiveness and cost-effectiveness. Broadly, therefore, the report attempts to evaluate and give due weight to the respective roles of CHD prevention and the treatment of those with the established disease.

4. CHD in Scotland is a mass disease currently affecting about half a million people. Some two-thirds of CHD deaths occur in the community, and most are sudden. In half of these cases, where there has been no previous diagnosis of CHD, scope for effective treatment is minimal. Population-based prevention initiatives should therefore be pursued, especially given the number of other conditions, such as cancer and stroke, which would benefit from a reduction in CHD risk factors such as smoking and high blood pressure. The main thrust of the report is therefore that there should be an increased emphasis by purchasers on health promotion and CHD prevention activities, provided these are cost-effective and properly evaluated. Prevention currently receives only 4% of NHS spending on CHD in Scotland. Interventions should focus on smoking, diet, exercise and high blood pressure. Small population changes in these risk factors potentially translate into major reductions in subsequent CHD. The report is at pains to try to strike the correct balance in relation to these activities. The pain and disability associated with established CHD, as well as the high cost of treating it, require the exploration of every avenue for reducing its incidence. Health Boards should be positive and vigorous in the pursuit of such work. They should not, however, develop particular initiatives without considering the outcomes which they can reasonably expect to obtain and whether the outcomes justify the costs. The report therefore stresses the need to routinely build evaluation into such schemes to assess their success, and

provide lessons for the design of future initiatives. It is for Health Boards to determine the extent to which they should allocate additional resources to such initiatives and, in the light of local needs, to judge from which sources any increase in resources might be found.

5. Along with CHD prevention, CHD rehabilitation is identified as being particularly cost-effective and worthy of increased resources. Much more could be achieved by rehabilitation than at present. The full potential of such avenues should be routinely explored before surgery is considered, unless the need is urgent. Conversely, Boards' purchasing of angioplasty and CABG surgery should be determined by a local needs assessment and the development of explicit clinical guidelines for the selection of appropriate patients. Until that work has been carried out, Boards are encouraged to consider the available evidence very carefully before allocating further increases of resources for these procedures. The new national standard of a maximum waiting time of one year for CABG treatment must operate within the context of needs assessments and the establishment of proper selection criteria.

Developing Purchasing Strategies

6. The report is aimed principally at purchasers, and is intended to inform the development of their strategies. Health Boards will need to involve GPs generally in their planning, and, given GP fundholders' separate accountability for their purchasing decisions, Boards will need to discuss with them the implementation of the report's recommendations.

7. Purchasers should therefore plan coherently, prioritise and allocate resources in order to produce a comprehensive CHD strategy for their area, using specialist purchasing expertise and based on an assessment of the needs of their population. With the devolution of responsibility for adult cardiac surgery, purchasers are now involved in the full range of activities in the CHD field. These comprise: health promotion and related lifestyle issues; the establishment and maintenance of alliances for health; clinical protocols for the management of CHD in the primary, secondary and tertiary sectors; prescribing practice and drug regimes; monitoring; clinical audit; outcome measures; and research and evaluation.

8. Rather than looking at the various CHD interventions in isolation, the strategic approach offers the most effective way of maximising health gain and reducing variations, both within and between Boards. The strategy will have 3 main components: (a) health promotion and CHD prevention; (b) treatment; and (c) rehabilitation. The degree to which resources should be allocated to each component will depend on each purchaser's assessment of local needs, and on each purchaser's assessment of the cost-effectiveness of every CHD intervention, as well as on local circumstances (the needs of remote areas will be different from urban areas, for example).

Health Promotion/CHD Prevention

8.1 CHD prevention activities are effective at the community or population level, and should be given greater emphasis, provided they are well-designed and targeted, and are subject to evaluation. In relation to targeting, the evidence suggests that different socio-economic groups make changes in risk factors over different time periods. For this reason, prevention campaigns may need to be focused on deprived populations.

Treatment

8.2 GPs are responsible for detecting and treating CHD risk factors in individuals. They treat the majority of patients with established disease (angina, heart attacks and heart failure). Hospital specialists provide advice and more intensive treatment in selected patients. In both angioplasty and coronary artery bypass graft surgery (CABG), the number of procedures purchased should be based on a local needs assessment. Clinical guidelines for angina management are also essential, so that, through appropriate patient selection, resources are targeted on those with the greatest capacity to benefit. Until these steps have been taken, purchasers should assess carefully the evidence of their effectiveness and cost-effectiveness before considering an increase in the level of resources for CABG surgery. Purchasers should also consider how to increase the proportion of suitable patients with acute myocardial infarction receiving aspirin and early thrombolysis. For acute myocardial infarction patients, speed of response and the time taken to initiate treatment are the critical factors. Purchasers should also adopt a rigorous approach in the evaluation of the work of Coronary Care Units, further expansion of which should only be contemplated where there is clear evidence of their value.

8.3 In considering the balance between services which should be delivered in a DGH and those which should be delivered from a tertiary centre, purchasers should bear in mind the evidence that better results are seen in those units treating larger numbers of CHD patients. In this context, it should be borne in mind that the demand for surgical procedures is effectively controlled by the number of coronary angiograms undertaken. At present, coronary angiography is confined to 5 tertiary centres in Scotland, but there are signs that some DGHs are contemplating expansion into this area of activity. The evidence on outcomes and benefit is also relevant to the number and size of secondary and tertiary units required within each Health Board area and for Scotland as a whole. Further reflection is needed on the implications for service development in Scotland.

Rehabilitation

8.4 Rehabilitation includes stopping smoking, exercise training, stress management, dietary changes and secondary prevention medications, and is effective for patients with established CHD. Although rehabilitation might halve the number of patients requiring CABG surgery, rehabilitation services are sparse, and their organisation can be improved. There are marked variations in provision and setting, and there are no agreed models of treatment, staff training or outcome measures. All heart attack survivors should receive appropriate rehabilitation and treatment to reduce the risk of further events and the need for surgery. Substantial expansion of this form of CHD intervention could be undertaken without requiring high levels of additional resources.

Monitoring

8.5 Current monitoring of CHD is poor, with little information on morbidity, particularly outside hospital. Enhanced monitoring would improve surveillance, planning and evaluation of both prevention and treatment services.

9. Purchasers require to strike a balance between the current and future needs of the population on the one hand, and the needs of individuals with overt CHD on the other. In developing their local strategies, purchasers will wish to review the existing balance between promotion, prevention, treatment and rehabilitation services, and the level of resources which they commit to each. In the light of their reviews, purchasers will wish to consider the scope for adjusting the balance of their purchasing strategies over time, bearing in mind other pressures on their resources and their assessment of other local needs.

10. Implementation of these recommendations should, over time, make a major contribution to reducing Scotland's greatest burden of death and disease.

11. Further inquiries about this MEL should be addressed to **Mr J S Aldridge, ME Purchasing Strategy Division, Room 266, St Andrew's House, Edinburgh EH1 3DG (0131-244 1772)**.