The Regulation and Quality Improvement Authority

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Independent Review of the Implementation of the Cardiovascular Service Framework

November 2012

informing and improving health and social care
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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest.

Our reviews are carried out by teams of independent assessors, most of whom are either experienced practitioners or experts by experience.

Our reports are submitted to the Minister for Health, Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

Executive Summary

The Service Framework for Cardiovascular Health and Wellbeing was the first of a programme of service frameworks to be launched in Northern Ireland. The framework set out 45 standards for prevention, treatment, care and rehabilitation. The Regulation and Quality Improvement Authority (RQIA) has agreed to carry out a review of the implementation arrangements for each service review after three years. This is the first report of a framework implementation review carried out by RQIA.

RQIA found widespread support among stakeholders for the service framework approach. The Cardiovascular Service Framework was considered to have facilitated service improvement and development. Examples of specific developments which have taken place since the framework was launched include the establishment of a consultant post for adults with congenital heart disease, a screening programme for abdominal aortic aneurysm, and fast tracking of thrombolysis for stroke patients.

At the time of launch in 2009, there was not an agreed implementation plan, which was subsequently developed. Accountability arrangements for service framework implementation and monitoring were clarified and strengthened in 2011 through the issue of a letter by the Chief Medical Officer.

Significant challenges emerged during the three-year period of implementation, which included:

- lack of available information to allow monitoring of progress against the standards in the framework
- changes in organisational structures
- financial pressures restricting available resources for implementation

RQIA makes ten recommendations for the implementation arrangements for future service frameworks from the learning from this review. For each framework, organisational responsibility for implementation should be designated. A regional lead officer should be identified to take forward the implementation process. A small number of high level indicators to monitor progress should be agreed, with suitable data sources identified.

RQIA welcomes the proposed development of a regional cardiovascular clinical network as an important initiative to build on the momentum which the framework implementation process has established. This will ensure that there are effective arrangements for patient involvement during implementation.

Table of Contents

1. Introduction and Background to the Review

1.1 Service Frameworks in Northern Ireland

In a letter dated 1 March 2007, the Chief Medical Officer (CMO) and the Deputy Secretary, Department of Health, Social Services and Public Safety (DHSSPS) Deputy Secretary announced that the DHSSPS had commenced the development of a range of service frameworks. These service frameworks would set out standards for health and social care. Patients, clients, carers and their wider families should be able to use the frameworks to understand the standard of care they could expect to receive. Health and social care (HSC) organisations would use them when planning and delivering services.

A service framework is a document which contains explicit standards underpinned by evidence and legislative requirements. Service frameworks set targets, timeframes and expected outcomes for specific service areas designed to:

- improve the health and social wellbeing of the population of Northern Ireland
- reduce inequalities and promote social inclusion
- improve the quality and safety of care
- safeguard vulnerable individuals and groups
- improve partnership working with other agencies and sectors

Service frameworks are designed to link to key policies and strategies already developed, and to draw on evidence from established sources, including the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE). Where appropriate, they include standards that have been developed elsewhere.

The guidance provided to the teams established to develop frameworks highlighted that each service framework should use a common template and include consideration of:

- prevention, promotion and protection of health and wellbeing
- appropriate assessment, diagnosis, treatment and care provision
- rehabilitation and end of life care

Development of service frameworks was seen as a major element of the service reform programme for health and social care in Northern Ireland. Service frameworks were designed to be used by the public, commissioners and providers of services, and those organisations that report on the performance and quality of services.

The development of service frameworks is being led by the DHSSPS and is undertaken in partnership with HSC organisations from statutory, voluntary and community sectors, as well as service users and carers. Where appropriate, they are developed in collaboration with established networks and groups. For example, the Regional Cardiac Services Network and members of the group that had

previously developed the Regional Stroke Strategy both played significant roles in the development of the Cardiovascular Service Framework.

Each service framework uses a multidisciplinary approach, recognising that the majority of care is delivered in the primary/community sectors, with active participation of individuals and carers. In addition, service frameworks recognise that care can go beyond traditional HSC boundaries.

Each service framework, prior to publication, is subject to formal consultation. The results are analysed and a final framework is produced, together with an easy access version. Further information and detail on the standards, rationale, criteria, performance indicators and audit criteria is publicly available on the internet.

The first group of frameworks focused on the most significant causes of ill health and disability in Northern Ireland: cardiovascular disease, respiratory diseases, cancer, and mental health and wellbeing.

Three further service frameworks in relation to learning disability, older people's health and wellbeing, and children and young people's health and wellbeing are being developed at present.

In a letter from Dr McBride, CMO, dated 22 December 2011, accountability for the implementation of all service frameworks was strengthened. The DHSSPS will now ask for assurance about outcomes at regular accountability meetings with the HSC Board and the Public Health Agency (PHA), held twice yearly. In his letter the CMO stated 'It will be for the HSC Board/PHA to secure assurance on progress made against standards and indicators from individual trusts and other service providers, where relevant.' RQIA will carry out a review of the implementation of each framework three years after it was launched. The Cardiovascular Service Framework is the first to be subject of a review by RQIA.

1.2 The Cardiovascular Service Framework

On 17 June 2009 the Service Framework for Cardiovascular Health and Wellbeing (the Cardiovascular Service Framework) was formally launched by then Minister for Health, Social Services and Public Safety. The framework was the first to be developed, as cardiovascular disease was recognised to be a leading cause of death and disability in Northern Ireland.

The framework set out standards for the prevention, diagnosis, treatment, care, rehabilitation and palliative care of individuals and communities at risk of developing or suffering from cardiovascular disease. Each standard was supported by key performance indicators, which set levels of performance to be achieved over a three-year period 2009-12.

Recognising that several diseases of the heart and systemic circulation can coexist, share common risk factors and can adversely impact on prognosis, the Cardiovascular Service Framework included consideration of:

- hypertension (high blood pressure)

- hyperlipidaemia (high cholesterol)
- diabetes (as a significant risk factor for the development of cardiovascular disease)
- coronary heart disease (e.g. angina, heart attack, heart failure)
- cerebrovascular disease (e.g. stroke)
- peripheral vascular disease (e.g. poor circulation in the legs causing ulcers/gangrene)
- renal disease associated with cardiovascular disease (e.g. kidney failure)

In common with other service frameworks, it also contained sections on communication, participation, health improvement and end of life care.

The standards in the Service Framework for Cardiovascular Health and Wellbeing are set out in Appendix A. A full copy of the service framework can be found on the DHSSPS website: http://www.dhsspsni.gov.uk/service_framework_for_cardiovascular_health_and_wellbeing.pdf.

1.3 Review of the Coronary Heart Disease National Service Framework in England

In England, the Coronary Heart Disease National Service Framework (NSF) was one of the early frameworks established. Published in March 2000, the Coronary Heart Disease NSF was intended as a blueprint for tackling coronary heart disease.

Ten years later, a systematic review of its effectiveness was undertaken, drawing on multiple data sources, including a literature review, interviews with national and local stakeholders, patient stories, and case studies of cardiac healthcare providers in six local areas.

The review concluded that, overall, the NSF was viewed as having positive effects and had universal support among the interviewees. It was credited with success in securing and directing an infusion of resources, catalysing innovation at local levels, addressing inequalities, and most importantly, improving access to health care services that are life-saving and life-enhancing.

The NSF was a comprehensive strategy, encompassing public health, primary and acute care, and community services. It spanned the continuum of prevention, diagnosis, treatment, rehabilitation and long-term care of people with coronary heart disease. This patient pathway approach focussed work around commonly desired patient outcomes and gave coherence to health service delivery that otherwise may not have been as well integrated. The shared sense of purpose and common understanding of direction ensured that those working in cardiac services had a clear focus, at a time when the structures of the National Health Service (NHS) were changing.

One of the most notable findings of the review was the acknowledgement that the NSF had "fostered the culture of improving care in cardiac services". This was considered to be particularly important within the context of the English NHS, where culture was often cited as the major barrier to clinical improvement. Strong clinical

leadership and the high level of clinical engagement in both the development and implementation of the approach ensured wide ranging adoption across the NHS.

The review of the NSF found that not all areas were equally successful. The report highlighted concern around the processes and outcomes of cardiac rehabilitation. Interviews with patients indicated that there had been insufficient focus on understanding how to motivate the necessary behaviour changes of individuals living with, or at high risk of, coronary heart disease.

1.4 RQIA's Independent Review of the Implementation of the Cardiovascular Service Framework

This report provides background information on service frameworks and cardiovascular disease in Northern Ireland. It provides a high level chronology of the key stages in the development and implementation of the Cardiovascular Service Framework and the implementation structure for the framework. The report sets out the findings of the review in relation to the three year implementation process 2009-12 and provides a set of recommendations for consideration by DHSSPS, based on the findings and conclusions of the review.

We thank all those people who facilitated this review through participating in interviews, attending the summit meeting or providing information.

2. Terms of Reference

The terms of reference for this review focused on the overall process of implementation of the Cardiovascular Service Framework. They were designed to inform the processes for the implementation of both this and future service frameworks.

The terms of reference for the review were to:

1. Appraise the implementation process for the Cardiovascular Service Framework within HSC organisations.
2. Consider the effectiveness and impact of the Cardiovascular Service Framework process on the delivery and development of services.
3. Consider how service users and carers, staff and the wider public have been involved in the implementation process of the Cardiovascular Service Framework, including planning, evaluation and review.
4. Identify any lessons learned from the implementation of the Cardiovascular Service Framework which are relevant to the implementation of future frameworks within the HSC.
5. Report on the findings, making recommendations as appropriate, to inform the planned substantive end of life cycle review of the Cardiovascular Service Framework.

3. Methodology

The methodology adopted for this review was designed to gather the views of a range of people who have been involved in the implementation of the Cardiovascular Service Framework. Perspectives were sought about the implementation process from voluntary agencies, patient representative groups and those with a specific interest in the Cardiovascular Service Framework. The method used included the following steps:

1. An initial literature review/desktop research was undertaken to examine the context in which the Cardiovascular Service Framework was established and developed. Lines of enquiry were developed to explore the implementation process and the impact this has had within health and social care. Key elements of this research have been used throughout the report to set the scene for the specific issues under review.

2. A series of information gathering interviews were held with key staff involved in the implementation process to explore their experiences and perspectives regarding the effectiveness of the process. A semi structured questionnaire was developed, using the five key principles set out in Wilcox:[1] The Guide to Effective Participation:

    - information giving
    - consultation
    - deciding together
    - acting together
    - supporting

3. Interviews were held with various voluntary bodies and patient representatives. Each of these interviews used a semi-structured interview approach using a list of specific questions designed by the RQIA review team. The interviews were conducted by Dr Philip Veal, Specialist Registrar Public Health, PHA and Helen Hamilton, Project Manager, RQIA.

4. The initial findings from the interviews were collated. The results were then discussed at a summit event, with representation from service user representatives, voluntary organisations and HSC organisations. This allowed for the information previously collected to be consolidated and to explore ways to improve the implementation process for service frameworks in the future. This event was facilitated by Joy Youart, Managing Director Designate, Kernow Clinical Commissioning Group,

[1] Wilcox: The guide to effective participation was published in 1994 and was supported by the Joseph Rowntree Foundation as part of its programme of research and innovative development projects. Designed to be of value to policy makers and practitioners, it provides both a theoretical framework for common understanding and a dictionary to facilitate the dialogue that can lead to successful participation. http://www.partnerships.org.uk/guide/

Cornwall and Isles of Scilly Primary Care Trust, who had been involved in the initial stages of the development of the Northern Ireland framework.

4. Cardiovascular Disease in Northern Ireland

Cardiovascular disease refers to a group of diseases which involve the heart and blood vessels. Many of the diseases have similar risk factors, including high blood lipid levels (hyperlipidaemia), high blood pressure (hypertension), smoking and diabetes. Examples of cardiovascular diseases include:

- ischaemic heart disease which can lead to heart failure or myocardial infarction (heart attack)
- cerebrovascular disease which can cause strokes
- peripheral vascular disease which affects the blood supply to the limbs
- congenital heart disease where the heart is affected by abnormalities from birth
- renal failure linked to vascular disease

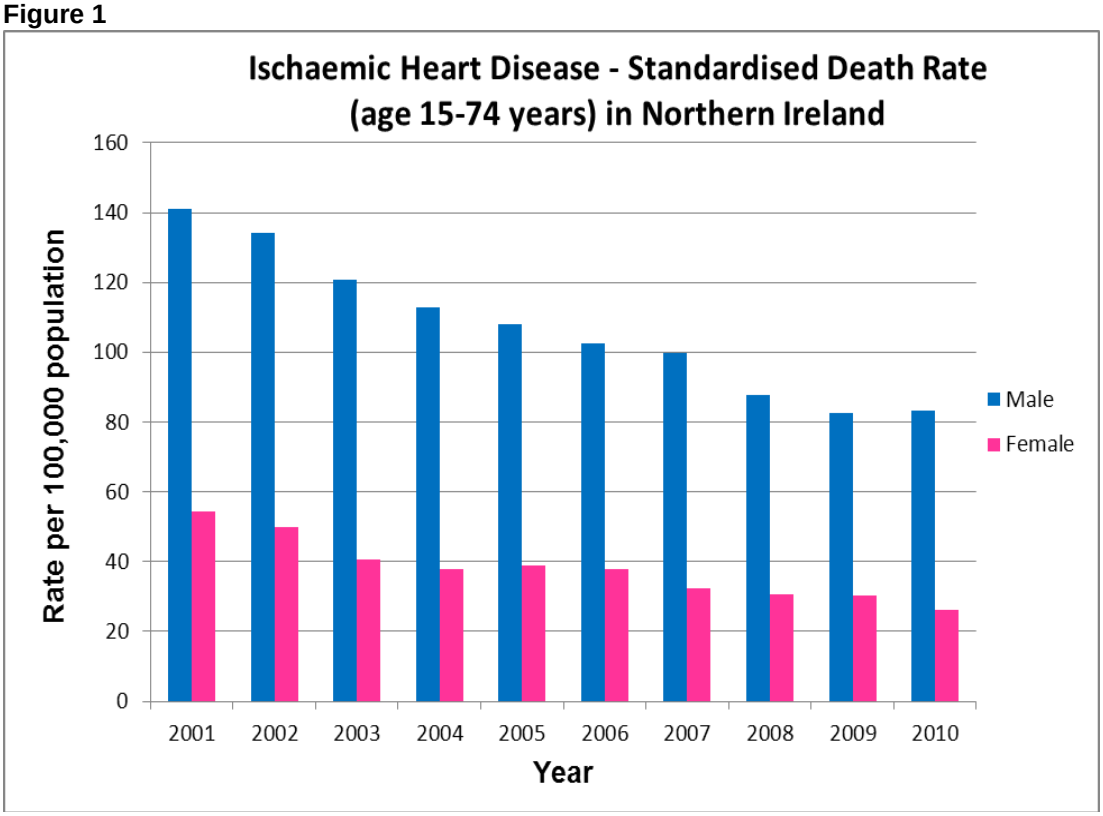
Cardiovascular disease was selected as the topic for the first service framework, in view of morbidity and mortality rates associated with these illnesses in Northern Ireland.

4.1 Trends in Death Rates from Cardiovascular Diseases

a. Ischaemic Heart Disease

There has been a very significant fall in death rates from ischaemic heart disease in Northern Ireland over recent years, although it remains a leading cause of death. Figure 1 illustrates the trends in ischaemic heart disease mortality rates for men and women aged 15 to 74 from 2001 to 2010. The standardised death rates represented in the graph are calculated to compare trends, having taken account of changes in the age of the population.

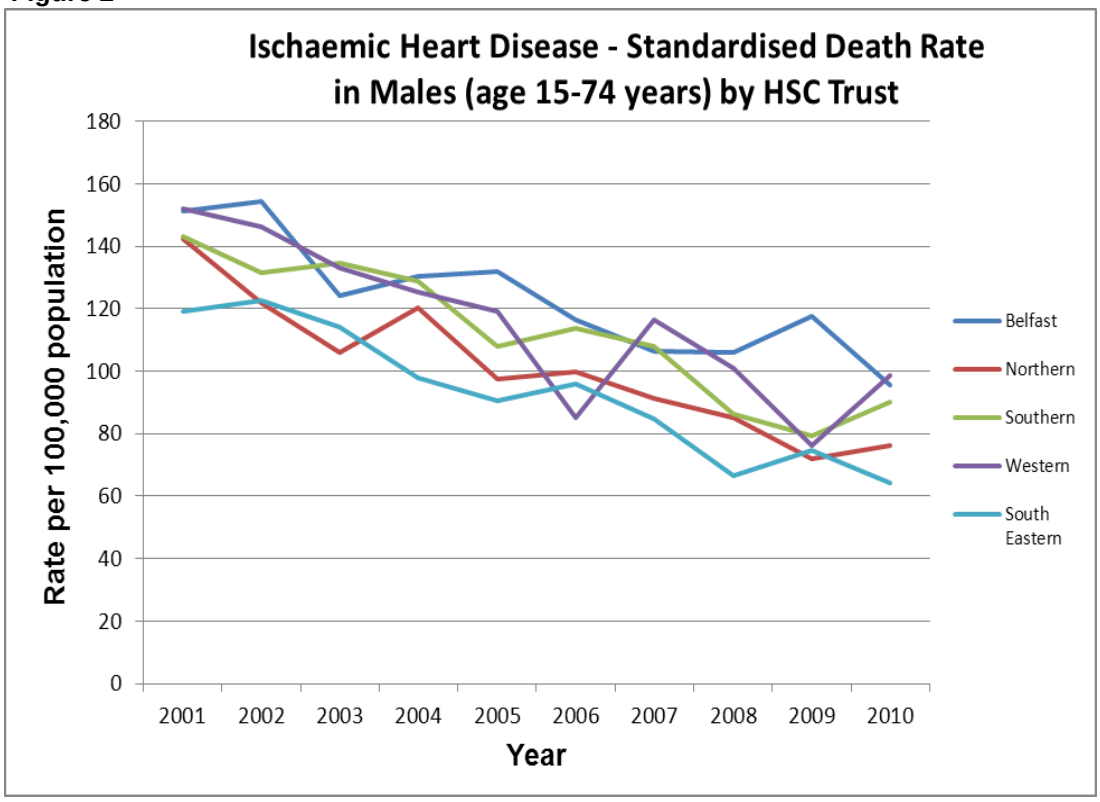
Figure 1



Source: Core Tables 2010: Director of Public Health Annual Report (2011)

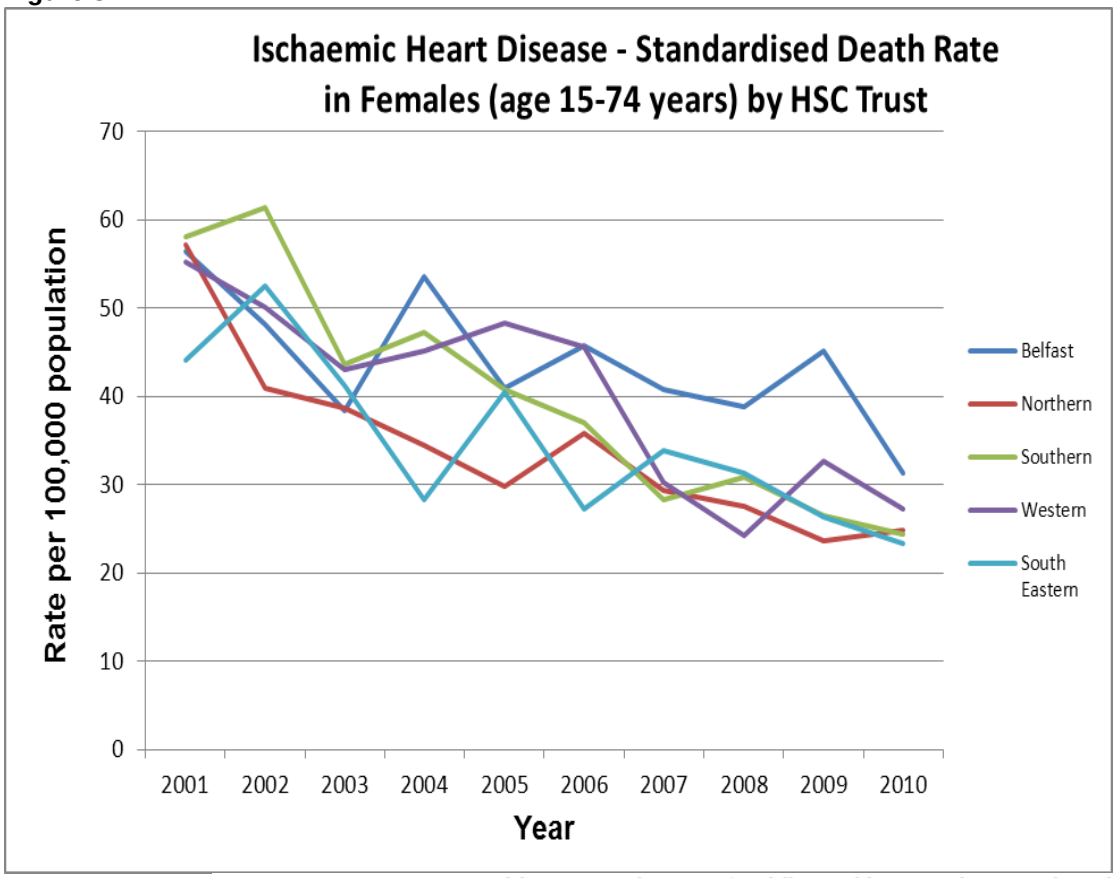
Figures 2 and 3 show trends in death rates, by HSC trust area, for men and women. The graphs demonstrate that decreases in ischaemic heart disease have occurred in each trust between 2001 and 2010.

Figure 2



Source: Core Tables 2010: Director of Public Health Annual Report (2011)

Figure 3

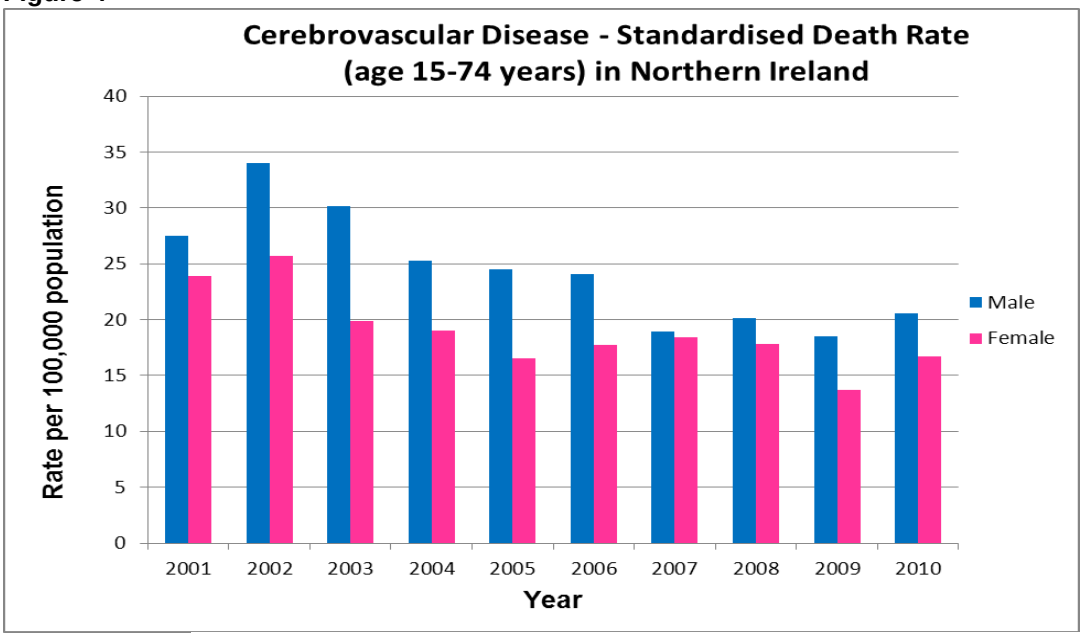


Source: Core Tables 2010: Director of Public Health Annual Report (2011)

b. Cerebrovascular Disease

Figure 4 below demonstrates that there were decreases in death rates resulting from cerebrovascular disease (stroke) from 2002 to 2006. However, this downward trend did not continue in the years 2007 to 2010.

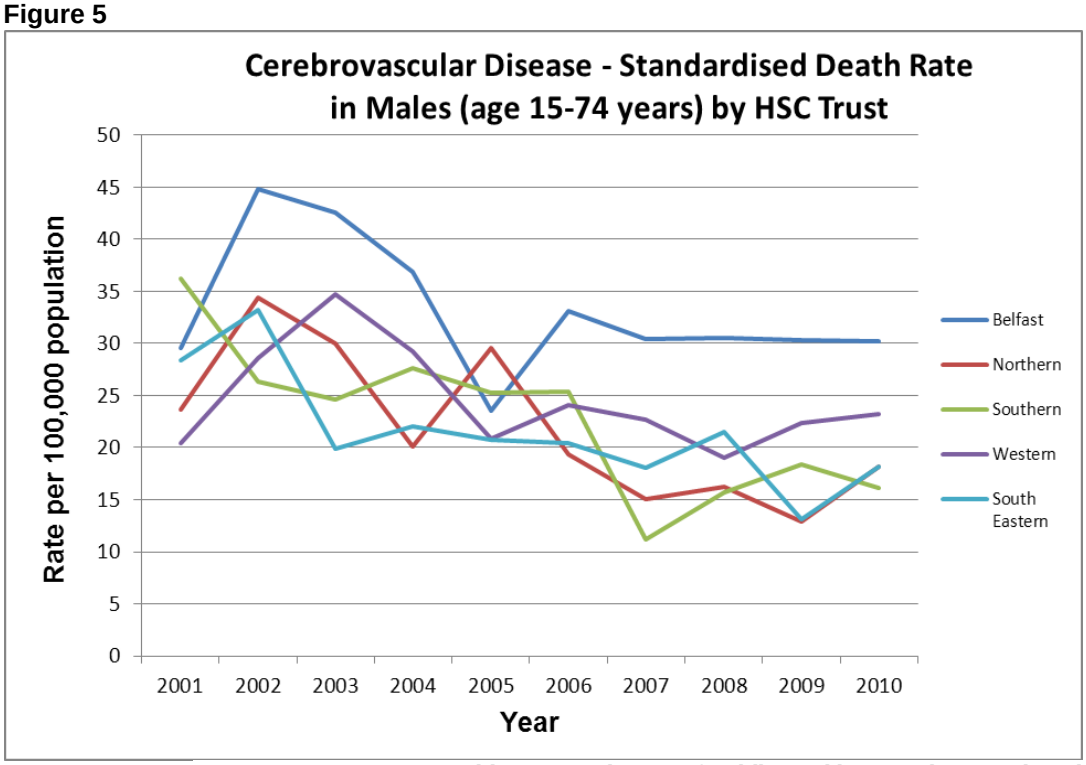
Figure 4



Source: Core Tables 2010: Director of Public Health Annual Report (2011)

Figure 5 sets out the trends by HSC trust for men. It indicates that the pattern has been different in the Belfast Trust area from other trusts. There have been higher death rates in the Belfast Trust area throughout most of this time period.

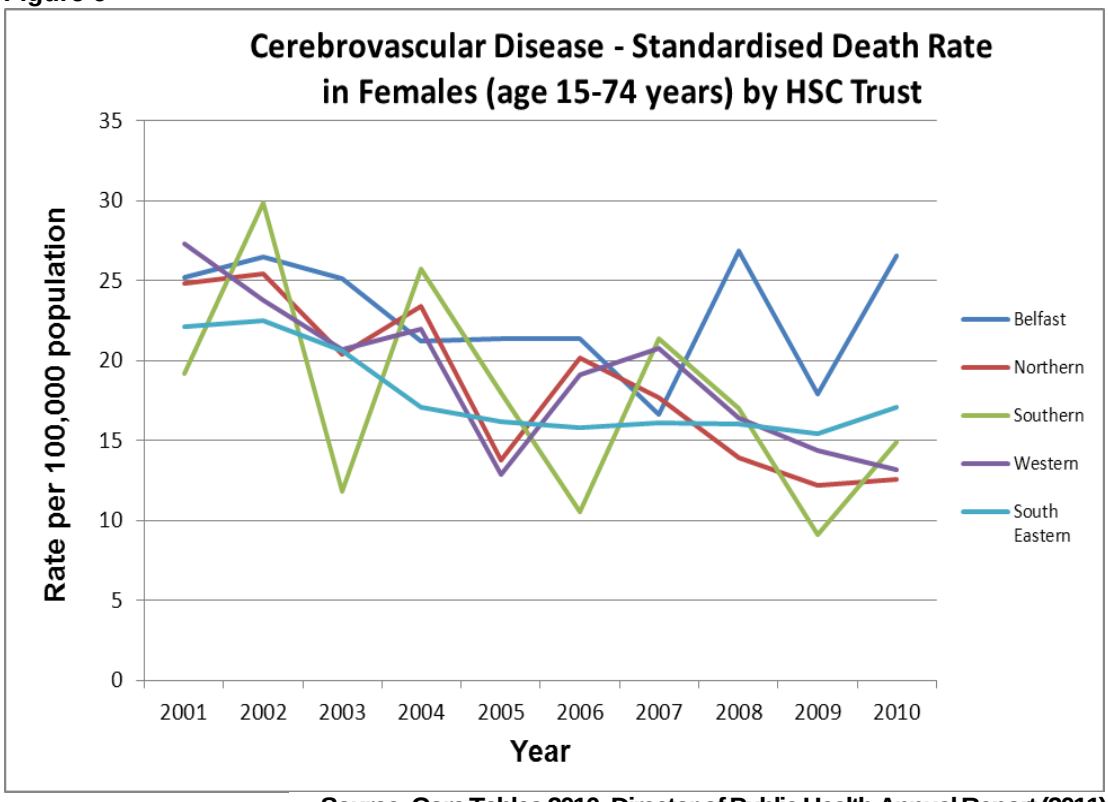
Figure 5



Source: Core Tables 2010: Director of Public Health Annual Report (2011)

Figure 6 shows the pattern in relation to death rates in the female population of Northern Ireland across all HSC trusts. This demonstrates an overall fall in all areas except for the Belfast Trust where death rates have generally risen in recent years, despite an initial reduction in the period 2002-05.

Figure 6



Source: Core Tables 2010: Director of Public Health Annual Report (2011)

4.2 Trends in Relation to Patterns of Deprivation

A health impact assessment of the Cardiovascular Service Framework, carried out by the Public Health Agency[2], considered how factors impacting on cardiovascular diseases are distributed across Northern Ireland. This revealed that trends have varied between areas of affluence and areas of deprivation. Mortality rates from cardiovascular disease have been significantly higher for those in the most deprived socioeconomic groups than for those in the highest socioeconomic groups.

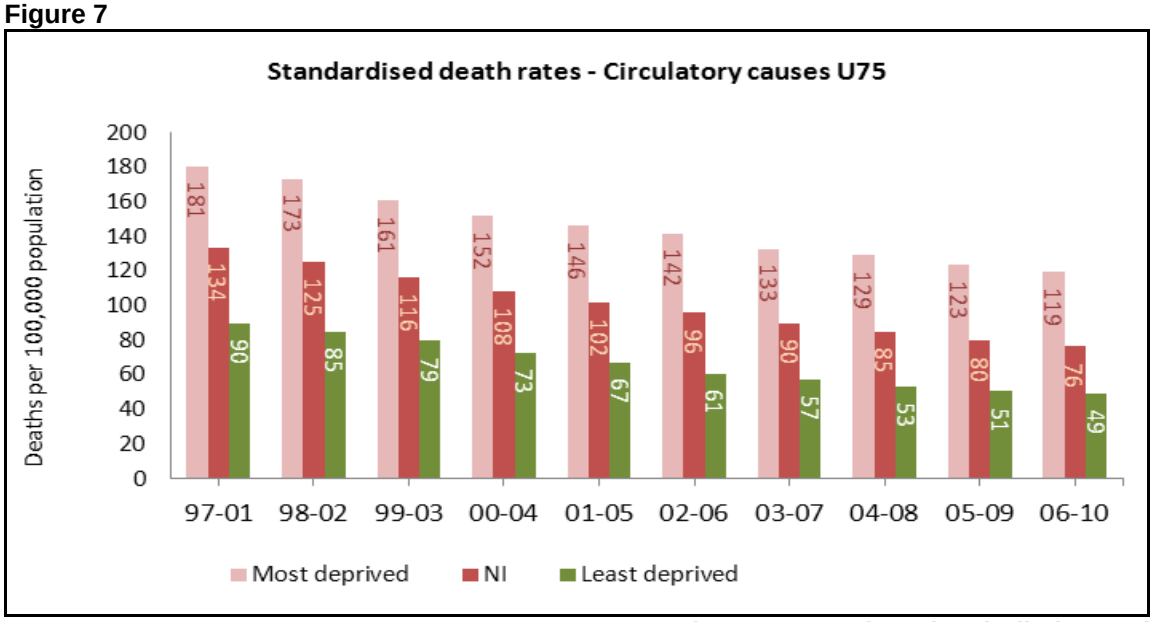
Figure 7 illustrates trends in standardised death rates for the most deprived areas and least deprived areas of Northern Ireland for cardiovascular diseases over recent years.

Overall mortality due to circulatory disease in Northern Ireland fell by more than two-fifths between 1997 to 2001 and 2006 to 2010. However, the most deprived areas saw a smaller reduction, where death rates fell by one-third. This meant that although mortality rates improved across all areas, the inequality gap between

[2] Putting a Health Inequalities Focus on the Northern Ireland Cardiovascular Service Framework, Summary Report (2011) http://www.publichealth.hscni.net/sites/default/files/Summary%20report.pdf

areas of deprivation and areas of affluence actually increased. In 1997 to 2001 deprived areas had twice the mortality rate of affluent areas. By 2006 to 2010 deprived areas had a mortality rate which was more than double that in more affluent areas (Figure 7).

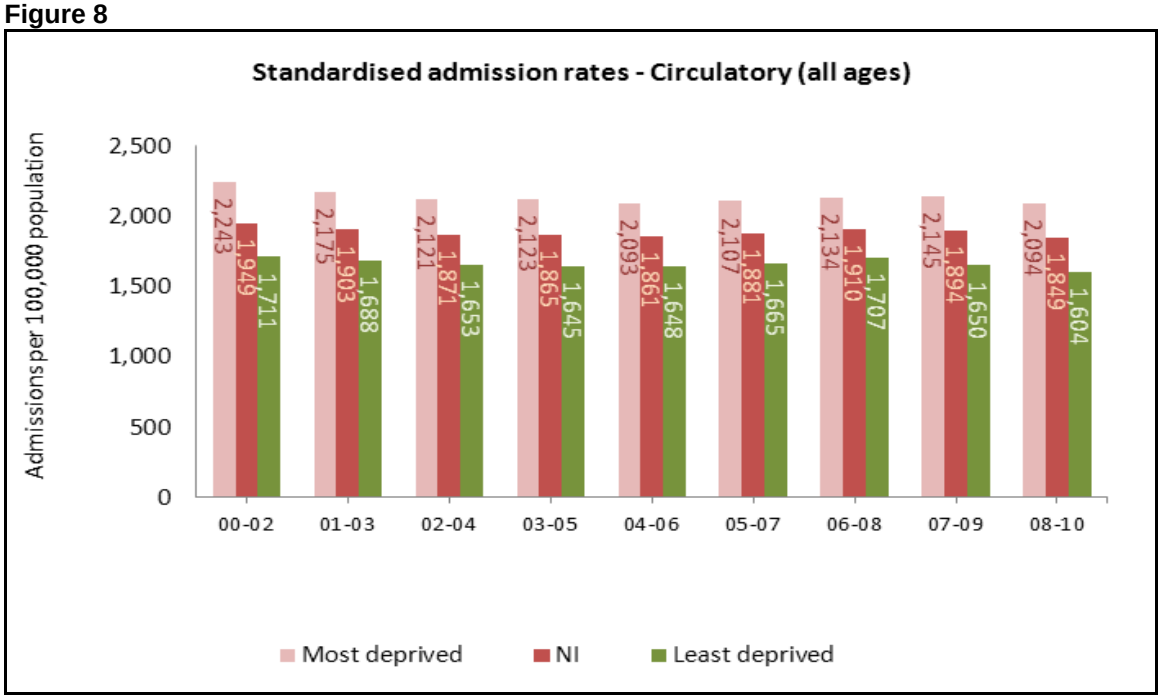
Figure 7



Source: (NISRA: Fourth update bulletin 2012)

The graph below (Figure 8) demonstrates the standardised hospital admission rate due to circulatory disease (all ages) by deprivation category. Admission rates are consistently higher for people living in deprived areas.

Figure 8



Source: (NISRA: Fourth update bulletin 2012)

5. Implementation of the Cardiovascular Service Framework

The regional document Priorities for Action[3] set out the requirements placed on HSC organisations for the initial phase of implementation of the Cardiovascular Service Framework by March 2010. A phased approach to implementation was to be adopted:

- all standards for which there was already a data source in place were to be fully implemented by March 2010
- by March 2010, for the remaining standards, appropriate steps were to be taken to establish data sources and baselines. Performance levels for these standards were to be determined once baselines had been established

The HSC Board and the PHA were required to provide assurance to the DHSSPS in relation to the achievement of all relevant standards on a six monthly basis, linked to the DHSSPS formal accountability process.

5.1 The Implementation Structure

Implementation of the framework is overseen by the Cardiovascular Health and Wellbeing Commissioning Group of the HSC Board and PHA. This group was established to provide advice to the HSC Board, PHA, service teams and local commissioning groups about the development, quality improvement and commissioning of cardiovascular and related services for the population of Northern Ireland.

The remit of the group is to:

- commission all aspects of cardiovascular services, ranging from primary prevention to end of life care, ensuring resource allocation in accordance with agreed HSC criteria
- develop commissioning priorities and plans for cardiovascular and related services for the HSC Board and PHA in line with evidence for equity, safety, responsiveness, effectiveness and efficiency
- work with and support the Cardiovascular Managed Clinical Network, once established, to ensure there are effective mechanisms for engagement with statutory and voluntary organisations, community groups and individuals to inform the commissioning process
- establish and maintain collaborative working relationships with other parts of HSC commissioning structures
- lead the implementation and facilitate further development of the Cardiovascular Service Framework
- contribute to the design of improved models of care for service development and patient pathways

[3] Priorities for Action 2009-10 DHSSPS, March 2009

- seek advice from the Cardiovascular Managed Clinical Network, once established, and Northern Ireland Medicines Management Forum on new and emerging technologies
- contribute to the HSC Board and PHA performance management arrangements, including monitoring and reporting on progress towards relevant ministerial and other targets
- act as champion and advocate for continuous cardiovascular health and wellbeing service quality improvements.

The group is accountable to the Joint HSC Commissioning Programme Board via the Long Term Conditions Service Team. The group held its first meeting on 26 August 2009, and meets monthly, and on an ad hoc basis as required.

The group collectively acts as the champion for the Cardiovascular Service Framework. In implementing the framework it is responsible for:

- communication – with a focus on identifying, establishing and maintaining information flows to monitor and report on progress
- coordination – collaboration with other individuals, groups, networks and organisations
- commissioning for cardiovascular health and wellbeing in accordance with the framework.

While the commissioning group is responsible for overseeing and facilitating implementation of the framework, the framework document clearly sets out the responsibilities of trusts, primary care and others for delivery and implementation.

The group has sought to work collaboratively with a wide range of stakeholders, including patients and members of the public, to reduce inequalities, and to ensure that the Cardiovascular Service Framework is implemented in a coordinated and balanced way.

Implementation of the Cardiovascular Service Framework required working in partnership with a number of established projects, networks, groups and organisations which included:

- Patient and Client Council
- local commissioning groups (LCGs)
- primary care units within the HSC Board
- Cardiac Network
- Stroke Strategy Implementation Group
- Northern Ireland Vascular Group
- Lymphoedema Network
- Palliative and End of Life Care Strategy Implementation Board
- respiratory and other frameworks
- Service Framework Informatics Working Group

A process to share learning about implementation between service frameworks has been established through the creation of a Service Frameworks Forum.

5.2 Health Impact Assessment of the Framework

A health impact assessment (HIA) is a means of assessing the health impacts of policies, plans and projects, in diverse economic sectors using quantitative, qualitative and participatory techniques. A HIA helps decision makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health. The World Health Organization (WHO) has supported the development of tools and initiatives in HIA to improve health and wellbeing across sectors.

In 2010-11 a HIA was undertaken to determine the potential for the Cardiovascular Service Framework to improve fair access to services and to help reduce health inequalities for people in Northern Ireland.

On 1 June 2011, the report of the HIA of the Northern Ireland Cardiovascular Service Framework was published[4]. This report confirmed that cardiovascular health is determined not only by access to HSC services and lifestyle choices, but also by the social and economic conditions which people experience. These include housing, employment, transport and access to fresh food.

The HIA concluded that, in Northern Ireland, some people have benefitted more from improvements in services and living conditions than others. This created differences in how people can access and make use of services. These inequities have, in turn, resulted in higher levels of ill health and premature death in some population groups. For example, men living in the least deprived areas live, on average, almost eight years longer than men in the most deprived areas. For women, this gap is five years. These differences are becoming greater, widening the gap between those who are more affluent and those who are not. Cardiovascular disease is not unique in this regard, however, was assessed to be the main contributor to inequalities in life expectancy in Northern Ireland.

The HIA determined that almost all standards in the Cardiovascular Service Framework related to areas of the HSC system where health inequalities and inequities already exist. These are due mostly to socioeconomic factors and variable access to services, mainly on account of geography, i.e. where services are delivered in relation to where patients live. Achievement of the standards creates the potential to reduce health inequalities.

Barriers were found to exist to the implementation of each standard. They include the capacity of systems, organisations and staff to facilitate and support change. On the other hand, the HIA identified potentially positive effects for staff arising from the implementation of standards, if adequately resourced. These included increased job satisfaction from the delivery of improved services.

A potential increase in demand for services was identified for just under half of the 45 standards within the framework. This may be as a result of increasing awareness among potential service providers and users, or increased service capacity to respond to previously unmet needs. Against this, about one third of

[4] Putting a health inequalities focus on the Northern Ireland cardiovascular service framework, Summary report (2011) http://www.publichealth.hscni.net/sites/default/files/Summary%20report.pdf

standards were likely to reduce the need for services in the future, through greater effectiveness in reducing the burden of cardiovascular disease.

6. Findings of the Review

6.1 Chronology Overview

From information provided, a timeline of events was prepared to help understand the process of development and the implementation of the Cardiovascular Service Framework. This is set out at Appendix 2.

6.2 Views of Stakeholders

This review was designed to gather the views of a range of people including the implementation leads from the Cardiovascular Health and Wellbeing Commissioning Group, who have been involved in the implementation of the Cardiovascular Service Framework. Perspectives were sought about the implementation process through interviews with voluntary agencies, patient representative groups and those with a specific interest in the Cardiovascular Service Framework.

The initial findings from the interviews were collated and the results were then discussed at a summit event with representation from HSC, voluntary organisations and service user representatives. This allowed for the information previously collected to be consolidated, and to explore ways to improve the implementation process in the future.

Participants included a cross-section of those who had been involved in the initial implementation of the Cardiovascular Service Framework, as well as people with a perspective on subsequent developments in the programme. This report captures their experiences and perspectives on the effectiveness of the implementation process, the successes achieved and the challenges that emerged.

6.3 Effectiveness of the Implementation Process

All stakeholders who were interviewed regarded the Cardiovascular Service Framework in a positive light, describing it as a framework that made change possible. The framework was considered, by stakeholders, to have set ambitious goals and overall was seen as moderately successful in achieving these.

Interviewees noted it was unclear whether the service improvements that had happened were due to the implementation of the Cardiovascular Service Framework. It was difficult to dissect the impact of the Cardiovascular Service Framework from the other changes that have taken place. However, stakeholders considered that there had been positive change each year since the framework had been established.

The Cardiovascular Service Framework is credited with providing a set of defined standards for the HSC to work towards.

When stakeholders were asked to rate the impact that they felt the Cardiovascular Service Framework has made within the HSC on a scale from 1 to 5 (where 1 was

Extreme Impact and 5 was No Impact at all); most stakeholders gave a rating of between 3 and 4.

When further asked to rate the effectiveness of the implementation process on a scale from 1 to 5 (where 1 was Extremely Effective and 5 was Not at all Effective) ; again most stakeholders gave a rating of between 3 and 4.

While some stakeholders believed that the Cardiovascular Service Framework did not have a significant impact on the quality of cardiovascular services, they did note that without it, progress would have been slower.

Despite some acknowledged successes, most stakeholders believe that continued improvement is needed in cardiovascular care. Stakeholders are concerned that reduced budgets may mean an imbalance in funding. Some expressed the view that there should be a ring-fenced budget for cardiovascular care, to allow for the savings made in some specific areas to be reused in others within cardiovascular care.

Progress in primary care was considered to be variable. The Cardiovascular Service Framework has succeeded in raising awareness of the prevention aspects of cardiovascular disease in primary care. It has assisted in raising the profile and benefits of brief interventions within primary care where previously this had been hard to achieve. However, some of those interviewed described a tension between delivering quality improvement and the delivery of Quality and Outcomes Framework (QOF) targets.

Patient awareness of the framework was considered limited. Voluntary agencies and patient representatives described very positive experiences of engagement during the development of the framework. However they reported less engagement as the implementation of the framework was progressed.

Stakeholders emphasised the importance of engagement with staff and a desire to ensure that frameworks were made real for patients. A range of methods were considered necessary to ensure that this is full and meaningful. It was believed to be particularly necessary to engage with hard to reach groups, if the framework was to achieve the impact desired to tackle inequalities in health experience. Above all, strong views were expressed that engagement should not be simply a token gesture.

There is a general perception among those interviewed that the framework standards have the potential to be very powerful, as they have the ability to ensure that health improvement and service improvement become the responsibility of all. Stakeholders considered that if the Cardiovascular Service Framework was adequately resourced it would have the potential to deliver real benefit. However, it was highlighted by some of those interviewed that the Cardiovascular Service Framework, and indeed all frameworks, need to be given high priority at trust and primary care level if successful delivery is to be achieved.

6.4 Successes Achieved

Establishing Mechanisms for Implementation and Accountability
Shortly before the formal launch of the Cardiovascular Service Framework, the PHA identified a lead person to implement the framework. Responsibility for implementation has since transferred to another individual and a number of service champions continue to drive the implementation process forward. Implementation of the framework is overseen by the Cardiovascular Health and Wellbeing Commissioning Group. It is noted that this group has continued to function throughout the period of transition.

The appointment of a designated lead for implementation of the framework was considered by those interviewed to be a critical factor in having a successful implementation process. This ensured that momentum was maintained.

The implementation arrangements have included a number of workshops to discuss specific issues and progress. These have helped to maintain wide ownership of the framework across stakeholders. RQIA observed one workshop considering annual priorities for action, and there was clear evidence of ongoing engagement with the framework process.

Health Impact Assessment
In 2010-11 a health impact assessment (HIA) was undertaken. Those interviewed believed that work on the HIA demonstrated tangible personal and public involvement (PPI), helping to inform the implementation of the framework. It provided an improved understanding of health needs and a baseline for information about cardiovascular health in Northern Ireland. The HIA was also considered to have highlighted inequities in health experience from cardiovascular disease and identified areas where improvements were required.

Availability of Information for Monitoring
As the implementation of the Cardiovascular Service Framework progressed, it led to identification, by the implementation team, of data discrepancies and shortfalls in information required to monitor progress.

In order to address some of the data issues, a Service Frameworks Informatics Working Group was established, led by DHSSPS. In addition, the Regional Informatics Group (RIG) was engaged to seek to bridge the gaps in data required.

The issue of lack of information was a recurring theme during interviews and some of those interviewed questioned the robustness of processes in place to address this issue.

Establishment of Networks
Interviews with stakeholders highlighted the importance of clinical networks in playing a vital leadership role in the development and implementation of the Cardiovascular Service Framework on the ground. There were some very positive perceptions of clinical networks and the work that they have carried out. In particular, their ability to facilitate cross-department/job role collaboration is seen as a major success. One key perceived benefit has been that services are now more

joined-up. Those interviewed stressed that there were clear benefits of having a cardiac network in place throughout the development and implementation stages of the Cardiovascular Service Framework.

Awareness Raising
The Cardiovascular Service Framework was noted to have raised the profile of some particular clinical groups such as adults with congenital heart disease. This had contributed to achieving mainstream funding for some specific service developments.

In particular, the implementation of the Cardiovascular Service Framework did help to underpin some specific initiatives including:

Triple Aim Project
The Triple Aim Project is a collaborative initiative taking place in Causeway and West Belfast Primary Care Partnerships. The aim is to bring about improvements in the identification and management of risk factors for cardiovascular disease, including hypertension. The Triple Aim model is the simultaneous pursuit of population health, enhanced individual care and controlled costs for a population.

Hyperlipidaemia Register
A business case has been developed for a register of patients who have family history of hyperlipidaemia (very high cholesterol). The aim is to identify, screen and treat family members who might be at risk. This initiative was set out in standard 12 of the Cardiovascular Service Framework.

Whiteboard Referral System
A new whiteboard referral system was introduced regionally at minimal cost. All patients requiring angiography are now put on a central queuing system and taken from the queue, regardless of their location.

New Consultant Post for Adult Congenital Heart Disease
As identified as a requirement in the Cardiovascular Service Framework, a new consultant post has been established for adult congenital heart disease in the Belfast HSC Trust.

Brief Interventions within Primary Care
The Cardiovascular Service Framework has raised awareness of the importance of brief interventions in relation to smoking cessation, obesity and alcohol problems. Training on brief interventions has been provided for general practitioners.

Abdominal Aortic Aneurysm (AAA) Screening
Following the publication of the Cardiovascular Service Framework a project was established to introduce a programme of AAA Screening in Northern Ireland. This programme commenced in June 2012 and offers AAA screening to all men in their 65th year in Northern Ireland. Men older than 65 years can opt into the programme, and request screening through the central screening office (PHA).

Fast track system for thrombolysis of stroke
If someone is having a stroke, a system has been put in place where the Northern Ireland Ambulance Service (NIAS) contacts the receiving hospital. If the patient is suitable for thrombolysis they are fast tracked to receive this treatment. NIAS operates a system of diverts to ensure that the patients go to those hospitals that can provide thrombolysis.

Patient and Public Involvement
The inclusion of patient and public involvement (PPI) and quality standards within the framework was welcomed, and was seen as an area for continued development. Considerable benefits have been achieved through collaboration between trusts, which it was noted would not have been achieved by trusts working individually.

Stakeholders described significant benefits achieved through collaboration and the contribution by voluntary agencies to the development of the framework. During implementation there has been continued collaborative/partnership working with various voluntary bodies, the benefits of which included:

- funding for part time trainers for electrocardiograph (ECG)
- support groups for those with chronic diseases
- funding an information DVD for patients requiring an iimplantable cardioverter defibrillator (ICD)
- funding of clinical physiologists
- funding of capital costs of a hypercholesterolemia screening service programme.

Setting Implementation Priorities
To promote shared learning from the implementation process a Service Framework Development Forum has been established which meets several times a year. This brings together the leads for each of the service frameworks, and provides an opportunity to advise key personnel of previous problems and pitfalls and how these may be avoided or addressed. The recent review of the generic standards, for all frameworks, was a direct result of work undertaken by the development forum. Leads from all of the service frameworks provided input into this review.

In general, staff believed that the Cardiovascular Service Framework provided a more "considered and systematic way of doing things"; that it is making improvements to the service on the ground, whilst providing a “reference point for progress”, and that the framework gave an opportunity to “hang out standards in public and to get these achieved”.

6.5 Challenges which Emerged

Establishing Mechanisms for Implementation and Accountability
The review team noted that the Cardiovascular Service Framework was the first framework, launched in June 2009. Members of the team charged with implementation advised the review team that they were exploring new territory with new systems and processes to be put in place.

When the framework was launched there was no agreed plan for implementation. The DHSSPS subsequently asked the HSC Board/PHA to provide an implementation plan. This was produced by October 2009 and was circulated within DHSSPS to policy and professional leads, thus allowing those staff to have a broad overview of the implementation plans.

However, as the programme for service frameworks progressed, it became clear to those involved with implementation that a more formal mechanism for accountability and review was required.

In terms of routine monitoring, at the outset, the implementation of the Cardiovascular Service Framework was a Priorities for Action (PfA) target which required the implementation of agreed standards from the Cardiovascular Service Framework by March 2010. A phased approach to implementation was to be adopted:

- All standards for which there is already a data source in place were to be fully implemented by March 2010.
- For the remaining standards, appropriate steps were to be taken to establish data sources and baselines by March 2010. Performance levels for these standards were to be determined once baselines had been established.

The HSC Board and PHA were required to provide assurance to the DHSSPS in relation to the achievement of all relevant standards on a six monthly basis, linked to the DHSSPS's formal accountability process.

Those interviewed indicated that despite this process, initial accountability for implementation was felt to be unclear. In 2009-10, reporting of progress was described as a low priority during the first stages of implementation. DHSSPS had no specific contact or routine meetings with individual leads for each of the disease groupings. All feedback was via the Long Term Conditions Group to which the Cardiovascular Health and Wellbeing Commissioning Group reported.

The arrangements for accountability are now formally established following the letter of the CMO, dated 22 December 2011.

Availability of Information for Monitoring

When the Cardiovascular Service Framework was launched in 2009, it immediately became apparent that there were issues around baseline measurement, audit of standards and information availability.

Health intelligence expertise was not utilised during the key performance indicators (KPI) development process (except in the case of heart disease where they were represented through the cardiac network). It became clear that data flows would be problematic and as a consequence, significant effort for the first year of the implementation of the framework was spent developing the data flows.

Despite work undertaken, there were difficulties establishing data flows for many elements of the framework. After the first year, the Cardiovascular Health and Wellbeing Commissioning Group was able to document outstanding issues. Due to a programme of ongoing work there are now improvements in most areas, however there are continued difficulties in respect of information in relation to palliative care.

Interviewees advised that the extensive work in relation to data flows meant that the actual implementation of the Cardiovascular Service Framework standards began to lose momentum. In order to reinvigorate the implementation process a workshop was held in June 2010. Following this workshop a series of papers was produced for DHSSPS to distil the information gleaned via the workshop and to analyse the outcomes from this. These included:

- implementation monitoring challenges in relation to KPIs
- data collection issues
- proposed changes for the Cardiovascular Service Framework

The workshop was felt to have provided a major stimulus to the implementation process. In autumn 2010 a service planning template was developed which allowed everyone involved in the implementation process to see the current position and the extent of the progress which was being achieved.

Ultimately the lack of data resulted in an inability to measure some of the KPIs within the Cardiovascular Service Framework. The implementation process was delayed while data sets were established. Despite work being undertaken, there are still continued difficulties in relation to data, including a lack of denominators for measurement, and no mechanisms available for the extraction of some data. There continues to be a lack of standardisation in information collected across the HSC and some of those interviewed felt that there is an over reliance on QOF data to measure progress against the standards.

The lack of data and, therefore, the lack of demonstrable progression was reported to have been both demoralising and frustrating not only for those implementing the Cardiovascular Service Framework but also for those with a particular interest in quality improvement and delivery of these services.

Stakeholders advised the review team that they believed that the HSC Board Corporate Plan should be supported by an information and ICT strategy, outlining how the business needs of the organisation should be met in terms of information and ICT provision.

Discussion with stakeholders around addressing these data issues focused on measuring what matters (the vital signs for improvement). It was noted that perhaps more evidence-based information and research should be used to support standards, KPIs and service developments within the Cardiovascular Service Framework. Stakeholders noted there were disadvantages in having to use national survey data as this may not be representative for Northern Ireland. They identified a need for systems to be linked from primary, to secondary, to intermediate care, to allow for accurate and complete data flows.

While an evidence-based approach is widely welcomed, there were mixed views on the use of targets and the implied development of a target culture. Respondents acknowledged both the advantages and disadvantages of such an approach. There was a variation of opinion among respondents. Some voiced support for the use of targets, whilst others considered that a target driven approach was more punitive, and that they believed that a quality improvement approach would be a more positive driver for implementation.

Organisational Changes
The implementation of the Cardiovascular Service Framework took place at a time of significant organisational change in HSC bodies. During this period, new organisations were established and new commissioning structures were developing. There were changes of leadership across the HSC resulting in a potential loss of relevant expertise. Staff who are now responsible for implementation were generally not involved in the development of the Cardiovascular Service Framework, nor during the initial implementation stages.

Despite the impact of change, the implementation process has continued to move forward. It was believed there had been some loss of opportunities for progression whilst reorganisation was underway. It was also noted that there was a lack of coordinated/organised engagement with patients, trusts and primary care during the implementation process.

Financial Environment
The implementation of the Cardiovascular Service Framework faced a number of financial challenges. The Cardiovascular Service Framework implementation plan was developed at a time when resources were predicted to be available to support the implementation. When the framework was issued in June 2009 it was announced that it would be underpinned by a £16 million investment in cardiovascular and stroke services. An additional investment of £1.54 million was made in General Medical Services in support of a directed enhanced service (DES) in cardiovascular primary care. Due to funding constraints in the later years of implementation, this amount had to be scaled back.

The review team was advised that there was no specific budget allocated for the implementation of the framework. It became clear that the implementation process for the framework would not be cost neutral.

The first year of implementation also coincided with the establishment of the first Health and Wellbeing Investment Plan (HWIP) 2007-10, which set out planned funding for a three-year period. In the third year there was significant pressure on HSC budgets and the third year's planned funding did not materialise.

Commissioning Structures
During the period 2009-12 new commissioning structures were put in place following the establishment of the Health and Social Care Board. In 2010 HSC Board commissioning teams (service teams) were being established within this structure. The Cardiovascular Health and Wellbeing Commissioning Group was accountable to the Long Term Conditions Commissioning Group.

Since the launch of the framework in 2009 there have been a number of other strategies launched. This has resulted in competing priorities for staff, resources and funding. Some of those interviewed indicated that the Cardiovascular Service Framework did not receive a high enough priority on the commissioning agenda.

The need to have a commissioning structure to support the implementation of the framework was highlighted by stakeholders. It was concluded that the process needed to be reviewed to reflect new arrangements being put in place, including the creation of integrated care partnerships.

Establishment of Networks

A need for networks to support implementation of frameworks was clearly identified. Stakeholders expressed a clear desire for the establishment of a cardiovascular network to encourage all relevant bodies to work together to achieve the goals of the Cardiovascular Service Framework. Stakeholders considered that the success of the Cardiac Network demonstrated the key role of networks in framework implementation.

Diabetes

One particular area of the Cardiovascular Service Framework where progress was limited is diabetes. Stakeholders concluded that this element was lost within the overarching Cardiovascular Service Framework. Discussions with stakeholders centred on the issue of diabetes being too complex to be part of a wider framework; it was considered there was a clear need for a stand alone framework. Despite this, some initiatives within diabetes were found to be progressing; however this progression was not directly attributable to the implementation of the Cardiovascular Service Framework.

Research and Development

The review team was advised that a perceived gap in the Cardiovascular Service Framework was the absence of standards related to research. It was believed that the inclusion of a generic research standard for future frameworks would be beneficial, with appropriate key performance indicators to enable achievement of the standard.

7. Conclusions

7.1 Context

The process to develop service frameworks for health and social care in Northern Ireland was initiated in 2007. The first framework, for cardiovascular disease services, was launched in June 2009. This review was established to consider the arrangements for implementation which were in place over the three-year period to 2012.

During the first three years of the framework, the wider environment in which it was being implemented changed significantly. Funding in the first two years allowed several important developments set out in the framework to be taken forward, however, in 2011-12, there was very limited funding available. New HSC organisations were created in 2009, which played key roles in the implementation process. Important strategic initiatives were established, which will impact on the future design and delivery of services. New developments in care and treatment continued to emerge, together with new evidence about effectiveness of different types of treatment.

When carrying out this review, RQIA was impressed by the enthusiasm and commitment of many individuals to ensure the standards set out in the framework were taken forward. The framework approach was very widely supported and there was a general belief that the Cardiovascular Service Framework had facilitated service improvement and development during this period. There was strong support for the view that the momentum generated by the framework needed to be maintained.

Against this background, RQIA considers that important lessons have emerged from the review which can inform the implementation of future service frameworks.

7.2 The Implementation Process for the Cardiovascular Service Framework

Establishing Mechanisms for Implementation and Accountability
The Cardiovascular Service Framework was launched in 2009 at a period of significant change in HSC organisational structures in Northern Ireland. When the framework was published there was not a specific blueprint for the implementation process. A key decision was taken when DHSSPS requested that the HSC Board and PHA should develop a plan for the phased implementation of the framework. RQIA has concluded that this ensured that there was clear organisational responsibility to take the process forward. The accountability arrangements for the implementation of service arrangements were strengthened in December 2011 through the issue of a letter by the CMO setting out areas of organisational responsibility.

In response to a request from DHSSPS, HSC Board and PHA identified a public health consultant as the lead for both organisations in taking the framework implementation forward. This responsibility subsequently passed to a second public health consultant. From a review of documentation, and the findings from

interviews, RQIA has concluded that the identification of a regional implementation lead has been critical in maintaining positive momentum on implementation of the framework going forward. Given the many organisations and individuals who have roles in taking such a wide ranging framework forward, it is recommended that a regional lead is identified for the implementation of each service framework when it is launched.

Financial Environment

During the development of the framework careful consideration was given by DHSSPS to the financial environment in which it would be implemented. The framework had an intended lifespan of three years, and the standards in the framework were not intended to be comprehensive, but to represent key areas for focus. The investment required to support the standards and milestones set out in the framework were identified. During the time period for implementation, however, the resource environment changed significantly.

In the first year of implementation, there was a significant investment in services relating to the framework. The prioritisation process which had taken place during the development phase facilitated agreements on where the investments should be targeted to best effect. By the third year of implementation, resources were very constrained and planned service developments linked to the framework standards were revised accordingly.

Perceptions of the success of the framework implementation have been influenced by the constrained financial environment during this period. Nevertheless, RQIA found that the concept of a framework setting out commonly agreed standards is widely accepted, regardless of the resource environment in which it is to be implemented.

Availability of Information for Monitoring

At the time of launch, there was no agreed plan for implementation. As this was being developed, a constraint emerged in relation to the availability of information to enable effective monitoring against progress towards some of the standards. This led to significant frustration among those responsible for implementation. Subsequently, a Service Frameworks Informatics Group was established by DHSSPS and processes to monitor progress were put in place for those standards where data was available.

An annual report on progress has been a key document in ensuring that progress is reviewed against the whole framework. RQIA recommends that the availability of data to support the monitoring of progress should be examined during the development phase of each future service framework.

Developing high level indicators of progress

Monitoring of the framework has included consideration of each of the individual standards of the framework. However, there were no agreed high level indicators for overall progress in tackling cardiovascular diseases set out in the framework. In England there is a move towards a vital signs approach to monitor overall progress of framework outcomes. This involves selecting a small number of indicators which are regularly monitored and the results disseminated. RQIA recommends that this approach is considered for future frameworks in Northern Ireland.

Setting Implementation Priorities
During the period of implementation of a service framework it is inevitable that there will be changes which will impact on the implementation process. Service frameworks in Northern Ireland have been established with a three-year time frame and there are arrangements in place for review. RQIA found that for the Cardiovascular Service Framework, a key learning point has been the benefit of setting up regular annual events to bring together stakeholders to consider the priorities for implementation for the next year. It is recommended that similar arrangements to prioritise actions for implementation are established for each subsequent service framework.

7.3 The Effectiveness and Impact of the Cardiovascular Service Framework on the Delivery and Development of Services

The Cardiovascular Service Framework was selected as the first regional service framework to be developed in view of the impact of cardiovascular diseases on illness (morbidity) and premature death (mortality) in Northern Ireland.

During the past 10 years, there have been very significant reductions in overall death rates from heart disease and stroke. These welcome trends have continued during the period of implementation of the framework. However, there is evidence that the rates of decline are lower in deprived areas compared to affluent areas, leading to increasing gaps in health outcomes.

RQIA has concluded that the process of implementation of the framework led to improved coordination and prioritisation of actions to tackle cardiovascular disease. The framework was built on key strategic initiatives such the Regional Stroke Strategy and the work of the Regional Cardiac Services Network. While the framework created a vehicle to bring these together it is difficult to disaggregate the unique contribution of each of them to the service improvement which has occurred.

A number of key service improvements and developments were highlighted by those interviewed as having been underpinned by the service framework implementation process. These included:

- establishment of a new consultant post for adults with congenital heart disease
- introduction of a screening programme for abdominal aortic aneurysms
- expansion of arrangements for fast tracking of thrombolysis for stroke
- creation of a hyperlipidaemia register
- roll out of programmes of brief interventions in primary care

In addition, the framework implementation process was supported by local initiatives to tackle cardiovascular disease. Examples included:

- West Belfast Partnership Healthy Hearts Project
- Triple Aim GP Cardiovascular Risk Factor Reduction Closing the Gap Project

West Belfast Partnership Healthy Hearts Project

Levels of Cardiovascular Disease including heart disease and stroke are higher in West Belfast, an area of severe socioeconomic deprivation, than most of Northern Ireland, causing disability and premature mortality.

Healthy Hearts in the West is a cardiovascular strategy for West Belfast, funded by PHA, Belfast Local Commissioning Group and Belfast Health Development Unit. It aims to raise awareness of cardiovascular disease, and involve people in a range of healthy activities. A major focus of Healthy Hearts in the West is promoting prevention of cardiovascular disease.

The Cardiovascular Service Framework was designed to cover a wide range of disease areas. In relation to diabetes, RQIA found that there were strong and widely held views that the service framework process had not been effective. Diabetes was considered to be too complex to be part of a generic cardiovascular disease framework. RQIA was informed that there has been significant progress in relation to services for diabetes but this had not been attributable to the framework.

RQIA has been advised that the Minister has instigated a review of the current Joint CREST/Diabetes UK taskforce report. The scope of the review encompasses the following areas;

- assessment of progress against report objectives
- assessment of current standards of care and their appropriateness
- identification of emergent issues
- assessment of the new policy context and proposed implementation mechanisms

It is envisaged that the recommendations following this work will enable a more strategic joined up regional approach to the development of diabetes services. The review group is also looking specifically at the diabetes standards as part of the fundamental review of the Cardiovascular Service Framework.

7.4 Involvement in the Implementation Process

The process for development of service frameworks in Northern Ireland was specifically designed to ensure that there was wide involvement of patients, service users and clinicians. RQIA met with representatives of patient groups and voluntary organisations to seek their views of the effectiveness of engagement in the implementation process. Interviews were also held with clinicians who had been involved in the development of the framework.

RQIA found that voluntary organisations and patient groups have contributed significantly to partnership working in relation to the framework implementation. A number of specific initiatives have been funded by voluntary organisations, such as electrocardiograph (ECG) training, information DVDs, equipment for screening and support group costs.

A strong view was held by both patient representatives and clinicians that implementation of a framework is greatly facilitated by having a related clinical network in place, with effective arrangements for patient involvement. The links between clinical networks and framework implementation have also been highlighted in England.

The development and implementation of the Cardiovascular Service Framework in Northern Ireland was facilitated by the work of the Regional Cardiac Services Network. RQIA understands that discussions are taking place to establish a wider cardiovascular disease clinical network. It is recommended that this network is given a lead role in ensuring that there is effective engagement of all relevant interests in the implementation process for the framework in the future.

The processes for engagement during framework development were commended. However, some of those interviewed by RQIA consider that there was less effective engagement during the implementation process. For all future frameworks, consideration should be given to facilitating effective arrangements for engagement of patients, service users and staff during implementation.

During the implementation period, it was agreed that a Health Impact Assessment (HIA) should be carried out on the framework. This proved to have significant benefits including:

- highlighting the differential impact of falling death rates from cardiovascular disease on areas of high deprivation compared to areas of affluence
- demonstrating the potential for frameworks to be used as a vehicle to improve health and to tackle inequalities
- helping maintain focus on the implementation process for the framework
- collating and analysing relevant data
- highlighting a number of areas for action to enhance the impact of the framework

RQIA recommends that consideration should be given to carrying out similar health impact assessment work in relation to future frameworks.

7.5 Summary of lessons learned from the implementation process for other frameworks

RQIA has concluded that, from the evidence collected in this review, key lessons for the implementation of future service frameworks include:

- the development of a service framework provides the opportunity to create a common vision for service development between commissioners, providers, patients and staff
- there is a need to plan mechanisms to ensure that an effective engagement process is maintained after a framework is launched, to avoid loss of momentum
- implementation of a service framework requires clear organisational accountability and is facilitated by having a designated regional lead
- clinical networks with strong patient and service user engagement can play a key role in the implementation process

- a small number of high level indicators should be agreed to monitor progress on the framework.

8. Recommendations

1. Clear organisational responsibility and accountability arrangements should be established for the implementation of each service framework when it is launched.

2. A regional lead officer should be identified to take forward the implementation of each service framework when it is launched.

3. The availability of data to support the monitoring of progress on implementation should be examined during the process of development of each service framework.

4. For each service framework, a small number of high level indicators should be selected for assessing progress towards the goals of the framework.

5. The implementation process for each framework should include arrangements to ensure on-going participation of all key stakeholders in the development of annual action plans after the framework is launched.

6. The standards relating to diabetes should be reviewed as part of the fundamental review of the Cardiovascular Service Framework.

7. Clinical networks should be facilitated to play active roles in the development and implementation processes for future service frameworks.

8. The Regional Cardiovascular Network, when established, should have a key role in ensuring that there is an integrated approach to the implementation of the cardiovascular services framework and that there is effective involvement of all relevant interests in this process.

9. For all future service frameworks, effective arrangements should be put in place for on-going engagement of representatives of patients, service users and staff during implementation.

10. For future service frameworks, consideration should be given to carrying out a health impact assessment, to inform the implementation process.

Appendix A: The Standards in the Service Framework for Cardiovascular Health and Wellbeing

Standard 1: Health professionals should keep all patients and their families and carers fully informed about their diagnosis and treatment. Each time they come into contact with the Health Service we should tell them clearly about the care and treatment we are offering.

Standard 2: Health professionals should provide opportunities for patients, carers and the public to get involved in planning and providing health and social care.

Standard 3: Health professionals should work with voluntary, education, youth and community organisations to stop young people becoming smokers.

Standard 4: Health professionals should identify people who smoke and make them aware of the dangers. They should help them by giving them information on stopping and telling them about services that can help them to stop.

Standard 5: Health professionals should identify people who do not take enough exercise. If appropriate, they should give advice and support on the best way to take moderate exercise through everyday activities for at least 30 minutes a day, five times a week.

Standard 6: People should be given support and advice to eat a healthy diet.

Standard 7: Health professionals should work with early years organisations, schools, workplaces and communities to help prevent obesity by promoting breastfeeding, healthy eating and physical activity.

Standard 8: Health professionals should identify people who drink harmful amounts of alcohol, advise them of the dangers and, if necessary, provide them with additional information.

Standard 9: Health professionals should work with schools, workplaces and communities to increase the emergency life support (ELS) skills of members of the public.

Standard 10: All adults should be advised on how to keep their blood pressure at the right level and have it checked every five years from age 45.

Standard 11: Everyone with high blood pressure should be offered drug treatment if:

- their reading is regularly 160/100 mmHg or higher, or
- regularly 140/90 mmHg or higher with an increased risk of heart disease, stroke, kidney disease or diabetes (because of family history, for example).

Standard 12: Everyone with a family history of familial hypercholesterolaemia, or FH (very high cholesterol), should be identified and treated. Their names should be

kept on a register to help identify, screen and treat other family members who might be at risk.

Standard 13: Everyone who has diabetes should have an accurate diagnosis.

Standard 14: Everyone with diabetes should be offered patient education programmes and emotional and psychological support.

Standard 15: All patients with diabetes should be offered a review of their condition at least once a year by a multidisciplinary team.

Standard 16: All pregnant women should be screened for congenital heart disease in their babies and have specialist services if a condition is found.

Standard 17: All children suspected of having a major congenital heart disease and acquired heart disease should have access to rapid diagnosis and specialist treatment.

Standard 18: Everyone suspected of having an inherited heart disease should have services that are designed to meet their needs, led by a consultant.

Standard 19: All adults with major congenital heart disease should have specialist services designed to meet their needs, led by a consultant.

Standard 20: Everyone diagnosed with an abnormal heart rhythm should receive fast assessment, treatment and support.

Standard 21: Everyone diagnosed with atrial fibrillation (AF) should receive fast assessment, treatment and support that are designed to meet their needs.

Standard 22: All patients suspected of having heart failure should be offered an electrocardiograph (ECG) and blood tests at their doctor’s surgery.

Standard 23: Everyone diagnosed with heart failure should be given the appropriate medicine and have their care guided by a specialist team.

Standard 24: Anyone suffering the most severe type of heart attack should receive clot busting drugs within one hour of calling for medical help. (The exceptions are patients who need a different type of emergency treatment and patients for whom clot busting drugs are not suitable.)

Standard 25: All patients who need help to readjust to life after a heart attack or heart surgery should be offered cardiac rehabilitation.

Standard 26: All patients with new chest pain suggesting angina should be examined at a rapid access chest pain clinic (RACPC) clinic within 14 days of being referred by a doctor.

Standard 27: All high-risk patients who suffer a less serious form of heart attack should have an angiogram or a referral for coronary bypass surgery within 72 hours of being diagnosed.

Standard 28: All patients suspected of having pulmonary arterial hypertension (PAH) should have their condition managed swiftly by a specialist team.

Standard 29: Anyone suspected of having a mini stroke, or transient ischaemic attack, should have rapid specialist assessment, diagnosis and treatment to avoid a major stroke.

Standard 30: Everyone suspected of having a stroke should have rapid access to specialist assessment, brain scans and emergency treatment, including clot busting drugs.

Standard 31: Everyone who has had a stroke should have access to a specialist stroke rehabilitation team in a stroke unit as soon as they go into hospital. Where necessary, the rehabilitation team should continue to work with the patient after they leave hospital.

Standard 32: Everyone who has had a stroke or a mini stroke should have a review in primary care at six weeks, six months and annually after leaving hospital. Those with continuing disability after six months should also be reviewed by a specialist team to assess the need for further rehabilitation or psychological support.

Standard 33: Everyone with a high risk of developing peripheral vascular disease (PVD) such as patients with diabetes, chronic kidney disease, smokers and the elderly should have easy and timely access to a specialist foot care team.

Standard 34: Everyone with an abdominal aortic aneurysm (AAA) should have the best treatment. Patients with a swelling wider than 5.5cm should be considered for standard or keyhole surgery to repair it. All men aged 65 and over should be offered screening for the condition.

Standard 35: Everyone who has taken a mini stroke with narrowing of the neck arteries of between 70% and 99% should have surgery of the affected area within two weeks. In the long term, the aim should be to reduce this to 48 hours.

Standard 36: Everyone who experiences leg pain that suggests peripheral arterial disease (PAD) should have an ankle-brachial pressure index test at their doctor’s surgery.

Standard 37: Everyone who has symptoms of thoracic aortic dissection should be assessed and referred to a treatment centre straightaway.

Standard 38: Everyone who has developed lymphoedema, or is at risk of developing it, should be offered information, assessment and treatment.

Standard 39: Everyone with chronic kidney disease (CKD) should receive fast and effective treatment and follow-up.

Standard 40: All dialysis patients should receive a high standard of safe and effective care, designed around their needs and available to all ages, provided by highly skilled teams.

Standard 41: All patients likely to benefit from a kidney transplant should receive a high standard of service to help them through the transplant and achieve the best possible quality of life.

Standard 42: Everyone at risk of acute kidney injury (AKI) should be identified quickly and referred to a specialist renal team where necessary. Prevention of AKI should be a priority in the Health Service.

Standard 43: All patients with advanced cardiovascular disease, and their families and carers, should be helped to identify and talk about the individual palliative and end of life care they need.

Standard 44: All patients with advanced cardiovascular disease, and their families and carers, should have their palliative needs met promptly to an agreed plan of care. They should have a named team member as a main point of contact.

Standard 45: All cardiovascular patients who need end of life care, and their families and carers, should have the information they need about their choices. They should have their dignity protected, and be given the maximum end of life comfort.

Appendix B: Chronology Overview

DATE	EVENT/ACTION
13 February 2007	Letter from the Chief Medical Officer to the director of Public Health, Eastern Health and Social Services Board, and chair of the Regional Cardiology Network requesting the establishment of a process to develop a Cardiovascular Health and Wellbeing Service Framework. The letter outlines that a first draft of the framework should be completed by December 2007.
1 March 2007	Letter from the Chief Medical Officer and Deputy Secretary DHSSPS to HSC organisations announcing the establishment of a programme to develop service frameworks.
23 April 2007	Correspondence from the DHSSPS enclosing a standardised template for the development of frameworks which was issued to ensure consistency of approach across all the frameworks to be developed.
27/28 September 2007	A two day workshop was held to look at the progress in developing the Cardiovascular Service Framework, to identify any gaps or overlaps and to decide how this work should be taken forward.
17 June 2008	The Cardiovascular Service Framework was issued for public consultation until the end of September 2008.
12 June 2009	Letter from DHSSPS to HSC Board and PHA, copied to trust Chief Executives, regarding the Service Framework for Cardiovascular Health and Wellbeing. This letter requested that the HSC Board and the PHA to : • develop a plan for the phased implementation of the Cardiovascular Service Framework. • submit a jointly agreed plan by 30 September 2009 for the phased implementation of the framework by March 2012. • provide assurance to the DHSSPS in relation to the achievement of the framework standards on a six monthly basis. This letter also stated that the Cardiovascular Service Framework would be underpinned by a significant investment of £16 million in cardiovascular and stroke services and an additional £1.54 million in general

	medical services in support of the cardiovascular Directed Enhanced Service (DES).
17 June 2009	The Cardiovascular Service Framework is formally launched by Michael McGimpsey, MLA, then Minister for Health, Social Services and Public Safety.
17 August 2009	Letter from PHA to the chief executives of HSC trusts regarding the Cardiovascular Service Framework. This letter asked trust chief executives to provide a named contact in each trust with whom the PHA Cardiovascular Service Framework implementation lead could liaise, in the development of an implementation plan for the framework.
26 August 2009	First meeting of the Cardiovascular Health and Wellbeing Commissioning Group (CVHWCG). At this meeting the phased plan for implementation was discussed. It was agreed that a workshop was needed to work through the standards and agree data definitions, sources and data flows. There was also discussion around the need to submit a phased implementation plan to the DHSSPS by 30 September 2009.
28 September 2009	Workshop held by CVHWCG to develop and agree the implementation plan. Workshop participants comprised members of CVHWCG, trust representatives and a representative from the Patient and Client Council. The implementation plan detailed the need to: • establish data definitions, identify data sources and secure data flows • undertake relevant audits • establish baselines • identify progress to date • enhance the quality and safety of care • improve services through commissioning Individual members of CVHWCG were given responsibility for overseeing and ensuring implementation of specific sections of the framework.
29 October 2009	A detailed implementation plan for the framework was approved by the board of the HSC Board.
30 November 2009	A data workshop was held by CVHWCG to discuss data flows. The workshop was designed to ensure that the KPIs were clearly defined; a report on the first year of implementation 2009-10 was required to be submitted by

	mid 2010. A full report was produced by CVHWCG advising the DHSSPS on the data issues that were emerging, the capacity constraints and systems constraints faced during the implementation process. This provided a detailed template for each of the 77 KPIs associated with the framework describing • what the KPI related to • the work outstanding in relation to data flows • the work outstanding in relation to service delivery • the work outstanding in relation to the commissioning plan At that time it was highlighted that new electronic data collection systems would need to be designed as some of the information collection in relation to KPIs was dependent on regional databases.
14 December 2009	Meeting of CVHWCG. This meeting discussed the output from the data workshop held on 30 November 2009. Work began to establish data flows which matched to the KPIs.
27 January 2010	Letter from PHA to trusts re the implementation of the Cardiovascular Health and Wellbeing Framework asking for • Details of how the trust was taking forward the implementation of the framework • Name of the lead contact person within the trust
22 February 2010	Meeting of CVHWCG. Approval had been given from the chief executive of PHA for a proposal to undertake a health impact assessment (HIA) of the Cardiovascular Service Framework. A steering group was to be established to take this forward.
28 April 2010	Meeting of CVHWCG. A traffic light progress update was circulated. It was agreed to forward this to the DHSSPS. Following group discussions it was agreed that a stakeholder event should be held in June 2010 in relation to the framework. An update on the first meeting of the HIA steering group was given.
25 May 2010	Workshop held to discuss the preliminary findings of an audit of health improvement processes relating to health improvement standards in the framework. This was

	undertaken in a sample of GP practices as a first step in establishing the baseline data required for a number of the standards.
24 June 2010	The first annual review workshop of the Cardiovascular Service Framework was held. This workshop was held to reinvigorate the implementation process, it specifically looked at • what needed to happen next • what needed to go into the HSC Board/PHA commissioning plan Participants in this workshop included managers, clinicians, staff and service users. Following the workshop a series of papers was produced for the DHSSPS to distil the information gleaned via the workshop and to analyse the outcomes from this. These included: • Implementation monitoring challenges in relation to KPIs • Data collection Issues • Proposed changes for the Cardiovascular Service Framework • First annual report of the Cardiovascular Service Framework implementation process.
28 June 2010	Meeting of CVHWCG. The group was given feedback from the workshop held on 24 June 2010. A final report on progress on 2010 targets was to be sent to the DHSSPS by the end of July 2010 including updated KPI worksheets and an updated traffic light report.
21 October 2010	A progress report on the Cardiovascular Service Framework Implementation was provided to the management team of the PHA. This report outlined the progress made and the challenges met on the Cardiovascular Service Framework implementation since April 2010. The report stated that implementation had been less labour intensive as effective information management and communication mechanisms now put in place could be built upon. It outlined the use of the results of the HIA in service planning and project design informing work especially in health improvement, community development and primary care. It stated that progress in some areas was not fully reflected due to the lack of corresponding standards and KPIs. It was noted that resource constraints have led to performance against

	some KPIs remaining static or deteriorating.
21 November 2010	The Director of Public Health's Annual Report provided an update on cardiovascular disease in Northern Ireland.
15 December 2010	Regional Service Frameworks: Health Improvement Standards Workshop was hosted by the PHA. The aim of the workshop was to raise awareness of progress in implementing the health improvement standards, which are common across all service frameworks, and to identify the actions required to further progress the implementation of these standards.
20 December 2010	Meeting of CVHWCG. The group was advised that suggestions for the HIA had been circulated to the Cardiovascular Service Framework leads to be considered for inclusion in the relevant service plans.
17 February 2011	Letter from DHSSPS to PHA implementation lead in relation to agreeing changes to the service framework for the next period. 1. Changes considered necessary during the lifecycle of a service framework and identified through the annual review process would be considered by the Service Framework Delivery Unit and subsequently the Service Frameworks Programme Board. 2. Following the three-year implementation period of a service framework, it will be formally reviewed in the fourth year, with a revised version released the following year. 3. Generic standards will be reviewed separately, with the first review happening in 2011-12
28 February 2011	Meeting of the CVHWCG. Letter about process to consider proposed changes to the Cardiovascular Service Framework was discussed and was circulated to leads for integration into data collection for 2010-11.
28 March 2011	Meeting of CVHWCG. The group discussed the adoption of proposed changes to the KPIs within the service framework.
18 April 2011	Meeting of CVHWCG. The group was advised that service planning for 2011-12 was underway and data collection for the KPI measurement of the Cardiovascular Service Framework was ongoing. A report to the DHSSPS is to be finalised mid-summer 2011.
23 May 2011	Meeting of CVHWCG. The group was advised that an annual report on performance in relation to the

	Cardiovascular Service Framework was being produced. A service planning workshop was to be organised for the autumn to allow feedback and the development of service plans.
1 June 2011	Launch event for the Health Impact Assessment of the Northern Ireland Cardiovascular Service Framework
27 June 2011	Meeting of the CVHWCG. The group was advised that the majority of data in relation to the KPIs within the Cardiovascular Service Framework had been collected and that an update traffic light report on these KPIs was to be circulated. The group discussed a draft paper on the establishment of a Cardiovascular Network. The proposal paper had been drawn up following an HSC workshop on the need for clinical engagement and future managed clinical networks held in May 2011. It was agreed that the establishment of such a network would be very useful and that it would provide structure for the implementation of regional policies and strategic priorities on an equitable and sustainable basis for Northern Ireland.
26 September 2011	Meeting of the CVHWCG. A final draft of the annual report and the updated traffic light progress report was to be submitted to the DHSSPS in September 2011.
18 October 2011	Cardiovascular Health and Wellbeing Service Framework Workshop. The aims of the workshop were to: • review the progress on implementation of the framework and the development of a Cardiovascular Network • agree quality improvement initiatives to progress the achievement of standards and key performance indicators • to prepare cardiovascular service developments and contributions to the joint Commissioning Plan for 2012-13
28 November 2011	Meeting of CVHWCG. The group was advised that a presentation on the Cardiovascular Service Framework, its achievements and challenges to the trust performance management directors went ahead on 9 November 2011. Feedback was reported as positive with a good deal of support for service frameworks. Discussion was held in relation to the updated Cardiovascular Managed Clinical Networks paper and

	discussion was to be held with the commissioning teams regarding the process for seeking funding to support the network.
November 2011	Terms of reference for the Service Frameworks Informatics Steering Group (established in 2010) were agreed. The aim of this group is to ensure that a strategic approach is taken to the development of information requirements for service frameworks. This group is chaired by the DHSSPS and includes representatives from each service framework team.
15 December 2011	Final draft of the annual report and the updated traffic light progress report was submitted to the DHSSPS.
22 December 2011	Letter from the Dr McBride, CMO, stating that accountability for the implementation of all service frameworks had been strengthened. The DHSSPS will now ask for assurance to be given at the regular accountability meetings (twice yearly). It will now be for the HSC Board/PHA also to secure assurance on progress made from individual trusts and other service providers where relevant. This letter further states that RQIA is currently undertaking its appraisal of the implementation of the Service Framework for Cardiovascular Health and Wellbeing. The framework was due for fundamental review in 2012-13 and the RQIA report would contribute to this.
21 March 2012	A DHSSPS review of diabetes services is announced at a workshop hosted by the South Eastern HSC Trust.
26 March 2012	Meeting of CVHWCG. The annual report on the implementation of the Cardiovascular Service Framework had been sent to the senior management team of the PHA. This was also to be shared with the senior management team of the HSC Board There was continued discussion on the development of a cardiovascular network. The substantive review of the Cardiovascular Service Framework was discussed. The guiding principles and terms of reference for the review were discussed and section leads were appointed.
28 May 2012	Meeting of CVHWCG. An update was given from RQIA on the Review of the Implementation of the

	Cardiovascular Service Framework. A research and development office representative joined CVHWCG. The original version of the Cardiovascular Service Framework did not include any standards specific to research. This was to be reviewed as part of the ongoing substantive review.
11 June 2012	Revised generic standards for inclusion in all service frameworks were launched for public consultation by the Minister for Health in Northern Ireland. Following an evaluation and review of the current generic standards, several proposed amendments had been made. New standards were proposed in areas such as carers, community development and person-centred care, independent advocacy and safeguarding. These additional standards reflected further priority areas for the Department and their inclusion as generic standards was designed to raise the profile of these important issues.
20 June 2012	RQIA held a stakeholder summit workshop as part of the validation process for the Review of the Implementation of the Cardiovascular Service Framework.

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