POLICY INTO PRACTICE

PUTTING VASCULAR DISEASE MANAGEMENT INTO PRACTICE

Insights from a Series of UK Workshops

Quantitative & qualitative reactions, ideas and progress from grassroot clinicians and managers on the implementation of the NHS Health Check programme, nice lipid modification, nice type 2 diabetes: newer agents and self management in cardiovascular disease



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LEAD ORGANISATION:

PCCS

IN ASSOCIATION WITH:

NHS Diabetes

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Creating Successful Partnerships Where Medicine Meets Management

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INTRODUCTION

2009/10 is the first year of implementation of the NHS's vascular assessment and management programme known as the 'NHS Health Check'. In June and September 2009, the Primary Care Cardiovascular Society (PCCS) held, with other professional bodies and charities[1], a series of regional interactive workshops to discuss putting vascular disease management into practice.

Patient-centred care and the development of chronic disease self-management programmes within primary care were featured in the workshops as was medical management of diabetes, heart disease and obesity. Syndicate meetings took place after presentations to discuss the issues involved locally and share experience. Keypad voting captured participant opinion and progress in vascular disease management.

The workshops, run by Medical Management Services (UK) Ltd, but created for the PCCS in association with the other professional bodies, were held under the group title Commissioning integrated vascular disease prevention and management. The five workshops were held in Warrington, Walsall, London, Glasgow and Leicester. This report captured highlights from the first three of these, all of which took place in June 2009.

[1]The Primary Care Cardiovascular Society (PCCS) in association with: NHS Alliance; National Obesity Forum; Primary Care Diabetes Society; Scottish Heart and Arterial Risk Prevention Group (SHARP); Diabetes UK; HEART UK; NHS Diabetes. The workshops and reports were produced with an educational grant from MSD.

The workshops and reports were produced with an educational grant from MSD.

Keypad feedback: Participants at Warrington, Walsall, London (N=380)

Key pad voting of the 380 participants from the three workshops revealed that the meeting split between clinical providers and payers/commissioners as follows:

Clinical providers*	43.0%
PCT/PBC commissioners, PCT board directors etc	42.2%
Cardiac or Diabetes Networks, hospital managers	13.8%

*GPs, consultants, nurses, treatment advisers, pharmacists, medicines management leaders

EDITORIAL

FROM THE PRIMARY CARE CARDIOVASCULAR SOCIETY

The Primary Care Cardiovascular Society (PCCS) welcomed the announcement of the introduction of a national Vascular Checks programme at the start of 2008, not least because the Society had been actively campaigning for a primary prevention programme for cardiovascular disease for several years previously.

Since that announcement, the PCCS has worked closely with the Vascular Team at the Department of Health to provide input and support to what has become the NHS Health Check programme. In addition, we have developed complementary cardiovascular education programmes such as a vascular risk resources toolkit and supporting workshop to facilitate non-spearhead PCTs to establish the health check programme in their locality; provided education and practical training courses on cardiovascular risk to key individuals responsible for delivering the health checks; initiated health checks in the workplace and contributed to the development of an interactive web-based behavioural change programme to assist individuals at moderate risk to modify their lifestyles and maintain good cardiovascular health.

The overall aim of the PCCS is to improve the care and outcome of people with or at risk of cardiovascular disease in the community setting. A key component of all our activities is to encourage the exchange of information and share examples of best practice. The Society was therefore delighted to accept the opportunity to lead on a second series of interactive workshops during 2009 on the subject of Putting Vascular Disease Management into Practice, organised through Medical Management Services with funding through an educational grant from Merck Sharp & Dohme.

As you read the following pages, you will appreciate that these workshops provided an ideal opportunity for NHS healthcare professionals, commissioners and providers to join forces to discuss issues and opportunities surrounding the national roll out and implementation of the Health Check programme, guidance on CVD risk factor management, new models of care and best practice, and the introduction of patient self management programmes.

The importance of joint working was a common theme throughout, and not just between the NHS workforce. Engagement with the individual concerned is a vital step in encouraging buy-in, commitment, and acknowledgement that they have a personal responsibility for improving and maintaining their cardiovascular health.

We tend to think of the National Health Service in terms of treating illness and disease. However, with more team working and exchange of best practice and models of care to help guide the effective implementation and follow up of the Health Checks Programme, we have a real opportunity to modify these perceptions such that the NHS becomes synonymous with promoting health, not just treating the sick.

Dr Fran Sivers, PCCS Executive Director, September 2009

FROM THE NHS ALLIANCE

The NHS Alliance were pleased to join forces with the PCCS and others through Medical Management Services to run a number of workshops looking at putting Vascular Disease Management into Practice during 2009. As this is the first year of implementation of the national vascular assessment and management programme (NHS Health Check) it was of vital importance to bring NHS clinicians and managers to review and plan implementation.

The reform programme in the NHS has attempted to achieve a number of objectives, but at its heart is health improvement and a reduction in health inequalities. The focus must now be on implementation and not policy alone. That is why the Vascular Disease Management Programme is not only one of assessment but also risk management. Put simply, there is no advantage in knowing about the extent of a problem without doing something about it. The workshops focused on this aspect, with practical examples given as to how health communities locally could plan to meet the challenge of improving health and targeting those most in need. This is of course a long term programme, which will produce results in both the short and long term.

One of the keys issues that have undermined the NHS for many years is a tribal approach. The Programme requires collaboration at all levels to produce both a vertically and horizontally integrated approach to disease management. Whilst there may be different views on who should lead - this has to be a partnership between primary and secondary care and across the different disciplines in primary care.

To achieve the potential of health improvement, we need not only effective health care, but also motivated, empowered and engaged communities and patients. This was a particular aspect explored at the workshops and rightly so. The consultation is a meeting of two experts, a notion going back to ancient Chinese medicine, with the clinician an expert in the disease, and a patient an expert in themselves and their circumstances. The phrase 'nothing about us without us' has been used for over 20 years as a slogan to promote the rights of disabled people, and was adopted in the Department of Health white paper on the strategy for services for people with learning disabilities, 'Valuing People', 2001. It is appropriate to vascular disease as it was to other areas. We need to learn how to engage and enable people to make the big difference to their own lives – this is the key to population health improvement.

Michael Sobanja, Chief Executive of the NHS Alliance

UPDATE ON THE 'NHS HEALTH CHECK' PROGRAMME

About 85% of Primary Care Trusts (PCTs) will have initiated the NHS Health Check programme by the end of 2009. This is the current estimate from the Department of Health (DH) presented at separate workshops by Professor Roger Boyle, National Clinical Director for CHD, Heather White, Deputy Branch Head for the Vascular Programme, DH.

This initiative is aimed at prevention of heart disease, diabetes, stroke and chronic kidney disease in the population through modifying the risk factors these diseases have in common. The programme has evolved with the input of stakeholders, learning networks, and other events. The speakers described the core elements of the programme and reported progress.

Vascular Risk Assessment and Management

Professor Boyle said that the 'NHS Health Check' is not only a risk assessment but also a management programme. He said, 'It begins with the vascular check. This is a single, universal, integrated check for all people aged 40-74, aimed at risk assessment as a first step to help prevent heart disease, diabetes, stroke and chronic kidney disease.' Then the individual is offered management - a tailored package of specific preventive measures according to specific levels of risk:

- Those found to be at low risk levels receive advice on staying healthy and have the check repeated in 5 years' time.
- Those at higher levels of risk are given specific interventions: e.g. exercise referral, smoking cessation clinic referral, and/or weight reduction classes.
- Those at the highest risk levels receive specific interventions: e.g. weight reduction classes, exercise referral, smoking cessation clinic referral, preventive statin medication, blood pressure control if necessary, and intensive diabetes prevention management.

Implementation of the NHS Health Check programme started this year. Full rollout is expected by 2012/13 although this is dependent on the next Comprehensive Spending Review. Full rollout means that each year 20% of the population will be called and 3 million checks will be offered. It is estimated that the Health Check programme will each year prevent at least 1,600 heart attacks and strokes, 650 deaths, and 4,000 people developing diabetes, and enable earlier detection of at least 20,000 cases of diabetes or kidney disease. The economic modelling estimates the cost per QALY to be about £3,500, so the programme is well below the NICE threshold of £20,000-£30,000 per QALY gained.

Delivery through PCTs

PCTs are to commission providers to deliver the NHS Health Check in a variety of settings, such as pharmacies, community centres, as well as GP practices. Ms White explained, that PCTs have in depth knowledge of their local communities and so can commission in ways adapted to meet the needs of different communities. She said, 'If the programme is implemented sensitively it will be a huge driver to reduce health inequality.'

Consistent standard

While many PCTs have well-established cardiovascular risk assessment programmes running, they rarely include diabetes and kidney disease. The NHS Health Check needs to be delivered to a consistent standard by all PCTs. The DH has issued 'Best practice guidance for the risk assessment and management of vascular risk'. This defines the NHS Health Check, gives details of each test, the thresholds of risk, and references the evidence and provides examples of best practice.

"... It begins with the vascular check. This is a single, universal, integrated check for all people aged 40-74, aimed at risk assessment as a first step to help prevent heart disease, diabetes, stroke and chronic kidney disease ..." Professor Roger Boyle

"... One of the dangers is that the PCTs do the risk assessment element of the NHS Health Check but don't have the management services to meet the demand this stimulates. So we want to be sure that PCTs have got the balance right between commissioning these services ..."
Heather White

Free A5 leaflets can be ordered by PCTs from the DH publications order line (www.orderline.dh.gov.uk). While the programme is being phased in, leaflets are being made available to people when they are offered a check. This is to help manage expectations and ensure that demand does not outstrip supply. Ms White said, 'One of the dangers is that the PCTs do the risk assessment checks but don't have the management skills to meet the demand. So we want to be sure they have got that balance right.'

Tailored and translated versions of the information leaflet will soon be available for South Asian and other minority ethnic groups. DVDs may be developed for people who cannot read in their ethnic language.

A PCT planning toolkit is available. An invitation letter template can be downloaded from *www.dh.gov.uk/nhshealthcheck.*

PCTs are encouraged to use the key elements of the national NHS Health Check identity and guidelines for doing so are available at: www.improvement.nhs.uk/nhshealthcheck. 'We understand from some of the social marketing work that you have done at a local level that there may be specific images that appeal more to your population, but some of the identity elements should be able to fit into your local materials as well. There is, therefore, flexibility in how the national identity can be used.'

Support for PCTs/commissioners

- Learning network (events, e-bulletin run by NHS Improvement, a website, case studies, test-bed sites)
- Next steps guidance
- Primary Care Service Framework
- PCT toolkit to help estimate additional interventions to commission
- Communications toolkit: e.g. includes national identity guidance; invitation letter
- Best practice guidance – details of tests, thresholds etc.
- Key role of SHAs

www.improvement.nhs.uk/nhshealthcheck
www.dh.gov.uk/nhshealthcheck
E-mail: nhshealthcheck@dh.gsi.gov.uk

Data into GP surgeries

The DH is developing national information technology for the call and recall system, along with the system of data transfer to GP surgeries. Ms White said, 'We are looking to see if there is something that we can nationally provide PCTs with so that data can be transferred back into GP surgeries.' She continued, 'All the information that has been gathered as part of the NHS Health Check should be part of the GP patient record. Obviously, if the check is being done in the GP surgery it is not a problem, but if we are to reduce health inequalities, it means that quite a lot of the risk assessments are going to take place outside, so we have got to have some mechanism to transfer the data efficiently and effectively back to the GP.

Keypad feedback: Participants at Warrington, Walsall, London (N=380)

Does your PCT currently have the NHS Health Check programme in place?

Yes	45.4%
No	44.9%
Don't know	9.7%

Note: The DH expects that by 2009, 85% of PCTs will have the NHS Health Check programme in place

Glasgow workshop

The NHS Health Check is not offered in Scotland. However, cardiovascular disease prevention remains a priority there but development of a structured and standardised approach is lacking outside targeted programmes.

At the Glasgow workshop Dr Martin Denvir, Chair NHS QIS Programme Advisory Group, Clinical Advisor NHS QIS, Senior Lecturer and Honorary Consultant in Cardiology Edinburgh, described the development of the standards for CHD in Scotland. The document is currently in draft form. Project groups are to meet to revise the standards later in 2009 and the final standards document should be available in March 2010.

Dr Alan Begg, GP Montrose and co-chair of SHARP captured the overall flavour of feedback from the Glasgow workshop. He said that the current draft standard had departed from the recommendations for a universal approach seen in the SIGN guideline on the prevention of CVD but reflects what is already in QOF. He said that in Scotland deprived communities were being targeted to the detriment of other priority groups. He believes that something like the NHS Health Check which is universally applied is really needed in Scotland. He said, 'The approach in Scotland seems to be that deprivation means everything. However, if you only address people in a deprived community, the people who might be at high risk including those with familial hypercholesterolaemia in a non-deprived community may miss out. That is a fundamental problem'.

QUESTIONS FROM PRIMARY CARE

Chair: The quality and outcome framework has proved efficient in driving service improvements in primary care. So many GPs question why the NHS Health Check is not formally in the QOF.

Ms Heather White: The programme is not suitable for the QOF because one of the major rules of the QOF is that all GPs across Great Britain can complete for incentives on the same basis. The NHS programme at present is only being rolled out in England. So that is one of the reasons we cannot use the QOF.

Professor Boyle: The plan is for these checks to be commissioned in every Primary Care Trust using different models of provision. Not all of it will sit in a GP practice. And this year, not every practice will be participating in the formal programmes as the incentive schemes around those programmes have not been finalised in every Primary Care Trust.'

GP: In South Asians the risk threshold of diabetes is younger than age 40. Is there any intention to bring the group age of 40-74 down for the NHS Check?

Ms Heather White: Not at the moment. Once the programme has been running a while, we will go back and review what the risk assessment tests are and look at some of the thresholds like age. When we ran the modelling 40-74 seemed to be the best age group for the national offer. But if PCTs decide within their communities that they would feel the community would benefit from earlier checks then that is a decision PCTs could take and action, using their own resources. I know in some parts of the country they have actually done that. Some London PCTs have decided for certain high risk groups they are going to check and manage them earlier than the national offer of 40-74.

GP: In the past we know that information from assessments, when gathered away from GP practices, hardly ever gets to GPs. What makes this system so certain to deliver data to GPs so that we can improve our service to patients?

Ms Heather White: Part of the PCT commission is to ensure that all the information will go into the patient record. That is why we are looking at a national system that PCTs can use. A lot of PCTs are working it out for themselves – using a paper-based approach.
But I think all PCTs are clear there needs to be some mechanism in place for that data. I would be very surprised to hear of a PCT commissioning a service that did not take that into account. There are a lot of PCTs already doing this effectively and we want to talk to them about their systems.

GP: There is a relationship between alcohol, blood pressure and stress. It does seem a good idea when we have the patient in front of us to talk about alcohol. But why is alcohol not included in the PCT toolkit?

Ms Heather White: Alcohol is not part of the NHS Health Check. This programme is about bringing together the risk factors associated with vascular constrictors and not vascular dilators, of which alcohol is one. However, I don' think there is any doubt that the programme is an opportunity to ask about alcohol. Where PCTs want to use the programme as an opportunity to ask about alcohol consumption, then that is up to them. As it is not part of the national programme, PCTs will have to fund that out of their own resources.

SHOULD ALTERNATIVE PROVIDERS LEAD ON THE VASCULAR RISK ASSESSMENT PROGRAMME?

Dr Chris Arden, GP and GPwSI in cardiology at Southampton, was among three speakers who made the case for GP practices to lead implementation of the NHS Health Checks. Mr Shafeeque Mohammed, Clinical Services Development Manager at Lloyds Pharmacy, spoke for alternative providers in two workshops.

The suggestion at the 2008 series of PCCS workshops that alternative providers do the checks aroused strong feelings. Dr Mike Dixon, chairman of NHS Alliance, said at the time: 'I believe there is a big danger of conflict or fall out between the laboratory, general practice and community pharmacy. He advised, 'As commissioners and providers, we need to integrate our care and perhaps not be played against each other.'

SHOULD ALTERNATIVE PROVIDERS LEAD ON THE VASCULAR RISK ASSESSMENT PROGRAMME?

For The Motion

Mr Shafeeque Mohammed emphasized that leadership was not about working in isolation but in partnering with key stakeholders to provide optimum patient care.

He did not believe GP practices could handle the volume of checks. When Birmingham PCTs had been asked about capacity, they had largely wanted the work to be done by alternative providers: 'Seventy percent of PCTs said that they didn't have the capacity and that they would prefer an alternative provider to carry out those checks as long as the results came back to be uploaded on the GP practice record'. He argued, 'It will be simpler and easier if an alternative provider – pharmacy maybe - provided the initial check and screen. And high-risk patients would then be referred to GP practices for follow up.'

Whoever the providers are they must be clinically credible, operationally effective, and have close links with primary care teams. He gave case studies to show Lloyds Pharmacy could fulfil these requirements.

In Case study 1 (Heart MOT), 'social marketing' to target the message at customers was fundamental to recruiting people. The target population could relate to and easily understand the 'Heart MOT' branding. He said 'We know that patients are more likely to come to pharmacies than GP practices. And we have data that shows that the most deprived and hard to reach populations will come into pharmacies.'

He compared this project with a second study (Case study 2), an opportunistic/systematic screening project in Manchester. This 3-month pilot service provided a cardiovascular risk assessment to people over 40 years old. It was delivered within thirty-five community pharmacies. Over 1500 patients were screened by ten Lloyds Pharmacies in 3 months. The pilot is currently being evaluated. He drew attention to the relatively high number of tests done in Manchester in fewer pharmacies in a shorter period: Birmingham, 900 tests in 14 pharmacies in 15 months in contrast with Manchester, 1,500 tests in 10 pharmacies in 3 months.

He put this greater efficiency down to true consultation and engagement with GP practices. The referral criteria were decided by the GPs who were directing the patients into the pharmacies, and the GPs received the data at their practices. There had also been consultation with GPs on the quality of the equipment and test results. He said, 'All that will lead to maximising service provision through pharmacy partnership with the PCT and GPs. So it does work, it can work as long as everyone is willing to make it work.'

"... This house believes that alternative providers rather than local GP practices are BEST placed to take the lead on implementing the Government's vascular risk assessment programme..."

Keypad feedback:Participants at Warrington, Walsall, London (N=380)

If your PCT currently has a primary care vascular risk assessment programme in place where is it based?

General practice	29.2%
Health centre	3.8%
Walk in centre	6.6%
Pharmacy	12.3%
Other	45.3%
Don't know	2.8%

Who carries out the checks?

GPs	23%
Practice nurses	55.3%
Other nurses	6.9%
Pharmacists	4.6%
Other pharmacy staff	2.3%
Health trainers	3.8%
Other	3.8%

Case study 3 (systematic CV checks using near patient testing in a community outreach programme) results are displayed in the panel. The perceptions of patients were studied in 1,783 patients: 99% satisfied with appointments, with the tests and the explanations given; 98% would recommend the service to a friend; 75% had a wait of less than 30 minutes; 76% 'plan to make changes' as a result of the clinic.

Case study 1 outcomes: Heart MOT

South Birmingham PCT on behalf of the 3 Birmingham PCTs commissioned Lloyds Pharmacy to provide 'Heart MOTs' opportunistically to people over 40 years old. Of a sample of 868 patients risk assessed by Lloyds Pharmacy, 49% were referred to their GP, of whom 27% were referred due to high CVD risk.

Case study 3 outcomes: Systematic CV checks using near patient testing in a community outreach programme.

The Birmingham Health and Wellbeing Partnerships commissioned Enhanced Healthcare Services to work with GP practices to extract patient records on men over 40 years of age.

BHWP commissioned Lloyds Pharmacy to provide screening events at evening and weekend clinics. These took place at both NHS settings and also at community settings, such as health centres, football clubs (Aston Villa and Birmingham City Football Grounds) and churches. Patients were referred to the GP practices, or if appropriate, a Health Trainer or PCT established services e.g. Stop Smoking. Results of the screen were sent to the GP practice.

- There was an over 80% attendance rate if appointment confirmed by phone compared with 20% if only sent a speculative letter of invitation.
- Around 10,000 males over the age of 40 have been screened.
- 65% of patients were referred:
  36% of these were identified as having a high CVD risk;
  30% identified with elevated BP;
  35% identified with elevated cholesterol;
  18% identified with elevated blood glucose.

"... We have data that shows that the most deprived and hard to reach populations will come into pharmacies ..."

Shafeeque Mohammed

He proposed a new service model in line with the best 'All the results will be uploaded on GP practice records, allowing GPs and practice staff and nurses to make informed decisions about patient care.

Against the motion

Dr Chris Arden, GP and GPwSI in cardiology at Southampton and Board member of the PCCS, made the case for GP practices being best placed to lead on implementing the NHS Health Check programme. He said, 'The core argument I think for using existing services in primary care is that you have your established structure there: you have the buildings; well trained clinical staff; and IT systems developed over many years.

A typical GP practice contains 5,600 patients. Therefore, offering vascular checks to eligible patients aged 40-74 years every five years would involve about 330 additional checks a year, which equates to an extra five appointments a week.

Moreover, the checks are known to work cost effectively in primary care. A lot of the economic modelling for the NHS Health Check is based on GP practices. A representative sample of about 90,000 patients within a GP setting was used in the model. He said, 'Within that setting and looking at the NICE threshold of £20,000 per QALY gained, the GP scenario certainly came out very cost effective indeed –about £3,500.'

He argued that primary care is well resourced for delivering the service and reaching out to patients whose contact might not be routine, but once identified and given an appropriate invitation could be engaged by the primary care team. 'There is no reason why we as GPs and nurse teams within primary health care should not be able to deliver this service.'

The key part of the NHS Health Check is the risk management after the assessment. He estimated that about 65% of patients after the assessment would require lifestyle intervention and signposting. At least 25% and possibly up to 40% will require a prescription of either an antihypertensive agent or lipid modification therapy. If alternative providers provide the assessment, people will need to be signposted and referred through to the primary care service anyway, with the risk of duplication of costs that that involves, and the risk of drop out increased.

In testing people who seem at risk for diabetes, a lot of patients would need either fasting blood glucose or an HbA1c. Delivering this again in a community independent setting where a patient may turn up without fasting or not be approached with appropriate care, may be an issue with a significant number of patients. He said, 'In my experience, they would commonly have a BMI over 30, diastolic blood pressure over 90mmHg. I believe about 30% of patients will need further evaluation. I would say that should be done in the one-stop scenario while the patient is in front of us. Why not organise that through the services that already exist!'

His biggest concern was the transfer of data from alternative providers to the GP practice record. 'Data captured in an independent community setting may not always make its way back to the GP. There may be solutions out there under study but when are they going to arrive in practice?

The IT system in primary care is fully integrated with local laboratories, and the risk assessment tool is embedded in the systems. 'We ourselves are working with QRISK and a lot of EMIS tools will be using QRISK2. Again, you really need uniformity here in the risk tools. There is no point using a different tool and then someone at a different location using another risk tool which may not give the same outcome.'

Communicating risk to patients is a skill. He said, 'GPs are very experienced in risk assessment and, especially important, communicating that risk. Risk communication is a skill that needs training, needs embedding. It is not something that can be delivered off the cuff.'

Keypad feedback:Participants at Warrington, Walsall, London (N=380)

What risk assessment method is being used?·

Framingham-based	72.3%
ASSIGN	1.5%
QRISK2	26.3%

GP surgeries can give both broad and highly personalised health advice and they can prescribe treatment. He said, 'We are in a position to prescribe. In a one-stop scenario, a person can have the assessment, and if they need further intervention they are in the setting to have that delivered.

The NHS Health Check is an opportunity to target and engage with patients who are relatively hard to reach. The Check can be used to capture a broader understanding of the patient for the patient record. 'I think it is an opportunity to identify other risk that may need appropriate advice or medication. There are sexual health and psychosocial issues. We can get that information into the system when patients come in for their health check. And we can use the check as health promotion as well.'

Outcome

The debate was good humoured. Strong links to the GP surgery were central to even the proposed alternative provider model of delivery. Despite this, Mr Shafeeque Mohammed, and his colleague, Michael Lennox, also from Lloyds Pharmacy, lost the debate.

Keypad feedback:Participants at Warrington, Walsall, London (N=380)

Does your vascular risk assessment programme find and engage with high risk and hard to reach groups?

Yes	67.1%
No	32.9%

If 'yes', how is this achieved?

Opportunistic testing of patients visiting the practice	48.2%
Structured approach e.g.employers, place of worship)	31.6%
'Outreach' initiatives to target people not visiting GPs	20.2%

"... We are in a position to prescribe. In a one-stop scenario, a person can have the assessment, and if they need further intervention they are in the setting to have that delivered' ..."

Dr Chris Arden

DO WE NEED COMPREHENSIVE LIPID MANAGEMENT?

Dr George Kassianos, GP and editor-in-chief of Drugs in Context, discussed the place of LDL cholesterol, HDL cholesterol and triglycerides as risk factors. He reflected on the usefulness of the QOF, NICE guidelines and European Society of Cardiology guidelines. He reviewed broadly some of the problems faced by GPs in adjusting lipid modification therapy and explained why he rarely uses the top dose of any statin in treating his patients.

There are three risk factors that account for half the risk of a first heart attack out of the nine potentially modifiable risk factors responsible for over 90% of the risk (1): lipids, smoking, and blood pressure. Lipids is the most important of the three.

On LDL cholesterol, Dr Kassianos cited a meta-analysis (2), 'Each 1 mmol/litre of LDL-C reduction reduces overall mortality by 12%; risk of coronary death or MI by 23%; need for coronary vascularisation by 24%; risk of stroke by 17%; and risk of any major vascular event by 21%. This is independent of age or gender.' Of HDL cholesterol he said, 'It is well known that low HDL is a risk factor, even in the presence of a low LDL.' A 0.03 mmol/litre increase in HDL cholesterol at 3 months reduces the risk of major CV events by 1.1%(3). He reviewed work showing that increased triglycerides is a risk for cardiovascular disease.

The abnormal lipid triad – high LDL cholesterol, low HDL and high triglycerides - is a strong predictor of CVD according to the findings of Lozano et al (4), and suggests the value of a comprehensive lipid assessment and management of patients with dyslipidaemia who are at higher risk.

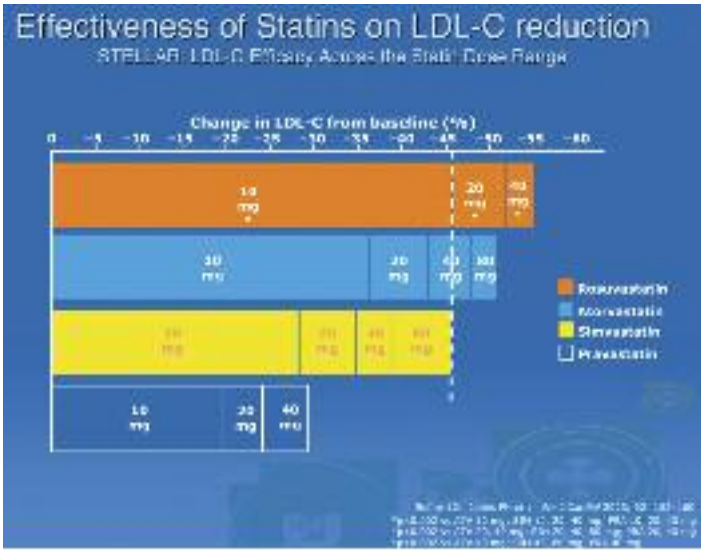
He suggested that a significant proportion of high-risk patients might be reaching QOF targets but still have significant risk in their lipid profile that the QOF was failing to flag up. He referred to research by a GP who had studied abnormal lipids in over 18,000 high-risk patients on statins, achieving cholesterol targets within routinely collected UK general practice data(5). He explained, 'What he did was to look at high-risk patients, CV patients in primary care, who passed the QOF fine. They got their points. If you now look at these patients you find that among them there were 9% who had low HDL; 24% who had actually raised triglycerides; and about 13% who actually had both.' He concluded that there was risk to these patients that the QOF did not target. Similarly, with the diabetic patients who passed QOF targets: 11% had low HDL; 7% had high triglycerides; and 18% actually had both.

"... Personally I abrogate using, and I am not the only one in the UK, the top dose of any statin in primary care unless there is a compelling reason ..."

Dr George Kassianos

NICE clinical guideline 67 – Lipid modification

He considered the relative efficacy of the statins across their dose range in a head-to-head study, the STELLAR study(6). He said of simvastatin, 'This is the statin that we must always start with. It is good and very cost effective. It does quite a lot, but if this does not actually achieve what we want we have to move on. NICE says move on to 80mg of simvastatin. Personally I abrogate using, and I am not the only one in the UK, the top dose of any statin in primary care unless there is a compelling reason.' He said that if simvastatin 40mg was not enough, the GP has the option to use atorvastatin 20mg, or atorvastatin 40mg at a considerable cost, or rosuvastatin 10mg at a much lesser cost and giving a similar effect to atorvastatin 40mg. 'If you move up to 20mg rosuvastatin, it actually gives you more than the 80mg simvastatin.'



Keypad feedback:Participants at Warrington, Walsall, London (N=380)

In patients with high cardiovascular risk despite taking a statin, would you consider their HDL-C and triglyceride levels to inform their ongoing drug management?

	Start of meeting	End of meeting
Never	10.2%	2.3%
Sometimes	21.8%	0%
On a patient-by-patient basis	44.9%	65.1%
Often	9.5%	14%
Routinely	13.6%	18.6%

He took issue with NICE's recommendations for primary prevention. These suggested that patients should be put on 40mg simvastatin and not have their cholesterol profile retested: the so-called 'fire and forget' policy. He said that patients deserved the same consideration as in secondary prevention and should never be forgotten.

In secondary prevention, NICE suggest 40 mg of simvastatin and then use up to 80mg of simvastatin if a total cholesterol of less than 4 mmol/litre or an LDL cholesterol or less than 2 mmol/litre is not attained. In the acute coronary syndromes they permit the use of higher intensity statins.

Returning to why he does not use the 80mg does of simvastatin he referred to the SEARCH study (7). This showed that by increasing the dose of simvastatin from 20 mg to 80 mg there was only a further 0.35mmol/litre fall in LDL. However, the myopathy and rhabdomyolysis rates were very much increased. In that study there were 53 cases of myopathy in the simvastatin 80 mg dose group compared with 3 cases in the 20 mg group, and 7 cases of rhabdomyolysis in the simvastatin 80 mg dose group versus 0 in the 20mg dose group. He concluded: 'That is the answer to NICE about using the top dose of simvastatin.'

He compared the NICE guideline with the European Society of Cardiology guideline. He said 'The ESC is, I think, a bit more sensible, because it is very difficult to get to below 2mmol/litre. What the ESC says is an LDL below 2.5, and if feasible below 2mmol/litre. What they also say is that if in a man the HDL is below 1 mmol/litre or in a woman is below 1.2 mmol/litre or the triglycerides are higher than 1.7 mmol/litres in either gender these are markers of increased cardiovascular risk. These values should be taken into consideration when we manage CV patients according to the ESC guidelines.'

TYPE 2 DIABETES: PATIENT CENTRED CARE GUIDELINES

Treat the patient in front of you and use your clinical judgement. Don't treat every patient to national guidelines. This was the opinion of Dr David Haslam, GP and Chairman of the National Obesity Forum, at the end of his critique of the NICE Type 2 Diabetes guideline 87 (1) and the changes to the Quality and Outcomes Framework (QOF).

Dr Haslam reviewed three studies, ACCORD (2), ADVANCE (3), and the UKPDS (4), that together highlighted the benefits of glycaemic control, but also illustrated the danger of over-rapid control leading to hypoglycaemia. Hypoglycaemic episodes are the biggest predictor of future CV events. Nearly two thirds of a survey of over 1,300 diabetic patients reported a daytime hypoglycaemic event in the 3 months before completion of the survey (5). The East Anglian Ambulance Service reports that only one out of 10 hypoglycaemic episodes attended by the Service are reported to the GP. Dr Haslam concluded, 'Hypos are 10 times more frequent than we realise. We often ask the wrong questions. If we ask the right questions, we will pick up on a lot more hypos.' He explained that while directly asking them if they have 'had a hypo' gets a negative answer, asking, 'have you felt funny and sweaty lately' or 'have you felt dizzy and really hungry' may prompt the patient to recall an episode.

The high death rates seen in the ACCORD study in the patients with type 2 diabetes who received intensive therapy that rapidly brought the HbA1c down to about 6.5% were, he believed, due to the consequences of hypoglycaemia. He said 'The reason why this rapid reduction in HbA1c killed people is almost certainly due to hypos leading to CV events.' He contrasted ACCORD with the ADVANCE study. He noted: 'In this study they treated patients down to about 6.5% HbA1c as well, but they did it slowly, responsibly.' As with ACCORD there was no reduction in cardiovascular risk, but there was a microvascular benefit in terms of retinopathy and renal disease. From these two studies he concluded that while it is important to treat HbA1c early and intensively and obtain glycaemic control and so reduce the microvascular risks, it is also important to do it gradually to avoid hypos. The UKPDS 80 showed the long-term benefits of early

glycaemic control in patients who had been newly diagnosed with diabetes, despite the loss of control after the nine-year study finished. The study originally showed a reduction in myocardial infarction (MI) in patients treated with metformin, while sulphonylurea and insulin treatment just failed to reduce MI. Within 12 months both the intensively treated group and the standard treated group showed no difference in HbA1c. values. However, the benefit due to the previous years of intensive therapy had increased. He said, 'Those who had been treated intensively still maintained their benefit and in fact that benefit increased. The reduction in risk of MI changed from significant to highly significant. And even the sulphonylurea and insulin group moved from not significant to significant at 10 years.' He concluded, 'So the message here is very clear: if you treat patients intensively early they will still benefit in the long term from your intensive but responsible reduction in HbA1c, that you induced early on in the disease. I cannot stress this enough. Early treatment is essential and the only way to treat early is by picking up early by screening. If we leave it 12 years and let the optician pick it up there is really no hope of improvement.'

NICE type 2 diabetes guideline

Dr Haslam discussed the NICE type 2 diabetes guideline, which recommends the relatively cheap older therapies but allows flexibility to use modern treatments that were less likely to produce hypoglycaemia or weight gain. 'The list of excuses is very good: if you are overweight then you should not use a sulphonylurea; if at risk of hypo, should not use a sulphonylurea.' He said, 'I would argue that everyone is at risk of hypos. If you are driving an HGV, of course you are at high risk. But what about it you are driving your kids to school, etc? I say anybody is at risk of hypos. And they should be avoided at all costs. So when you are looking at second line treatment, a sulphonylurea causes weight gain and causes hypos, so you should think very carefully before doing what NICE say on cost benefit grounds. So this flexibility opens the door for the newer agents. The thiazolidinedones are still around and don't ignore them - but it does open the door for agents like the DPP4 inhibitors.'

Keypad feedback: Participants at Warrington, Walsall, London (N=380)

If you are a commissioner or a clinician would you welcome a generic skills training seminar on how to implement NICE guidelines?

Yes	82.1%
No	17.9%

One-day seminars to support best practice in the commissioning and delivery of NICE guidelines are available. Contact Medical Management Services or MSD for further details

New QOF

Dr Haslam also reviewed the new QOF. He said, 'We are being asked to treat to tighter thresholds. Some people will be better treated. The worry is that some will undergo worse treatment- the hypo-inducing sulphonylureas.' He noted that the new QOF encourages screening indirectly because a target of 7% is easiest to reach very early in diabetes.

Keypad feedback: Participants at Warrington, Walsall, London (N=380)

Do you expect the publication of the NICE guidelines on Type II diabetes newer agents to affect your prescribing or your PCT's prescribing recommendations?

Yes	76.6%
No	10.8%
Dont Know	12.6%

Keypad feedback: Participants at Warrington, Walsall, London (N=380)

What would normally be your FIRST choice or your PCT's FIRST choice for a patient who is taking maximum doses of metformin monotherapy, when glycaemic control becomes or remains inadequate (HbA1c >7.5%)?*

Add a DPP-4 inhibitor (gliptin)	21.1%
Add a sulphonylurea	42.2%
Add a TZD (glitazone)	9.2%
Other	1.8%
I don't know (e.g.I am a manager)	25.7%

What would normally be your SECOND choice or your PCT's SECOND choice

Add a DPP-4 inhibitor (gliptin)	16.8%
Add a sulphonylurea	27.1%
Add a TZD (glitazone)	28%
Other 0.9%	0.9%
Don't know (eg I am a manager)	27.1%

*assume the patient is compliant with medication and diet.

"... We can benefit our patients by treating them intelligently, responsibly and early' ..."

Dr David Haslam

He said that while the new QOF promotes better management in some people, there are flaws in it. The financial incentive to meet targets could produce an over-rapid control of newly diagnosed diabetics to meet the requirements of the 'QOF police'. He said, 'Vulnerable patients will be aggressively and irresponsibly treated inducing dangerous hypoglycaemia'. Newly diagnosed patients should have a one-year buffer zone for appropriate treatments to be responsibly initiated to meet QOF targets. Also, the QOF contradicts NICE. NICE gives a threshold of 7.5% for initiation of third-line treatment, so the QOF is stricter than NICE.

He felt that QOF should also be giving GPs the incentive to screen obese people for high blood pressure and diabetes rather than simply adding them to a list of obese people. Early treatment of diabetes is crucial. Type 2 diabetes has a long asymptomatic pre-clinical phase. He said, 'At the time of diagnosis, over half have one or more diabetes complications. Retinopathy rates at the time of diagnosis range from 20% to 40%. Since the development of retinopathy is related to duration of diabetes, it has been estimated that Type 2 diabetes may have its onset up to 12 years before its clinical diagnosis.' He concluded: 'We can benefit our patients by treating them intelligently, responsibly and early. We now have the agents that allow us to do that. Distinct from insulin and sulphonylureas we have the newer agents that are accepted by NICE, and help us meet QOF targets. When you have your QOF targets in mind, have your individual patient also in mind. If it is not appropriate to treat that patient down to HbA1c by using certain drugs don't do it.'

References

1.NICE clinical guideline 87. Type 2 diabetes. May 2009
2.ACCORD study group. N Engl J Med 2008;358:2545-59
3.ADVANCE collaborative group. N Engl J Med 2008:358:2560-72
4. UKPDS 80 FULL REFERENCE PLEASE
5. Currie, 2006 full reference please

New QOF

Two indicators, DM 7 and DM 20, with HbA1c targets have been changed. A new indicator, DM 24, has been introduced.

DM 23: Replaces DM20 (which has a HbA1C target of 7.5% or less and is worth 17 points) The percentage of patients with diabetes in whom the last HbA1c is 7 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (17 points; thresholds 40-50%)

DM 24: New. The percentage of patients with diabetes in whom the last HbA1c is 8 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (8 points; thresholds 40-70%)

DM25: Replaces DM 7 (which has a HbA1c target of 10 or less and is worth 11 points. The percentage of patients with diabetes in whom the last HbA1c is 9 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months. (10 points: thresholds 40-90%)

Flaws of the new QOF

- Those with HbA1c of 10% and over may be neglected.· Those people with improvements in HbA1c of 12% to 10% will have a negative effect on incentive payments rather than positive.
- Newly diagnosed patients should benefit from a 1-year buffer zone for appropriate, rather than rapid treatments to be responsibly initiated to meet the QOF target.
- Screening of obese/high risk patients is not incentivised, so early treatment is neglected.
- HbA1c was already the least achieved clinical target 7% target may be ignored as unachievable; therefore in practice the target has gone up to 8%.
- NICE states 7.5% for initiation of third line treatment, so QOF is stricter than NICE.
- There may be medico-legal issues involved in treating a person to gain a financial incentive if they have, say, a fall due to a hypoglycaemic episode because they have been treated to a strict target.

CO-CREATING HEALTH IN DIABETES

Co-Creating Health (CoCH) is a patient self-management initiative of the Health Foundation. It currently consists of national demonstration projects at eight sites, developing programmes for people with diabetes, COPD, depression and musculoskeletal pain. The three-year term of the projects ends in August 2010. Dr Maria Barnard, The Whittington Hospital NHS Trust, London, and Honorary Senior Lecturer at UCL Medical School, is the clinical lead for diabetes at the local CoCH site at The Whittington Hospital NHS Trust.

The aim of the CoCH initiative is to transform healthcare for people with long-term conditions by making self-management an integral part of care. There are 15 million people with a long-term condition in England. The average person with diabetes has just 3 hours contact a year with a healthcare professional, and self-cares 8,757 hours. Dr Barnard noted, 'The idea of having high quality care that empowered patients, and care planning, is very much part of the Darzi report, NHS Next Stage Review.'

Dr Barnard explained the concept of CoCH: 'To create change. To create a shift in the way we support patients with long-term conditions and support self-management' A whole systems approach is needed to sustain change in the long term. 'So you have your patient actively self-managing. You also have practitioners who are skilled in supporting self-management, and in addition to this you are working in an environment – a service - that supports self-management. And we think that where you bring all these three elements together, that is where you have high quality care and sustained effects.'

"... The idea behind this is to create change. To create a shift in the way we support patients with long-term conditions and support self-management'..."

Dr Maria Barnard

The eight sites of the CoCH initiative

Diabetes

- Guy's and St Thomas' NHS Foundation Trust, NHS Southwark·
- Whittington NHS Hospital Trust, NHS Islington, NHS Haringey.

COPD

- NHS Ayrshire and Arran
- Cambridge University Hospitals NHS Foundation Trust, NHS Cambridgeshire

Depression

- South West London and St George's Mental Health NHS Trust, NHS Wandsworth
- Devon Partnership NHS Trust, NHS Torbay Care Trust

Musculoskeletal pain

- Calderdale and Huddersfield NHS Foundation Trust, NHS Calderdale, NHS Kirklees
- North Bristol NHS Trust, NHS Bristol

At each site of the CoCH initiative, hospitals work in partnership with their local PCT. She reviewed the programme in diabetes sited at The Whittington Hospital, London.

Self-management programme

The self-management programme, running over seven weeks, sets out to build patient skills and knowledge to self-manage, in collaboration with a healthcare professional. Groups of 12-16 patients work together. Two tutors, one a healthcare professional and the other a lay tutor facilitate each group.

The content of the programme combines information about diabetes with self-management techniques, including problem solving, becoming more physically active, goal setting and action planning, communication with healthcare professionals and accessing healthcare services. Additional course content, such as risk communication, and the development of the course in other languages is being considered.

Twelve tutors have been trained so far: six healthcare professionals and six lay tutors. Six self-management programmes have been completed, involving a total of 87 patients. There are 12 more courses to be run over the next year, before the initiative finishes in August 2010. Overall the local aim is to complete 20 self-management courses involving 240 patients by then.

Patients have been very positive in the formal feedback collected. All patients would advise other people to attend the self-care management programme. She summarized feedback from the patients on the steering group: 'They feel that the project is going to enable them to feel more confident that they are being managed in the right way, at the right time by the right person. They said that it reduces the expectation that a nurse is needed for everything.'

Advanced development programme for clinicians

The advanced development programme provides training for clinicians to enhance communication and consultation skills that will support patient self-management. Each course consists of three sessions, one every month over three months. Dr Barnard said, 'The ADP is based around three principles: you create a shared agenda with your patient; you then do goal setting with your patient and then you do follow up.'

Courses have involved mixed groups from primary and secondary care. Three advanced development programmes have been completed, involving a total of 38 clinicians of various disciplines. Five local trainers for ADP have been trained. Three of these are healthcare professionals, and two are lay tutors.

Dr Barnard said that they are now considering training entire GP practices: 'Everyone including receptionist, nurses, and doctors. And I think that primary care practitioners seem interested in that.'

Service improvement programme

In CoCH they used the PDSA cycle (Plan Do Study ACT) to create rapid cycle change and so improve the service throughout the project. One development from this has been the 'agenda and goal setting sheets' to use with the patients before they see the healthcare professional. She explained, 'They score themselves with how well they are doing on various points, e.g. exercise, weight management, blood sugar, and they also score what they want to do better. This gives patients a menu of choices that they want to discuss in the consultation. Then at the bottom they set a goal that they are going to work on, scoring how important the activity is to them, and scoring how confident that they will be able to make that change.'

GPs have also made changes within their practices. For example some practices have changed their EMIS template, to display a specific agenda that focuses the consultation on self-management. ' The other thing some of our practices are doing is sending test results to patients before they come to see their GP or practice nurse so that they come prepared, having thought about what they want to discuss in the consultation.'

EMPOWERMENT AND SELF-CARE: A PRACTICAL OVERVIEW

Rosie Walker, Co-founder and Education Director of Successful Diabetes provided insights into the skills and techniques helpful in motivating and empowering people with long-term conditions to self-care. She discussed the use of processes that engage and involve people in shaping their care as individuals, notably Personalised Care Planning and Patient Reported Outcome Measures (PROMS). At some workshops the presentation was given by Jill Rodgers, co-founder and Business Director of Successful Diabetes.

Mrs Walker asked participants to reflect upon what motivates people to take a healthcare professional's advice and self-manage a long term condition. She also asked them to consider styles of communication that might tend to demotivate people. She explained, 'For example it might be demotivating if you are treated like "a diabetic". That is what a lot of people with diabetes do say. That they are not treated as individuals and that they feel like a "target" that has to be met.'

An example of a technique to change behaviour is to reframe what is asked of people: to advise them to try to do more of the healthy behaviour rather than to stop doing the unhealthy behaviour. The scientific literature in behaviour change suggests that people find it easier to do this.

"... Our working systems may be easier to change than our consultation styles because this involves behaviour change on our part' ..."

Rosie Walker

What is motivating?

Personal concerns are leading factors in motivating people, and the healthcare professional needs to identify these concerns in the individual. She advised, 'Find out what bothers people most because that is what they are going to act upon. If people aren't concerned about something they will not act on it. Your concerns do not make a difference to their behaviour. You have to get on the same page as the patient, and that is what "care planning" is all about.

Also, learning has to be personally meaningful to motivate people to change behaviour. Often people do not understand what is said to them.

How other people, especially 'someone like me', behave in similar situations and the social support they have available to them will affect motivation: 'Other people are hugely important in behaviour change. That is why Weight Watchers works well. Introduce people to someone like them.'

Enquire how confident a person is about taking specific actions on a scale of 0-10, for example about losing weight or taking tablets. If they give a number of less than 7, then they are unlikely to change their behaviour. The barriers may then be explored to find out what they think might increase their confidence.

Reward, success and praise makes a huge difference to people, yet people tend more often to feel that they are being told off when they are given advice by healthcare professionals.

She said that motivation coming from within the patient that involved autonomy and self determination is more effective than external ' threats', eg from health professionals, in producing results.

What is demotivating?

Being told what to do is demotivating. She said, 'It may have an effect in the short term, but we are talking about chronic conditions. Don't tell them what you want them to do. Find out what they want to do and how confident they are about achieving it. 'Also, 'threat messages' are likely to have a short-term result only: 'People do know what the consequences of diabetes are and telling them about it repeatedly does not make any difference.'

Being told off or made to feel a failure and being judged are also demotivating. Mrs Walker says, 'A lot of people with diabetes say that they feel they are being followed by the 'diabetes police'. We take away people's decision-making capacity, if we are not careful by putting our judgements on them.'

Empowerment

Empowerment means helping people have greater success in their self-management of their condition. 'We can't make decisions for people- but we can provide good information and work in a helpful way for people to decide what they want to do about their situation. It is only what people think, feel, and do, that will make the difference. Not what we believe.'

Personalised Care Planning

Personalised care planning is one of the policies being implemented to promote greater self-management and partnership working with health professionals. Care plans are meant to be in place by April 2010 for people with long-term conditions. The Year of Care pilot in diabetes care is demonstrating how care planning and commissioning can be implemented in routine practice. Support resources and information for people with long term conditions are available via the NHS Choices website, 'Your health, your way' http:www.nhs.uk/YourHealth/Pages/Livingwithyourcondition.aspx

She gave an example from diabetes care of personalised care planning. Routine tests are carried out before the patient's annual review. The patient is sent these results together with the interpretation, and is invited to think about the results and their concerns so that they can bring their questions to the consultation. She said, 'We are offering people greater involvement in the results that belong to them. The consultation takes place a week or so after they have their results. And then they can come with their agenda and talk about the things that concern them most, the things that they are likely then to act upon.'

The style of conversation with patients that is effective in care planning requires a variety of skills from the healthcare professional. 'It is no good getting people involved in their care if we are just going to tell them what to do when they come to their consultations. It involves asking open questions to find out their concerns and agenda, paraphrasing and reflecting upon what the patient says, and acknowledging the content and the emotions in people's words. Helping people think through their own situations rather than offer advice. Allowing time to think and being comfortable with silences. Then being skilled at summarising, goal-setting and action planning.'

The initial experience of Patient Reported Outcome Measures (PROMS) was about health and quality of life before and after surgical operations. The report 'Patient involvement and collaboration in shared decision-making: a review' identified it as crucial to involve patients in decision making and to collaborate with them in order to improve care. PROMS can influence the commissioning of effective services based on the support people identify that they need for their self-management, through the care planning approach. Said Mrs Walker, 'If we can identify the services that people are using being successful in their behaviour change we can commission more of those services and perhaps decommission services reported as ineffective.'

Mrs Walker concluded: 'Empowerment, care planning, and PROMS – are all about engaging and involving people more in their care at an individual level. Documents and guidance provide us with structured ways that enable us to support patient choice better in practice. Our working systems may be easier to change than our consultation styles because this involves behaviour change on our part – which is equally hard whether or not you have diabetes or any other long term condition.'

Recommended reading

Anderson B, Funnell, M (2005) The Art of Empowerment. Stories and Strategies for Diabetes Educators. 2nd Edition. Alexandria. American

Diabetes Association (available in the UK from www.amazon.co.uk or similar online bookstores)

Keypad feedback:Participants at Warrington, Walsall, London (N=380)

Will you have a personalised care plan (PCP) in place for all patients with LTCs by April 2010?

Yes	22%
No	78%

If you will NOT have a personalised care plan in place by then, is this because you (either as a commissioner or clinician):

Do not feel confident that you have sufficient skills to commission PCPs	4.3%
Do not feel confident that you have sufficient skills to implement PCPs	2.2%
Are in need of tools and resources (e.g. money, staff etc) to commission and/or implement PCPs	93.5%

SYNDICATE FEEDBACK

Participants worked in syndicate groups on tasks set to stimulate thought and interaction. A member of each syndicate was delegated to feed back the results of their discussions at the last session of the meeting.

The first task was to consider the patient groups who require comprehensive lipid management, and give reasons why the clinician should look beyond total cholesterol and/or LDL cholesterol.

The following groups for comprehensive lipid management were named in the feedback session.

- Familial hypercholesterolaemia
- Secondary prevention for heart disease
- Acute coronary syndrome
- Obesity
- Diabetes
- Prediabetes/metabolic syndrome
- South Asian origin
- Smokers

The second component of the task produced a general consensus on two issues: the importance of lifestyle intervention, and that the whole lipid profile should be considered in assessing patients. Low HDL and high triglycerides should be considered in the identification of at risk patients and managed, even if LDL cholesterol is within the target range.

There was concern that clinicians were tending to focus on achieving targets with pharmacotherapy and not putting sufficient effort into helping patients self-manage change in lifestyle. One delegate represented his group's opinions on the management of metabolic syndrome as follows: 'Our first approach would be exercise; second would be exercise; and third would be exercise and lifestyle. Only after that would we consider pharmacotherapy.'

The second task set for the syndicate groups was to identify key skills that commissioners and clinicians each need to implement NICE guidelines for Type 2 diabetes and personal care plans.

One London group representative from a cardiac network commented on features of NICE guidance that obstructed implementation. NICE guidance was considered too long and the well-known emphasis that NICE guidance has on cost-effectiveness detracted from its reputation for impartial consideration of scientific evidence. He said, 'NICE has possibly lost some credibility with the controversy around the cost effectiveness of drugs. That is affecting keenness to implement NICE guidance.' He added that NICE guidance also takes a long time to be finalised and is often perceived as being out of date when it does arrive. New medications coming through for diabetes need to be taken in more rapidly to the guidance.

To implement NICE guidance, PCTs need to: increase awareness of the guidance with education sessions, provide protected education time and learning time, and fund resources to support this strategy

The 'skills' commissioners need to put the above into place include:

- Understanding local population needs
- Understanding the impact of the guidelines on the local population
- Understanding the impact on budgets
- Skills in giving value for money
- Ability to deliver
- Ensure clinical input into commissioning
- Ability to listen and discuss
- Skilled in creating public awareness.
- Solicit feedback from patients on services
- Encourage care pathways to be developed
- Encourage NICE guidelines to be implemented and provide advice
- Have meetings to argue, persuade and agree interpretation and implementation locally
- Skilled at tailoring messages to the local community
- Skills to spend money wisely
- Skills at incentivising clinicians

The skills identified as being needed by clinicians, particularly with respect to personal care plans, centred on motivating the patient to self-manage and the need to consider the patient's problems at home and work. One delegate summarised his groups contribution as follows: 'There is one real skill only. The consultation skill. Everything else comes under this umbrella. You have to develop good consultation skills. You have to address the patients' agenda. Help them change to better health and when they are ready work with them for the change. Often the skill in the consultations with them is to 'listen and pause'. When you do that you allow the patient to set the agenda and talk about what they wanted to talk about or ask. Engage the patient with open questions. And really work in the practice as a practice team.' Knowledge of local services to refer patients to and knowledge of the outcomes achieved by these services was also very important.

POLICY INTO PRACTICE

PUTTING VASCULAR DISEASE MANAGEMENT INTO PRACTICE

Insights from a Series of UK Workshops

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