

POLICY INTO PRACTICE

PUTTING COMPREHENSIVE CVD RISK MANAGEMENT INTO PRIMARY CARE

Insights from UK primary care workshops

Primary care reactions and ideas on DH Prevention for All, NICE Lipid Modification, and NICE Type 2 Diabetes from five UK workshops



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INTRODUCTION

INSIGHTS FROM UK PRIMARY CARE WORKSHOPS

The insights of primary care workers on the front line of delivering the national cardiovascular and diabetes screening programme have been harvested from a series of Primary Care Cardiovascular Society (PCCS) regional workshops.

The workshops, run by Medical Management Services (UK) Ltd, but created for the PCCS in association with a number of professional bodies*, were held under the group title 'How comprehensive cardiovascular screening, management and practice based commissioning reduces hospital admissions and inequalities'.

There were five during June 2008 - in Leeds, Manchester, London, Birmingham and Glasgow. Almost 500 participants took part, including GPs, practice nurses, secondary care doctors and nurses, Primary Care Trust (PCT) managers and pharmacists. The May 2008 National Institute for Health and Clinical Excellence (NICE) Lipid Modification guideline (1) and the NICE Type 2 Diabetes guideline (2) were particular foci of the discussion.

The sessions started with presentations on primary prevention and finished with group syndicates to discuss the issues involved, share experiences and suggest pathways.

This printed report is based on a full formal report available as a PDF at www.pccs.org.uk and www.cormackmedicalnews.com.

The report constitutes an insight into the views, reactions, and ideas of the people who will deliver the risk assessment and management programme to patients.

*Association of British Clinical Diabetologists (ABCD); Heart UK; NHS Alliance; National Obesity Forum; Primary Care Diabetes Society (PCDS); Scottish Heart and Arterial Risk Prevention Group (SHARP)

The workshops and printed report were produced with an unrestricted educational grant from MSD.



So far: PBC Screening

- Teaching (GP, nurses, APP)
- Initiatives to "free-up" Practice Nurse Time e.g. PCT urgent clinics
- Screening >40yrs - identify diabetics, pre-diabetics, thyroid disease } Follow up
- ↓
approx 60-50% uptake of people invited as well as opportunistic patients
- LES - target groups such as:
risk stratified by their group { hypertensives, pre-hypertensives (not on treatment), smokers
- GPs' pharmacy screening → rely on patient to seek GP follow up then GP action

EDITORIAL

PCCS REACTION TO PUTTING PREVENTION FIRST

Following the announcement of a national cardiovascular and diabetes screening programme by the Prime Minister, Gordon Brown, on 7 January 2008 the Department of Health Vascular team commenced work on Putting Prevention First. The PCCS was one of the organisations asked to help with this initiative.

We were delighted to be able to join forces with Medical Management Services Ltd (UK) to run these five sessions of consultation around the UK and to provide this report outlining the results of this activity.

Primary care must lead

Primary prevention risk scoring and diabetes screening is going to become a reality from 2009 and will have £250 million of funding annually to support the initiative. The main base of this activity and the follow up of positively screened patients will be in primary care. Therefore, it is of vital importance that we lead this process in our respective Primary Care Trusts.

The initiative will include not only local general practices but also retail pharmacists and PCT-led mass assessment programmes based in workplaces and community centres. It is extremely important that these different work streams are coordinated as if they are one process and that effective channels of communication are an integral part of the process. Patients should be selected for screening by using available data from primary care and then given a unique identification number to avoid screening the wrong people and duplication of effort. We must not only reassure the worried well but also reach out to the disadvantaged elements of society who need this intervention the most.

The people carrying out the assessment should be adequately trained in a uniform manner. The programme will need national advertising and a single, identifiable brand name.

No Direct Enhanced Service

We had hoped that the funding would be ring fenced and available via a Direct Enhanced Service. This has not been possible and it is likely that individual PCTs will receive a finance allocation and will have autonomy as to how the money is spent. It is important that this process is transparent so that we can easily see how each Trust has spent their allocation.

We need robust computer codes for recording the assessment outcomes and we need to use a single, proven, reliable risk-assessment calculator. The Society currently feels that we should stick with the NICE Lipid Modification CG67 recommendation of using the Framingham equation and we would prefer that the JBS 2 version be used. QRISK 2 may still be the preferred model in some quarters but is still not fully validated and there are questions about whether or not there is sufficient HDL-C data in the equation.

“... Whether or not we have sufficient resources to provide a universal scheme for all people aged 40 to 74 remains in doubt. But we do have resources to start the job and therefore we need to get on with it, target those at greatest risk and provide a consistently high quality service. ...”

Secondary care must not be excluded from the process. In particular, there is a role for local chemical pathologists in ensuring diagnostic quality control as well as the views of hypertension, lipid and diabetes specialists to be taken into account. There may be a role for integrated care in the ongoing management of those identified as ‘at risk’. Let us not forget that those below the threshold for drug treatment are still at risk and that lifestyle issues are of importance to all our patients.

Is £250 million a year enough?

Will £250 million a year be enough? I feel the answer is, ‘probably not’. It should be noted that in 2004 only 3.4% of cardiovascular healthcare costs were allocated to general practice with 16% spent on drugs whilst 60.4% of spending was in hospital care. If we are to develop robust preventative care that money will need some redistribution. Only 10% of the allocated sum is intended to support the assessment process with the rest being needed to tackle the prevention interventions required for the patients unearthed by this process.

Whether or not we have sufficient resources to provide a universal scheme for all people aged 40 to 74 remains in doubt. But we do have resources to start the job and therefore we need to get on with it, target those at greatest risk and provide a consistently high-quality service.

Terry McCormack, Chairman of the PCCS



DH POLICY CHALLENGE AND PRIMARY CARE CONCERNS

The programme of vascular risk assessments for people aged 40-74 should be available in a variety of settings, according to the Department of Health (3). The aim is to be accessible to even people who rarely visit GP surgeries or who are unregistered. The deprived and those with South Asian origins are particular groups to target.

Primary Care Trusts (PCTs) will commission the service. 'Early Adopter Schemes' (a phrase preferred to pilots) will be run by all PCTs this year. These will be centrally audited and report to the Department of Health after 3 and 6 months. Each PCT is expected to create a local implementation team that includes a GP, practice nurse, retail pharmacist and biochemist.

Implementation of the programme will begin during 2009/10 and by 2012 the Department expects 3 million people every year to be offered a vascular assessment check (4).

'Learning networks'* are being set up by the Department to inform the process of planning and to learn from what people are already doing. Workshops are to be held in London and/or Leeds between September 2008 and April 2009. The programme will use the term 'risk assessment' rather than 'screening'. The rationale is that 'screening' stratifies people as 'at risk' or 'not at risk'. Everyone is 'at risk' of cardiovascular disease and the assessment grades that risk. Similarly, risk is said to be 'managed' rather than 'treated'. The word 'treatment' implies management always involves medication and also implies the patient may have a disease when they are just at risk of a disease.

*To find out more or join the learning network, contact Julie.Harries@improvement.nhs.uk

“... What I see us doing in Scotland is having a structured and standardised approach to high risk primary prevention. That needs to be delivered through the Scottish QOF, which would be through a Direct Enhanced Service in the future. It will not happen for nothing ...” Dr Paul MacIntyre

'It will not happen for nothing'

Dr Paul MacIntyre, Chairman of the Scottish National Advisory Committee for CHD, and Lead Clinician for CHD put the Scottish position on risk management at the Glasgow workshop: 'Cardiovascular disease prevention remains a national priority in Scotland. We do not have a national screening programme. I don't see us having a national screening programme *per se*. What I see us doing in Scotland is having a structured and standardised approach to high-risk primary prevention. That needs to be delivered through the Scottish QOF, which would be through a Direct Enhanced Service in the future. It will not happen for nothing'. Dr MacIntyre is also a consultant cardiologist at the Royal Alexandra Hospital, Paisley.

The Department of Health's economic modelling for the vascular checks, published after the workshops, suggests that the policy is cost effective, with a cost per Quality Adjusted Life Year (QALY) of around £3,000 (5). The estimated cost impact will be about £40 million in Year 1, increasing to £210 million by Year 5. From Year 6 cost should be about £180 million to £243 million a year. These figures are, of course, estimates. The Department writes: 'We expect the true costs to depend significantly on the delivery route for the programme and roll-out plans which will be developed via engagement with stakeholders over the coming months'

Healthcare costs of cardiovascular disease in the UK for 2004, show that primary care costs only represented 3.4% (£584.3 million) of the total spent on cardiovascular disease. So plans to fund a primary prevention scheme predominantly based in primary care with £250 million a year extra are significant. However, Dr Terry McCormack cautioned that this might not be enough: 'About 10% of that figure is for the risk assessment process. But once you find these patients, this is a very small proportion of what you are going to do. We could do a lot more in primary care if there was a better budget there.' Dr McCormack is chair of the Primary Care Cardiovascular Society and a GP in Whitby, Yorkshire. He chaired and spoke at three of the workshops.



Dr McCormack's editorial (P4) reflects the current understanding of how funds will be allocated in England. He said: 'We had hoped that the funding would be ring fenced and available via a Direct Enhanced Service. This has not been possible and it is likely that individual PCTs will receive a finance allocation and will have autonomy as to how the money is spent. It is important that this process is transparent so that we can easily see how each Trust has spent their allocation'.

PCT support for PBC low in some areas

Practice Based Commissioning (PBC) is the key to vascular prevention, along with payment by results, according to Dr Michael Dixon, chair of NHS Alliance. He believes that these mechanisms provide clinicians with the incentive to save in some areas and use those savings to engineer change. He said, 'If we can show upstream that we can save costs and improve services and improve health, then we can - as commissioners - improve what we are offering patients and make better use of the finances available.'

But GPs enthusiastic to implement PBC have been disappointed at the failure of some PCTs to respond to their ideas. Lack of PCT support is behind the slow progress in PBC in some areas of the West Midlands, according to GP Dr Roger Gadsby. Dr Gadsby is associate professor at Warwick University, and was on the NICE Type 2 Diabetes guideline development group. He said, 'The thing that upsets me and concerns me is the variability around the country. How can we take a countrywide view of whether PBC is working or not when there is this huge variation between one PCT and another PCT! No wonder Bristol is doing well. They have four NHS graduate management trainees working, supporting commissioning consortia. And that is hugely different from my local PCT. And surely I have a right to say that degree of difference - although I know why it has happened - should not happen.'

Primary care vs secondary care

In the current market system, primary care providers feel played off against each other. There was a strong illustration of that at the London workshop. A chemical pathologist was concerned over losing work to pharmacies or other providers as they take on near-patient lipid profiling and glucose testing for the vascular checks. He argued: 'I see duplication of work here. Hospital laboratories with professionals who are supposed to be doing the tests are being starved of funds everyday, and here there is another body funding a group of people who are not even certified to do the test.'

The debate on pharmacies was not just one of competition, but on quality control of the service provided and the potential for duplication of work.

“... How can we take a countrywide view of whether PBC is working or not when there is this huge variation between one PCT and another PCT! ...”



Dr Roger Gadsby

For instance, some GPs are repeating the lipid profiles done at the pharmacies to confirm the results and risk levels of the patients.

After witnessing the debate on this issue at the London workshop, Dr Mike Dixon said: 'I think there is a big danger of conflict or fall-out between the laboratory, general practice and community pharmacy. You may say that the government had engineered exactly this to happen - to create a competitive market.' Dr Dixon took this message from the debate: 'As commissioners and providers, we need to integrate our care and perhaps not be played off against each other. Maybe that is one conclusion to take home today: to make sure that the pharmacist is part of your practice based commissioning consortium, and equally, for pharmacists to make sure that they are part of commissioning as well as of provision.'

“... I see duplication of work here. Hospital laboratories with professionals who are supposed to be doing the tests are being starved of funds everyday, and here there is another body funding a group of people who are not even certified to do the test ...”

Chemical pathologist



At another workshop Dr Roger Gadsby commented: 'My perception is that the politicians think that by putting different parts of the health-care system in competition with each other you create efficiency. And I am not sure that there is any evidence that is necessarily true.'

There were, he said, disincentives built into secondary care now: 'The hospitals get more money the more patients they see. And PCTs want to keep people out of hospitals. That is just a crazy perverse incentive. That needs to change, and we all need to work together for the good of patients.'

Dr Stuart Smellie, consultant clinical pathologist, County Durham and Darlington NHS Foundation Trust felt that it was questionable whether the competitive model had been shown to work in any part of the world. He said, 'There are now increasing signs in some of the journals that we are heading towards integrated primary and secondary care rather than setting different parts of the health service against each other.'

Evidence base for cardiovascular screening lacking

The evidence base for diabetes risk management programmes is strong in a targeted population, in contrast to that for cardiovascular risk management programmes. Some participants and speakers cautioned against commitment of resources to initiatives that have not been supported by a firm evidence base of cost effectiveness. The danger is that resources might be diverted from other important services without sufficient proof of their effectiveness. However, the opposite view was also put: that this initiative was groundbreaking, based on reasonable hypotheses, and welcome. The opportunities to collect data that could validate important work should not be neglected.

Guidance

The guidance that primary care uses to inform their delivery of prevention should be clear. Dr McCormack recommended in particular the UK National Screening Committee book, *The Handbook for Vascular Risk Assessment, Risk Reduction and Risk Management*(6) There was criticism of the consistency and the clarity of some of the other current guidance, with inconsistencies between the full versions and the quick reference guides or summaries of both NICE guidelines and of JBS2.



“... There are now increasing signs in some of the journals that we are heading towards integrated primary and secondary care rather than setting different parts of the health service against each other. ...”

Dr Stuart Smellie

“... As commissioners and providers, we need to integrate our care and perhaps not be played off against each other. Maybe that is one conclusion to take home today: to make sure that the pharmacist is part of your practice based commissioning consortium, and equally, for pharmacists to make sure that they are part of commissioning as well as of provision. ...”

Dr Michael Dixon

FINDING AND ENGAGING WITH HIGH-RISK PATIENTS

The NICE Lipid Modification guidelines recommend that people aged 40-74 at high risk should be identified mainly through a systematic strategy and not just opportunistically. They are to be prioritised for full cardiovascular risk assessment on the basis of an estimate of their cardiovascular disease (CVD) risk before offering them a full formal risk assessment. This estimate of CVD risk should be worked out from CVD risk factors already recorded in the primary care electronic medical records. People should be given the option to decline the full risk assessment.

The Department of Health particularly do not want the initiative to widen health inequalities. This would be a pitfall of simply sending patients letters inviting them in for an assessment at the practice. Such invitations tend to be taken up disproportionately by the middle-classes, the retired, and the 'worried well'. The Department states that it wants the approach to 'offer a real opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities.'⁽³⁾

Table 1. Practice steps in vascular assessment and risk management for CVD

Create accurate disease registers for CHD, stroke, transient ischaemic attack, and diabetes

Create accurate risk registers: hypertension, obesity, chronic kidney disease, smoking, increased glucose tolerance, and family history

Conduct searches of patients aged 40-74 years, prioritising those likely to be at risk but who are not being managed already for vascular risk

Call for assessment, giving patient the opportunity to consent or opt out

Undertake assessment (need standard operating protocols and quality assurance)

Review results and work out risk score/need for glucose tolerance test.

Inform patient of the risk assessment results, communicating the risk clearly

Discuss the intervention, and give the intervention if the patient agrees to it

Follow-up

Audit

Programmes aimed at engagement with socially deprived people, ethnic minorities, and traditionally hard-to-reach people were presented at the workshops. Among the most creative presented were those in Scotland. Some of their special features are summarised in the section 'Outreach' later in this article: Have a Heart Paisley and Keep Well. Table 1 lists key practice steps in the vascular assessment and risk management process in a general practice setting. During the workshop syndicate meetings and presentation various patient groups were considered potential priority targets (See Table 2). The National Screening Committee's *Handbook of Vascular Risk Assessment, Risk Reduction and Risk Management* was published on March 2008 and was highly recommended at the workshops. (6)

Various self-assessment tools and facilities for people were considered - in the waiting room or available nationally on the Internet. Self-assessments might be sent out to the patient on simple forms with the initial invitation.

Table 2. Priority targets for CV risk assessment

People with diagnosed hypertension

People with high blood pressure readings who have not been formally diagnosed as having hypertension

Raised blood sugar but no diagnosis of diabetes

BMI > 30

Waist circumference > 102 cm for males and >88cm for females

Smokers: It should be an integral part of every smoking cessation clinic that there is a proper evaluation and that primary prevention is being done

South Asian or Afro-Caribbean origin

Family history*: family history of cardiovascular disease in a first degree male relative under 65 or female relative under 55

People who are deprived*: people receiving benefits, postcodes in deprived wards

Patients in whom there is very little data

Erectile dysfunction

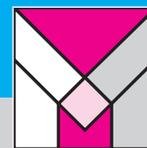
The above reflected the general consensus of the syndicates at the workshops, but the following additional targets were also mentioned:

Sleep apnoea

Autoimmune disorders

Occupation. E.g. calling all those patients who have asked for a DVLA medical examination, as heavy goods driving may correlate to unhealthy lifestyle.

*In Scotland they currently use family history as a surrogate marker for ethnicity, and the ASSIGN risk calculator includes the Scottish Index of Multiple Deprivation score for residential postcode as a measure of deprivation. The Scottish workshop was far more accepting of the usefulness of postcodes than the English workshops.



Approaches to finding patients

Dr Paul D MacIntyre, Chairman of the Scottish Advisory Committee for CHD, and Lead Clinician for CHD in Scotland, advises that three fundamental approaches should be used to ensure that the offer of vascular risk assessment reaches as many people in the targeted population as possible.

1. Opportunistic testing of patients when they come to the practice.
2. Structured approaches to identify and engage with patients who might be at risk of CVD.
3. 'Outreach' to target people who do not visit their GPs, often from socially deprived communities.

1. Opportunistic testing of patients when they come to the practice

A practice needs to decide how they will manage routine opportunistic approaches to patients, which may not always be welcomed by patients, and what resources will be needed to do it. Useful self-assessment opportunities for patients might be available in the waiting room. For example, weighing machines and self-assessment forms to discuss with the doctor or nurse.

2. Structured approaches to identify and engage with patients who might be at risk of CVD

Invitations for a vascular check by letter, might be followed up by more direct approaches. For example, by phone or by a skilled communicator visiting and engaging with some of the hard-to-reach patients. Large-scale PCT risk assessment could be directed at employers such as Councils, in places of worship, adult social clubs and school pickup points. The risk of overloading practices following mass risk assessment in an area should be recognized and appropriate strategies developed to stagger the load or give support to those practices.

Patients might be sent a 'ticket' for the vascular assessment, enabling the targeted patients to have their assessment done at a high-street pharmacy, mobile unit or work place, rather than at the practice. The ticket could have an electronic number tagged to the NHS number to facilitate communication to the GP and guard against duplication of work.

Most of the work of the risk assessments is likely to be done by nurses, but pharmacists also have a growing role.

Solutions from Information Technology

Information technology can provide solutions to finding patients in practice records and prioritising them. Dr McIntyre said that he had been working with MSD Informatics to see if there was an information technology solution to identifying at risk patients from Scottish practices.

Paul McIntyre

'Our ideas are to use an existing software package to interrogate the GP databases, to try and identify who might be at risk of CVD. Recognising that there might be missing data in there - such as cholesterol, BP - the software would automatically populate those missing data fields with Scottish average levels, so that we generate this virtual list of patients who might be at risk in a practice, and then we try to engage with them'.



There are a number of software packages available to interrogate clinical systems to find patients for risk assessment. Some of these have been compared by the UK National Screening Committee (6). Oberoi Consultancy Ltd. <http://www.oberoi-consultating.com> EMIS, E-nudge, Sandwell

MSD Informatics has also been working with Sandwell Primary Care Trust (PCT) and the University of Birmingham to redevelop risk stratification tools to identify and track patients with a high risk of developing CVD. Company representatives attended all the workshops as exhibitors, and one contributed to the discussions at the Glasgow meeting. (To learn more about this system contact: msdinformatics@merck.com.)

The Clinical Risk module of the MSD Information tool filters those patients that currently do not have CVD and assesses their future risk by applying the appropriate local risk-factor calculator. For instance, in Scotland, the ASSIGN algorithms and look-up tables provided by SIGN are used. The ASSIGN Risk Calculator is also available within Clinical Support for G PASS Practices. In the Birmingham area, algorithms and look-up tables provided by the University of Birmingham - based on Framingham with South Asian Male Weighting - are used. The software is compatible with all major GP clinical systems that support Read V2 and is part of the MSD Informatics Clinical Manager suite of applications. The software automatically identifies those patients whose clinical notes are not complete and applies local population defaults to enable an estimation of their risk. A new register is produced each time Clinical Manager is run. GPs can prioritise patients by their risk and use mail merge to ask patients to make appointments for an assessment and monitor their progress over time.

Missing data?

In the Department of Health's economic modelling for vascular checks, they used data from one million patients and found the following data was missing (5):

- 72% did not have a cholesterol reading
- 47% did not have a Body Mass Index reading
- 24% did not have a blood pressure reading
- 8% did not have a record of smoking status.

Pharmacy role in delivering risk assessments

Mr Shafeeque Mohammed, Clinical Services Pharmacist at Lloyds Pharmacy, presented the work of Lloyds Pharmacy at two workshops. Said Mr Mohammed, 'We have a proven track record of delivering services like cardiovascular disease screens and diabetes screens and also targeting the socially deprived areas and hard-to reach populations'. Another important part of their work is medicines use review, which helped patients to make best use of their medicines, such as statins and diabetic therapy.

The positive message coming out of the discussion of potential difficulties between GPs, pharmacies and local pathology services (P. 4-5) was to ensure that a pharmacist is part of the practice based commissioning consortium, and also that pharmacists make sure that they are part of commissioning as well as of provision of services.

3. 'Outreach' initiatives

A number of initiatives presented went out to where the target population congregates or lives. Lloyds Pharmacy have been involved as outreach teams doing vascular checks at Aston Villa Football Ground, Birmingham City Football Ground, and the IMAX centre Birmingham. This was a Birmingham Health and Wellbeing Partnership commissioned service.

Questions to Mr Shafeeque Mohammed

GP: We have got the same set up, but through the hospital, where the patient's blood test is done and results are sent by e-mail and we have the results the same evening. As soon as the result comes there is a flag on the screen saying this person's HbA1c is high, or this person's cholesterol is high. And we have to treat it accordingly, and if we don't treat it, during the QOF checkups it comes out of our points. If you do this at your pharmacy, I think it would be repetition of the service, and perhaps a waste of money. At the end of the day all the hospital results are sent to our computers the same evening.

Mr Shafeeque Mohammed: With the mass screening events all the results are transferred to the GPs who then receive an incentive payment for entering the data onto their systems.

Chemical pathologist: Have those GPs difficulty in getting the results from the established laboratory? Why is it that they send the patients to your establishment rather than send the sample to the laboratory.

Mr Shafeeque Mohammed: There was an opportunity to mass screen and some GP practices felt they did not have the resource to do that and hence turned to an alternative provider-pharmacy.

Lloyds Pharmacy

Lloyds Pharmacy has over 1700 pharmacies based in communities. Over 600 of these pharmacies are in under-doctored areas, and 450 pharmacies are in 62 spearhead PCT areas. More than 300 are in health centres with GPs. They have a workforce of 15,000 health-trained staff, and private consultation rooms with access to NHS Choices (<http://www.nhs.uk>) in over 90% of premises. Roughly two million people visit Lloyds Pharmacy every week. He said, 'I think that the pharmacies are well placed not just in terms of geography but also in terms of our skill set, our experience, and our commitment to become a more integrated part of health and social care teams. A few of us have formed partnerships with the NHS and local authorities'.

Among the services these pharmacies offer is a programme for vascular checks for everyone between the ages of 40 and 74. The service was designed in conjunction with HEART UK, and the vascular risk assessments are calculated using the Framingham equation and is approved by Professor Paul Durrington, an author of the Joint British Societies guidelines. The vascular assessment is in line with Joint British Societies guidelines and NICE. Total and HDL cholesterol are measured using the Cholestech LDX Monitor (Medicines and Healthcare products Regulatory Agency approved for near patient testing and the only machine approved by HEART UK). The staff doing the checks are trained and standard operating procedures are used to ensure high standards are met. The results are discussed with the person being assessed and a health plan offered. People found to be at high risk are given a referral letter for their GP.

Heart MOT

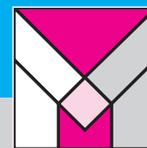
South Birmingham PCT on behalf of the 3 Birmingham PCTs, commissioned Lloyd's Pharmacy to provide 'Heart MOTs' to people over 40 year old. This is funded by the Birmingham Health and Wellbeing Partnership. Of a sample of 868 patients risk assessed by Lloyds pharmacy, 49% were referred to their GP, of whom 27% were referred due to high CVD risk.

The evolving role of community pharmacy in diabetes and CVD care

Prevention	Prediction	Personalised Continuity of Care
<ul style="list-style-type: none">Information & choiceBehavioural changeDiet & exerciseWeight managementSmoking cessationAlcohol awareness	<ul style="list-style-type: none">Vascular risk screeningType 2 diabetes screeningBlood glucoseCholesterol TC, HDLBPBMI & waist circumference	<ul style="list-style-type: none">First script complianceRepeat RxMedication use reviewMedication reviewLong Term Condition monitoring (e.g. HbA1c)

Regular day to day contact with the local communities and trusted by their patients

www.birminghamheartmot.nhs.uk



These evening and weekend clinics were delivered by Lloyd's Pharmacy and targeted men over 40 years of age. Over 7,500 people have been risk assessed. Of those invited to attend a clinic the uptake rate was 80% when contacted by phone.

Have a Heart Paisley (HaHP) and Keep Well are two Scottish initiatives. Have a Heart Paisley (HaHP) is the Scottish national demonstration project for coronary heart disease that ended in February 2008. Part of the Paisley project focussed on unmet needs. They helped remove some of the social issues that people had to deal with before they could be receptive to self-managing CVD prevention as a priority in their lives. Health coaches were used to individualise and encourage lifestyle changes, and also to suggest other existing support services.

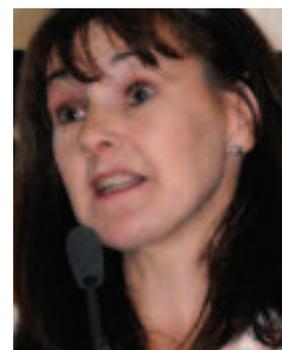
www.healthscotland.com/resources/networks/Heart-Healthnetwork.aspx

The HaHP evaluation reports can be found at:

www.chs.med.ed.ac.uk/ruhbc/evaluation/hahp/eag/

www.keepwellscotland.com

“... The combined resource has allowed us to target our most deprived zones and to use the personal approach of skilled communicators to engage with our target population.



So using that model you get about 70% of attendance and sometimes 100%. And that is patients who did not attend their initial appointments. ...”

Jill Madden

Keep Well

The Keep Well programme in Scotland is aimed at health improvement not in 40-74 year olds, as is the focus of vascular risk assessments in England, but in 45-64 year olds living in areas of greatest need. Keep Well has a particular focus on early intervention for those at high risk of coronary heart disease and diabetes.

The target population receive a letter or a phone call inviting them to attend a Keep Well health-check risk assessment. Based on this assessment, individuals will be offered or directed to services and support.

Keep Well Glasgow

The Glasgow Wave 1 team of Keep Well employ outreach workers to visit the homes of patients who have not yet engaged with the Keep Well project. These workers work across several practices and target the truly hard-to-engage patients. If a patient has been contacted three or more times without responding, a letter is sent out informing the patient that an outreach worker will visit them. (The patient can opt out of a visit by contacting their practice.) Keep Well Pharmacy Long Term Medicines and Keep Well Pharmacy Smoking Cessation services are enabling community pharmacies in North and East Glasgow to support hard-to-engage patients from the Keep Well practices.

Keep Well Lanarkshire

Jill Madden (Jill.madden@lanarkshire.Scot.nhs.uk), project manager, on the Keep Well programme, spoke

at the Scottish workshop on Wave 1: Lanarkshire, reporting some initial results. Engagement of people by letter produced an average attendance of around 40%. 'This method gave a slight over-representation in our most affluent population,' she said. To improve on this attendance the model of engagement now includes phone calls using North Lanarkshire's call centre - the Keep Well freephone helpline - along with home visits from outreach workers. She said, 'The combined resource has allowed us to target our most deprived zones and to use the personal approach of skilled communicators to engage with our target population'. She said the outreach workers were often welcomed by the patients. 'So using that model you get about 70% of attendance and sometimes 100%. And that is patients who did not attend their initial appointments.'

Early analysis shows that in 6 practices, 46% of patients had a CVD risk of 20% or more. A total of 617 prescriptions were required for cardiovascular-related illness. The highest number of prescriptions (237) was for lipid lowering drugs and 190 patients were put on disease registers. She concluded: 'Our plans for the future are to build on and expand our links with our partner agencies in both the statutory and voluntary sector to ensure we have a comprehensive, sustainable model of anticipatory care. This will form part of Lanarkshire's long-term condition's strategy.'

www.keepwellscotland.com

RISK MANAGEMENT USING STATINS

The NICE lipid guidelines state that statin therapy is recommended as part of the management strategy for the primary prevention of cardiovascular disease (CVD) for adults who have a 20% or greater 10-year risk of developing CVD. Treatment for primary prevention of CVD should be initiated with simvastatin 40mg (Table 1). If there are potential drug interactions, or simvastatin 40mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen.

Primary prevention: 'Fire and forget'

The most controversial of the NICE recommendations was paragraph 1.4.10. This states that 'repeat lipid measurement is unnecessary' once a person is on a statin for primary prevention.

Opinion was divided within the NICE guideline development group on whether to recommend or not this so called 'fire-and-forget' policy. Robert Short, medical journalist and editor of *Cormack Medical News* interviewed Professor David Wood on 'fire and forget' for this report.

Professor Wood was on the NICE Guideline Development Group and is Garfield Weston Chair of Cardiovascular Medicine, Imperial College, London. He said that the decision was controversial: 'That was a subject of enormous controversy in the guideline development group - which was split. A majority was in favour of the "fire-and-forget" policy. A minority, including myself, wanted to see repeat investigations and up-titration where targets were not being achieved, but we did not win that argument.'

Professor Wood added that his own practice was in accord with JBS2: 'In the joint British Society's guidelines, which I chaired, the view that we should be targeting those at highest risk and then measuring the risk factors and the impact that lifestyle and drug therapies have on risk factors and if necessary intensifying therapies - whether blood pressure lowering or lipid lowering - is central to our recommendations.'



"... That was a subject of enormous controversy in the guideline development group - which was split. A majority was in favour of the "fire and forget" policy. A minority, including myself, wanted to see repeat investigations and up-titration where targets were not being achieved, but we did not win that argument. ..."

Professor David Wood

Table 1. Extract from NICE clinical guideline 67 - Lipid Modification

Drug therapy for primary prevention

1.4.6 When the decision has been made to prescribe a statin, it is recommended that therapy should usually be initiated with a drug with a low acquisition cost (taking into account required daily dose and product price per dose*).

1.4.7 Treatment for the primary prevention of CVD should be initiated with simvastatin 40 mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen.

1.4.8 Higher intensity statins** should not routinely be offered to people for the primary prevention of CVD.

1.4.9 A target for total or LDL cholesterol is not recommended for people who are treated with a statin for primary prevention of CVD.

1.4.10 Once a person has been started on a statin for primary prevention, repeat lipid measurement is unnecessary. Clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.

*This recommendation has been taken from 'Statins for the prevention of cardiovascular events'. NICE technology appraisal 94. See www.nice.org.uk/TA094

** 'Higher intensity statins' are statins used in doses that produce greater cholesterol lowering than simvastatin 40 mg, for example simvastatin 80mg.



AGAINST 'FIRE AND FORGET' IN PRIMARY PREVENTION: SIMVASTATIN 40MG AND NO CHECK OF CHOLESTEROL LEVELS



Dr George Kassianos

I don't believe that you should put patients on anything - statin or anything - and forget. You need to follow them up. Take them through the benefits of treating hypertension. The benefits of putting them on a statin and lowering the cholesterol. And then I leave the decision up to them. They say, 'I will not take the statin, I will take the ACE inhibitor' or whatever. Fair enough. I document that. So don't try to treat patients, just advise them. If you do that they will comply with the therapy they agree to



Dr Stuart Smellie

We know, however, with statins, that if we are going to get to an optimal level it might be that 40mgs is not enough. OK! That is going to cost a bit and we might have to put pressure on Government. It is not going to cost a fortune. A large proportion of people are still going to be managed on 40 mg or 80 mg of simvastatin.



Dr Sarah Jarvis

Statin therapy for all who need it is indeed cheap therapy and it is an extremely cheap way to go. What I do not believe is that there is any argument for doing what the Government has advocated and say to someone 'just because you haven't had a heart attack all you are getting is simvastatin. We are not going to take account of the size of your risk. We are just going to give you the cheapest stuff out there.'

The conflict of opinion was examined in the workshops in a debate over 'fire and forget' in primary prevention as opposed to individualised treatment to target levels of total cholesterol and LDL cholesterol.

Against 'fire and prevent' in primary prevention

A general consensus of the arguments against 'fire and forget' at the workshops appeared to be as follows: 'Fire and forget' does not differentiate between someone at 20% risk over 10 years and someone at 50% risk at 10 years. Neither the doctor nor the patient knows if acceptable levels of cholesterol have been achieved with 'fire and forget'. Patient compliance is improved by a patient knowing that they are reaching a target level of cholesterol. Patients are increasingly aware from the media and advertisements on TV that the blood cholesterol 'number' is important. If they are to continue to take a drug they want to know it produces the effect intended. 'Fire and forget' is patronising and hypocritical and does nothing to encourage self-management of risk factors or engender trust in doctors.

Speakers in the workshops were generally in favour of at least one cholesterol measurement in primary prevention to confirm that simvastatin 40 mg prescribed was working in the individual patient, but agree that annual tests were not necessary. For example, Dr Kassianos said: 'We need to monitor. If you actually have a patient on a drug, you need to monitor the effects of the drug. What we might think about is to ease up on the frequency of monitoring.'

The view also was that the NICE statement 1.4.10 saying that repeat lipid measurement is unnecessary should not overshadow the second sentence in the same paragraph which states 'Clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile'.

For 'fire and forget' in primary prevention

The arguments for 'fire and forget' with simvastatin 40mg were less consistently supported, when speakers were released from the sophistry of debate.

Combined with the vascular checks programme to find people at high risk of CVD, giving 40mg of simvastatin without checking the effect on blood cholesterol is a cheap efficient way of getting masses of high-risk patients on basic statin intervention. Once on therapy, the patient will be coming to the practice regularly for review, as with any medication. Therapy may then be individualised under 'clinical judgement' as advocated by NICE in the same paragraph as the statement to use 40mg simvastatin. So 'Fire and forget' is not what NICE said, because the patient is not forgotten and the GP has the option to individualise treatment at a later date. The other argument was one of cost containment - so that the Government could afford to get more people onto basic statin treatment.

IN SUPPORT OF CLINICAL JUDGEMENT

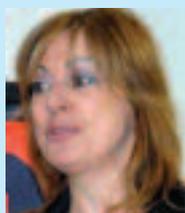
NICE Lipid Modification guideline

Clinical judgement and patient preference should guide the review of drug therapy and whether to review the lipid profile.



Dr Colin Waine

Remember in this world of guidelines and rules and regulations and QOFs that the essential unit of medical practice is when, in the privacy of the consulting room or sick room, the person who is ill seeks the opinion of someone he trusts. This is the consultation and all else in medicine stems from it. And I would submit that the Government has no place in the consultation.



Dr Fran Sivers

These are guidelines rather than instructions that have to be followed. Clinical judgement should be emphasised as well.

Dr Adrian Brady, consultant cardiologist, Department of Medical Cardiology, Glasgow Royal Infirmary said: 'Low cost statin and blood pressure lowering therapy saves thousands of lives. Higher cost statins do save more lives but can we afford it?' He showed the devastating effect that using more powerful statins might have on drug budgets in Scotland.

Secondary prevention

The drug therapy for the secondary prevention of CVD in the NICE lipid modification guidelines (Table 2) was discussed with less controversy in the English than in the Scottish workshops. English lipid targets are now more aggressive and accord more with international trends towards 'the lower the better'.

The footnote on 'higher intensity statins' in the NICE document is confusing. It seems to imply that simvastatin 80mg is a higher intensity statin than 40 mg, whereas many doctors would understand 'higher intensity statins' as meaning a more powerful statin. Certainly, Dr Terry McCormack appeared to interpret it this way. He said at the workshop: 'In acute coronary syndromes, they say use the higher intensity statins. What they mean is atorvastatin and rosuvastatin. There is no doubt that if you have just had an event you want your cholesterol pushing down as far as you can.'

The use of simvastatin 80mg was not supported by speakers at the workshops, because of the increase in side effects of the higher dose of simvastatin, lack of evidence of its efficacy at that dose, and lack of efficacy relative to other statins.

Table 2. Drug therapy for secondary prevention in the NICE Lipid Modification guideline

Drug therapy for secondary prevention

I.4.17 For secondary prevention, lipid modification therapy should be offered and should not be delayed by management of modifiable risk factors. Blood tests and clinical assessments should be performed, and comorbidities and secondary causes of dyslipidaemia should be treated. Assessment should include:

Smoking status

Alcohol consumption

Blood pressure (see 'Hypertension', NICE clinical guideline 34)

Body mass index or other measures of obesity (see 'Obesity', NICE clinical guideline 43)

Fasting total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides (if fasting levels are not already available)

Fasting blood glucose

Renal function

Liver function (transaminases)

Thyroid-stimulating hormone (TSH) if dyslipidaemia is present.

I.4.18 If a person has acute coronary syndrome, statin treatment should not be delayed until lipid levels are available. A fasting lipid sample should be taken about 3 months after the start of treatment.

I.4.19 Statin therapy is recommended for adults with clinical evidence of CVD*.

I.4.20 The decision whether to initiate statin therapy should be made after an informed discussion between the responsible clinician and the person about the risks and benefits of statin treatment, taking into account additional factors such as comorbidities and life expectancy.

I.4.21 When the decision has been made to prescribe a statin, it is recommended that therapy should usually be initiated with a drug with a low acquisition cost (taking into account required daily dose and product price per dose)*

I.4.22 People with acute coronary syndrome should be treated with a higher intensity statin**. Any decision to offer a higher intensity statin should take into account the patient's informed preference, comorbidities, multiple drug therapy, and the benefits and risks of treatment.

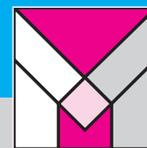
I.4.23 Treatment for the secondary prevention of CVD should be initiated with simvastatin 40mg. If there are potential drug interactions, or simvastatin 40 mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen.

I.4.24 In people taking statins for secondary prevention, consider increasing to simvastatin 80mg or a drug of similar efficacy and acquisition cost if a total cholesterol of less than 4 mmol/litre or an LDL cholesterol or less than 2 mmol/litre is not attained. Any decision to offer a higher intensity statin** should take into account informed preference, comorbidities, multiple drug therapy, and the benefit and risks of treatment.

I.4.25 An 'audit' level of total cholesterol of 5mmol/litre should be used to assess progress in populations or groups with CVD, in recognition that more than half of patients will not achieve a total cholesterol of less than 4 mmol/litre or an LDL cholesterol of less than 2 mmol/litre.

* This recommendation has been taken from 'Statins for the prevention of cardiovascular events', NICE technology appraisal 94. See www.nice.org.uk/TA094

** 'Higher intensity statins' are statins used in doses that produce greater cholesterol lowering than simvastatin 40 mg, for example simvastatin 80mg.



“... So with “4” that is the entire health budget for Scotland. That would mean no Herceptin, no antidepressants...”

Dr Adrian Brady

Dr Stuart Smellie's statement is typical: 'Simvastatin 80mg is not well proven and the loss of the alternative options I think is a very retrograde step. We do need to examine the cost effectiveness of the more effective treatments.' Similarly Dr Miles Fisher, Glasgow Royal Infirmary, says: 'There is no study showing that 80mg simvastatin reduces events. In fact the study of simvastatin shows increased side effects.'

The target for secondary prevention is a total cholesterol of less than 4 mmol/litre or an LDL cholesterol of less than 2 mmol/litre (paragraph 1.4.24). The stated audit target of 5mmol/litre has incentives attached to it already for GPs, as it is on the QOF.

In the English workshops these new more aggressive targets of 4 mmol/litre total cholesterol or 2 mmol/litre LDL were not controversial, on the grounds that 'lower is better'. However, in Scotland Dr James Grant, GP in Auchterarder, took issue with the evidence for these targets, based on SIGN's rigorous review of the evidence as published in SIGN 97. He was on the development group of SIGN 97. He said: 'NICE have moved on to 4 and 2 but I would still argue with NICE that the evidence for 4 and 2 is not there.'

In fact, in Scotland SIGN 97 recommends 'The existing total cholesterol target of <5mmol/litre in individuals with established symptomatic cardiovascular disease should be regarded as the minimum standard of care.' A reduction to 4mmol/litre would have devastated NHS Scotland's resources. Dr Adrian Brady presented the figures. With a total cholesterol target of <5mmol/litre, the cost to Scotland of 5 years primary and secondary prevention would be £80 million. In contrast, with a cholesterol target of <4mmol/litre, the cost to Scotland for 5 years of primary and secondary prevention would be £380 million. Said Dr Brady, 'So with “4” that is the entire health budget for Scotland. That would mean no Herceptin, no antidepressants.'

Management of blood lipids in diabetes

Speakers at the workshops focussed principally on the lipid modification aspects of pharmacological treatment in the NICE diabetes guideline.

Table 3. Management of blood lipid levels extracted from NICE Type 2 Diabetes guideline

- 1.10 Management of blood lipid levels
 - 1.10.1 Statins and ezetimibe
 - 1.10.1.1 Review cardiovascular risk status annually by assessment of cardiovascular risk factors, including features of the metabolic syndrome and waist circumference, and change in personal or family cardiovascular history.
 - 1.10.1.2 For a person who is 40 years old or over: Initiate therapy with generic simvastatin (to 10mg) or a statin of similar efficacy and cost unless the cardiovascular risk from non-hyperglycaemia related factors is low (see 1.0.1). If the cardiovascular risk from non-hyperglycaemia-related factors is low, assess cardiovascular risk using the UKPDS risk engine (see 1.9.2) and initiate simvastatin therapy (to 40 mg), or a statin of similar efficacy and cost, if the cardiovascular risk exceeds 20% over 10 years.
 - 1.10.1.3 For a person who is under 40 years old, consider initiating generic simvastatin therapy (to 40 mg), or a statin of similar efficacy and cost, where the cardiovascular risk factor profile appears particularly poor (multiple features of the metabolic syndrome, presence of conventional risk factors, microalbuminuria, at-risk ethnic group, or strong family history of premature cardiovascular disease).
 - 1.10.1.4 Once a person has been started on cholesterol-lowering therapy, assess his or her lipid profile (together with other modifiable risk factors and any new diagnosis of cardiovascular disease) 1-3 months after starting treatment, and annually thereafter. In those not on cholesterol-lowering therapy, reassess cardiovascular risk annually and consider initiating a statin (see 1.10.1.2 and 1.10.1.3).
 - 1.10.1.5 Increase the dose of simvastatin, in anyone initiated on simvastatin in line with the above recommendations, to 80 mg daily unless total cholesterol level is below 4.0 mmol/litre or low-density lipoprotein [LDL] cholesterol level is below 2.0 mmol/litre.
 - 1.10.1.6 Consider intensifying cholesterol-lowering therapy (with a more effective statin or ezetimibe in line with NICE guidance*) if there is existing or newly diagnosed cardiovascular disease, or if there is an increased albumin excretion rate, to achieve a total cholesterol level below 4.0 mmol/litre or an LDL cholesterol level below 2.0 mmol/litre.
 - 1.10.1.7 If there is a possibility of a woman becoming pregnant, do not use statins unless the issues have been discussed with the woman and agreement has been reached.

*Statins for the prevention of cardiovascular events (NICE technology appraisal guidance 94); Ezetimibe for the treatment of primary (heterozygous -familial and non-familial) hypercholesterolaemia (NICE technology appraisal guidance 132).

Dr Roger Gadsby, GP and an associate clinical professor, Warwick Medical School, University of Warwick was on the development group for the NICE Type 2 Diabetes guideline.

He drew attention to paragraph 1.10.1.6 (see Table 3), 'We are highlighting microalbuminurea as a significant risk factor for CV risk. And in that situation the guideline does give a significant amount of freedom. I understand that the lipid guideline is more restrictive.'

Glucose control

Glucose control as reflected by HbA1c control was also discussed, a target of HbA1c of 6.5%, being set. Professor Azhar Farooqi, GP, East Leicester Medical Practice and an author of the *UK National Screening Committee Handbook on Vascular Risk Assessment* advised doctors and nurses to remember the other risk factors and not to concentrate on glycaemic control to the exclusion of all else. He said, 'I think that in your diabetic clinics at least half your time, if not more, should be spent looking at the other risk factors. It should be about lipids, should be about blood pressure, and should be about aspirin prescription rather than the glycaemia. The glycaemia is important. We cannot dismiss it.'

Aspirin in diabetic patients

The blood pressure below which aspirin of 75mg daily could be prescribed in diabetic patients was discussed at two workshops and debated. A proportion of GPs commonly do not set an upper threshold low enough, and so put the patient at increased risk of stroke or bleeding into the stomach. In contrast, some GPs tended to withhold the benefits of aspirin from patients until they achieved blood pressures that are normal for non-diabetic healthy individuals - 140mmHg systolic (or even 135mmHg systolic in international guidelines).



“... I think that in your diabetic clinics at least half your time, if not more, should be spent looking at the other risk factors. It should be about lipids, should be about blood pressure, and should be about aspirin prescription rather than the glycaemia. The glycaemia is important. We cannot dismiss it.’ ...”

Professor Azhar Farooqi



“... 145mmHg is probably a bit ambitious because you are not going to get everyone to 145 anyway. So you pretty much exclude half of your hypertensive patients from ever having aspirin. So I don't actually agree with what NICE said there. But certainly you should have the systolic definitely below 160 and preferably below 150 ...”

Dr Terry McCormack

Dr Terry McCormack felt the NICE advice was too ambitious. He said: '145mmHg is probably a bit ambitious because you are not going to get everyone to 145 anyway. So you pretty much exclude half of your hypertensive patients from ever having aspirin. So I don't actually agree with what NICE said there. But certainly you should have the systolic definitely below 160 and preferably below 150. Especially if they have just had a stroke event and not had CT.' He said that if aiming too low, for instance 135mmHg, most patients will be deprived of the benefit of aspirin. He said, 'I think the key thing is to have some control'.



SYNDICATE FEEDBACK QUOTATIONS AND CONCERNS

UNDERSTANDING LIFESTYLE AND NEED

GP: The next task was to explain why patients were at high risk. What does this mean in terms of management and treatment? We talked about a holistic approach. Understanding the psychology of the patient: the grandmother who is looking after the child because the daughter is in prison and the son is a drug addict. You have to understand those issues before you can understand the glucose level.

Also understanding the reasons why people do not eat healthily, such as prices. The price at the local shop may be more than Asda. However, they don't go to Asda because of the transport. Maybe in PBC we should be looking to do something innovative around healthy eating and exercise.

Nurse/practice manager: We sit in our ivory towers and we talk to people about lifestyle and changing the diet and eating healthier. But when the cost of a bag of frozen chips is 50p and frozen peas is £1.67 you can see why people don't take our advice. GP: Health and social care is important.

Understanding what voluntary sector services there are, and making sure those voluntary care services tell practices what is available to us is vital so that we can refer into them.

Participants at all workshops were divided into syndicates in the afternoon.

They were given the same task: discuss how they would - in their own practices or PCTs - prioritise for pre-assessment those patients who might be at high risk; consider how they would do the assessments; and how they would manage the risks of patients.

This section contains quotations from the plenary feedback. Participants were assured that they would be anonymous, so names are not used. One group's flow charts from the Manchester meeting have been reproduced to give readers an insight into the dynamic thinking in these multidisciplinary groups.



Putting Comprehensive CVD Risk Management into Primary Care

GP: One of our group had a practice where there was a 35% turnover of people every year, as people move on from one rented flat to another.

GP: Practices should take into consideration their local environment, one size doesn't fit all. You cannot have a single algorithm for everywhere because it will be different in rural areas.

GP: The government only thinks in terms of urban areas. But if it is 17 miles to the hospital it is much more difficult - when there is no transport in a relatively deprived rural area. You have to try to organise hospital cars.

GP: She said that she needed money to go to the gym, because it wasn't safe to walk where she lived.

GP: Why are these patients high risk? We tried to look at the modifiable and non-modifiable factors, and determine whether those were lifestyle choices made or environmental factors. It is a difficult to make yourself exercise if you live in high story environment or your area is unsafe for walking.



EVIDENCE BASE FOR ACTION?

Nurse/practice manager: Mr Brown is making all these sweeping changes, and we never have the chance to evaluate things in primary care anymore. We just go along with the changes. We keep changing all the time and coming up with new programmes for things but we never evaluate what we do and find out what works best.

USE QOF SMOKING CHECKS

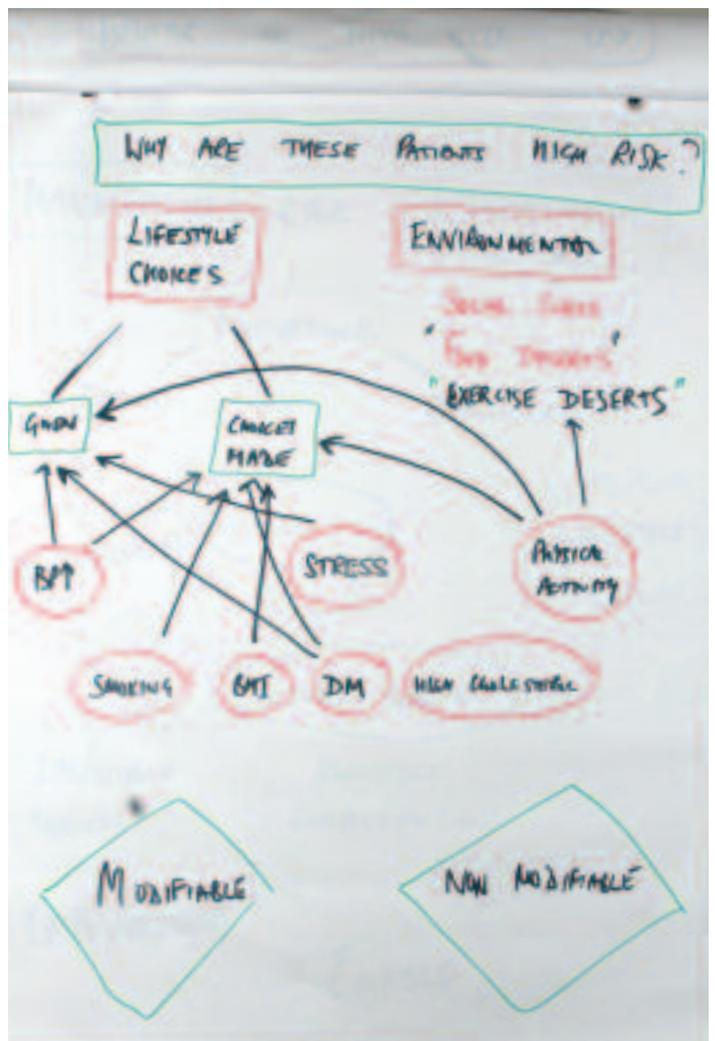
GP: We noted that some practices may have QOF failures because they don't recheck whether non-smokers have started smoking again. Indeed, some patients may lie about their smoking habits.

FINDING HIGH-RISK PATIENTS

GP: We were asked to look at identifying profiles of patients with a high risk of CV disease. So for pre-assessments, we could search on the computer.

Ethnicity was a big issue for us. Afro-Caribbean groups and South-Asian groups. Smokers obviously, BMI, waist circumference. We also looked at those patients who had received DVLA medical examinations, because they tend to be long distance drivers. Not much exercise, eating on the road, possibly smokers. They tend to be a male group which is very difficult to reach. Female group have smears etc. We have opportunities to see women in the practice on a regular basis but not men. So we may perhaps need to go out and see those.

Nurse: The PCT should liaise with gyms with respect to BP records. We get a lot of gyms that will take BP. Maybe, with a patient's consent, we can get those BP recordings as well. Maybe as nurses, because we are good at taking BP and risk managing, we could go out to places.





Where I work, if I go out to McDonalds I would probably meet 90% of the practice population. I could do some work there, as well as going to churches and mosques to find high risk patients.

GP: Also utilising large employers, occupational health services. Because patients don't have to come out of work. They can actually get assessed while they are at work.

GP: There was even a suggestion that we involve NHS Direct-reversing what they usually do. Instead of patients ringing them, they could ring patients and encourage them to come for checks.

GP: We had a description of a couple of systems which were already in place.

One, where a practice started its own screening initiative for patients over 40 who were overweight. They picked up a lot of diabetics, prediabetics, thyroid disease. About 40-50% of the people they wrote to came in.

And then there was a Locally Enhanced Service where they were instructed to target hypertensives who had not had a risk screen, and those people who had a high BP on their system but not diagnosed as being hypertensive. So, similar to people who have raised blood sugars but who are not recorded as diabetic.

GP: It was interesting to get some feedback from the local doctors in Birmingham about Lloyd's Pharmacy.

They said that the patients get the assessment, but do not always come to the surgery, and the surgery does not know whether that person has been screened or not.

There is, according to that GP, no third piece of paper identifying the patient and passing directly to the practice. And there was a general perception of a lack of communication about the scheme.

MANAGEMENT OF RISK

GP: A co-ordinated care and agreed management plan, with patient involvement in the care plan, so engaging the patient rather than asking the patient to do things and hoping they adhere to it.

GP: With the high-risk primary prevention there is not an option in the current guidance to extend beyond the standard 40 mg category. And I think that the view that came out of our group was, whatever algorithms were decided, this: with a person having very high risk coming into your clinic, when you have done your optimal in terms of lifestyle modification, most of us would really change this and not stick to a 'one drug suits all' approach.

GP: We had issues about whether it was possible to screen for family history. The only real opportunity to ask about family history is in a new patient medical. We thought it was not a good idea to go down the route of asking employers and DSS to help us with that, because of insurance implications to the patient.



Putting Comprehensive CVD Risk Management into Primary Care

Nurse: Lifestyle could be to do with housing and deprivation and it is important that there is some collaboration with local councils to achieve the best outcome.

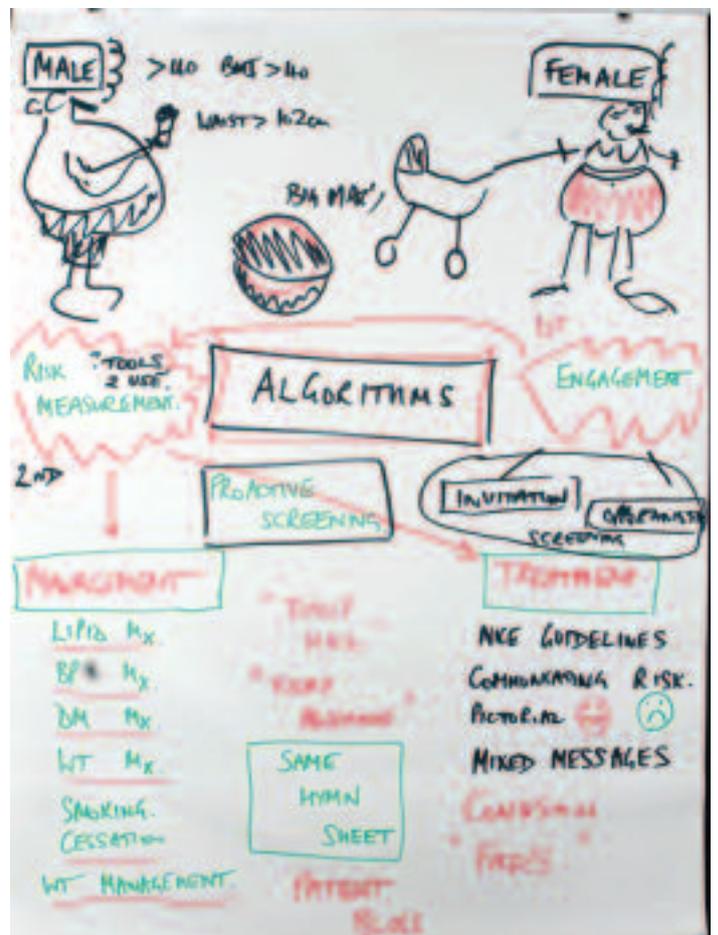
GP: We need to motivate professionals more to encourage lifestyle changes. This needs to be resourced adequately to enable engagement, and overcome barriers. We are talking about explaining the same risk factor to different cultures. Language barrier. Knowledge and comprehension of the lifestyle changes required needs to be communicated and perhaps some people will find it hard to understand these risk factors in the first place.

GP: We felt that a lot of the medication to control people's hypertension, cholesterol and so on - is the easy bit. This is where we know what the return on investment is and that we can get reductions in mortality. But if we are going to move towards a future of primary care that will decrease morbidity we are going to have to tackle the hard bit, where we don't know the return on investment. Where we try to tackle morbidity through physical activity, dietary advice, weight loss programmes etc.

GP: Assessing patients expectations of their treatment . Deciding how you are going to effect behaviour change. Making sure that the programme of care is individualised for the patient.

GP: Looking towards the DOH and local and national campaigns to increase patient awareness, like national smoking campaigns, local healthy eating campaigns. Again national and local guidelines. All tied in again to educating patients. And also collaborating with local councils. Holistic approach to patients.

GP: They don't need to go to a gym. It is about walking more, using stairs rather than lifts.



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