

Primary Care Partnerships

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NSF for Diabetes services sets challenging targets for primary care

The long-awaited National Service Framework has been broadly welcomed by healthcare organisations. Paul Streets, Chief Executive of Diabetes UK looks at it's challenges for PCTs



Paul Streets

After the initial announcement in 1999 it has been a long and sometimes painful wait for the English diabetes National Service Framework (NSF) to become a reality. However, at long last the delivery strategy has been published and Primary Care Trusts now have the framework for improving services nationwide. Although there are some omissions, publication of the framework is certainly a step in the right direction and now we need to ensure implementation is as smooth and effective as possible.

This NSF will be the first real test of *Shifting the Balance of Power* and PCTs have the opportunity to address local needs in the communities they serve. Differences between the diabetes NSF and previous ones could be highlighted by the lack of performance indicators to monitor success and a failure to provide ringfenced funding. However, the delivery strategy does set out the need for PCTs to provide 'challenging and measurable' targets and suggests they 'use the funds made available in baseline allocations'. PCTs are expected to deliver all the standards in the next ten years.

It may seem like a daunting task but priorities for the first three years have been outlined and two specific targets have been set. Firstly, to provide a retinopathy screening programme and secondly to provide practice based registers for systematic treatment of diabetes. In addition to this it is expected that a needs assessment will be undertaken in each area and targets set according to local needs.

Issues to bear in mind include the importance of this local needs assessment and

workforce review, the involvement of the person with diabetes in all aspects of their care and the efficient use of a local diabetes network to enable service co-ordination and effective delivery.

Delivering support to people with diabetes relies on the establishment of practice based registers. The framework states that these will provide the cornerstone of care and the basis for call and recall, clinical care, prevention, continuous quality improvement, monitoring and clinical audit. Highlighted as an important part of this is the fact that people with diabetes should have a personal diabetes record and agreed care plan. The care plan should include the personal goals of the person with diabetes, set out how their diabetes is to be managed until their next review, identify health, social care and education needs, how they will be met and who will be responsible and identify a named contact.

The above outlines just some of the elements which we hope will ensure people with diabetes get the best possible care. We only need to look at the current situation in order to understand why the framework is needed more now than ever.

There are currently 1.4 million people in the UK with diabetes and this figure is set to double by 2010. People are remaining undiagnosed for years, standards of care vary dramatically and there is a lack of specialist staff. Undiagnosed or poorly treated diabetes can and is leading to heart disease, kidney disease, blindness and nerve damage leading to amputation. Diabetes must be prioritised, and it must be prioritised now.

Concerns over NSF

While welcoming the initial targets, the Royal College of Physicians has expressed concerns about the NSF's focus on primary care and its failure to recognise the role of consultant diabetologists in patients with complex problems.

RCP President Professor Carol Black said: 'Early detection of diabetes in the community and continuing surveillance and management can improve the outlook for patients. It requires accurate and complete identification of those at risk. A practice based register, run by the primary care team that has responsibility for each patient, is a tried way of supporting this work. Moreover, it promotes team working in a practice and also clinical audit with the improvements in care that audit encourages.'

'Secondly, the demonstration that screening for diabetic retinopathy can lead to treatment to prevent or retard worsening vision represents a great advance in care.'

*Recognising the importance of NSFs, PCP with the support of MSD and Schering Plough is pleased to include in this month's issue, the first of a series of supplements on the progress of the NSF for CHD.

Retail Pharmacy Services Report

The Office of Fair Trading has published a report into the UK market for retail pharmacy services and whether consumers are best served by the current statutory controls under which pharmacists can dispense prescriptions. This can be found in full on their website www.of.gov.uk/ please select **Marketinvestigations/Investigation/pharmacies.htm** Stakeholders in England who want to comment on OFT's recommendations should contact Peter Dunlevy the DOH's community pharmacy policy manager: peter.dunlevy@doh.gsi.gov.uk

Promise to Non-Executives

Sir William Wells has been re-appointed Chair of the NHS Appointments Commission for another four years. On acceptance he said he looked forward to building on progress already made and to 'improving the appointments process to NHS boards and in developing the skills of non-executive directors.'

Broadband Upgrade for NHSnet

A £45 million major upgrade to NHSnet for hospitals, GPs and NHS trusts has been announced by Health Minister Lord Philip Hunt. The upgrades will give every GP practice a 256Kbps fixed link NHSnet connection. Each trust including PCTs and Strategic Health Authorities will be upgraded to a 2Mbps fixed link NHSnet connection. Roll-out of the bandwidth upgrade by NHSnet suppliers BT and Cable and Wireless, is due to be completed by March 2004.

Performance Indicators

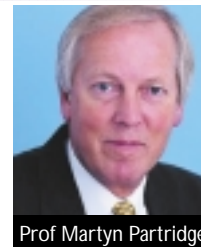
Critical issues such as clinical governance, service re-design and demand management have been left out of the government's 50 proposed PCT performance indicators for 2003/04, according to the NHS Alliance. Dr Michael Dixon, Alliance Chair, said: 'We are fully committed to the principles of openness and performance assessment, but we have got to get it right – the right targets and accuracy too. Last year we saw one in ten PCTs having significant inaccuracies in the published indicators. It would be regrettable if such errors were repeated.'

Skilled for Health

A joint programme launched by the DoH and Department of Education and Skills aims to help the seven million people in the UK who have difficulty reading the label on a medicine bottle. *Skilled for Health* aims to improve literacy through linking it to health issues. It will help people manage practical situations such as making an appointment with a doctor and calculating a dosage of medicine.

Commissioning guidance

NHS priorities threaten care of patients with respiratory disease



Prof Martyn Partridge

Patients with respiratory diseases such as asthma, tuberculosis, sleep apnoea and allergies are suffering from inadequate NHS care because their conditions are not national 'priorities' and are not covered by an overall National Service Framework, according to a new report, *Bridging the Gap*

Co-author Martyn Partridge, Professor of Respiratory Medicine at Imperial College London and Chair of the Respiratory Alliance said the report aimed to help PCTs make a start on improving respiratory services.

He told PCP: 'I think PCTs are understanding of the size of the problem of lung disease and are quite empathic, but they have been chained to deliver targets in priority areas.'

He added: 'We risk seeing patients with respiratory diseases treated like second-class citizens in the NHS because their conditions, with the exception of lung cancer, are not officially classed as a priority.'

Adhering too strictly to NHS priorities at the expense of respiratory disease runs the risk of discrimination by disease, without taking into account patients real clinical needs.

'This is the first document of its kind - and should help to bridge the gap that exists between the health services currently provided for those with allergies and long-term respiratory diseases and those required to meet the expectations of patients.'

'Those who commission healthcare services have a real opportunity to make a major impact on the lives of the eight million people with respiratory disease. We hope that this opportunity will be firmly grasped.'

The study from the Respiratory Alliance warns PCTs that concentrating mainly on NHS priorities may distort clinical practice, resulting in 'disease discrimination' where patients with 'non priority' diseases, lose out.

Respiratory disease kills one in four people in the UK and places a high burden on the health service. It is the most common reason for general practice consultation or emergency medical admission to hospital. The authors state that given the size of the problem, it 'is astounding that the management of respiratory disease is not attracting greater national attention'.

Bridging the Gap is the first ever comprehensive document which aims to help PCTs to commission and deliver high quality allergy and respiratory care, and states that PCTs can improve patient care and reduce both emergency hospital admissions and use of health care funding.

It offers a comprehensive checklist for health service providers summarising services they should provide to meet reasonable patient expectations. It is hoped that the checklist will help improve the quality of services provided for patients with serious respiratory diseases such as:

- rhinitis/sinusitis and other allergies
- obstructive sleep apnoea
- tuberculosis

For example, in asthma, reasonable patient expectations are defined as:

- timely and accurate diagnosis
 - best possible control of symptoms according to national guidelines
 - provision of a written personal action plan of what to do when symptoms get worse.
- In asthma, key health services that should be provided are defined as:
- training for healthcare professionals in asthma management
 - defined standards for the delivery of asthma care
 - a practice register of patients
 - written personal action plans for each patient of what to do if symptoms get worse
 - systems for regular review and follow-up
 - referral to primary care specialists and secondary care services if necessary.

The document also says there is 'considerable scope' to improve the diagnosis and management of Chronic Obstructive Pulmonary Disease (COPD). Ideally spirometry (the vital breathing equipment used to measure lung function and diagnose COPD) should be available within each practice using trained staff. If this is not possible open access secondary care lung function laboratories should be used.

The Alliance also states that pulmonary rehabilitation services (providing exercise-based therapy to reduce disability for COPD patients) are limited across the country - despite widespread evidence of their effectiveness.

Specialist allergy services are also in very short supply so that people with allergies are often being dealt with in primary care by staff without appropriate training or support. Rhinitis causes under appreciated reductions in quality of life and ability to learn and work effectively. It is frequently missed and/or mistreated; and yet often precedes and exacerbates asthma.

The Respiratory Alliance says PCTs should appoint clinical and non-clinical leaders of respiratory and allergy services, charged with making sure patients receive high quality integrated services for their lung condition.

The report urges PCTs to bolster education and training for GPs and nurses in rhinitis/allergy and also in COPD, spirometry and smoking cessation where it says the current skills base is 'woefully inadequate'.

It calls on PCTs to make use of the 'considerable skills' already in the primary care team, such as the 6,000 GPs with a declared special interest in asthma and COPD - and the 15,000 practice nurses and others who have completed a diploma or degree level course in respiratory conditions.

The authors state that innovative approaches such as peripatetic specialist nurses and COPD 'home care teams' may be needed to bridge the gap between current services and those that patients deserve.

Is the right to choose always a good thing?

John Appleby, Chief Economist, and Anthony Harrison, Senior Fellow at the King's Fund look at the reality of patient choice in the NHS and examine the knock-on effects.



Anthony Harrison



John Appleby

Since last summer cardiac patients waiting to go into hospital have had the right to be offered a choice of where to be treated – a choice which would mean quicker access to care. In London ophthalmology patients have been choosing quicker treatment since last autumn. By this summer the London patients choice project will have extended this choice to all specialities.

Improving choice has undeniable popular and political appeal: who could argue against the desirability of allowing patients more say in decisions concerning them? At first glance, improving choice seems unequivocally a good thing, giving patients quicker access to care and also exerting some pressure on poorly performing trusts to tackle their long waiting times. In fact, extending choice may improve access to some, but equally, it is likely to make access worse for others by both delaying and denying their chance of being treated.

The right to choose will inevitably involve trade offs with other, equally desirable objectives such as equity of access. Surprisingly, 'equity' was notably absent from the list of key terms defined and discussed by the Department of Health in its publications setting out the policy on patient choice.

The assumption appears to have been that offering choice to everyone means that there is no need to worry about equity. What if choices are more likely to be exercised by those who are more educated, more articulate, fitter and more able to travel?

Extending choice always involves a cost. In the case of a patient seeking quicker treatment outside their area, extra travel and accommodation costs may be involved. Much more importantly, while the NHS capacity to treat patients remains limited, the gain to those getting quicker treatment can only be at the expense of others who are forced to wait longer.

Given a fixed health care budget, there is an irreconcilable conflict involved between allowing individual patients unconstrained choice, between treatments which are free at the point of consumption and the allocation of resources in a cost effective manner. Individuals may choose treatments that are the most effective (and that best meet their preferences) but not most cost effective (or that reflect the preferences of society as a whole) - with corresponding opportunity costs in terms of health gain foregone by other patients.

Crudely put, one patient's choice may deny another's treatment.

Of course, the 'costs' (not just financial) associated with the right to choose are not necessarily prohibitive. For example, allowing patients to choose between different treatments may reduce rather than increase costs if, as in the case of prostate cancer, they tend to prefer watchful waiting to aggressive intervention. But in general, in choosing to promote choice we should be aware of the sacrifices we will need to make.

In our view, the current initiatives to improve choice are motivated as much by the objective of reducing waiting times as that of improving choice. Moving beyond these relatively limited initiatives will require careful consideration. At the heart of this debate is whether choice is a means to an end or is an end in itself. If the latter, we need to be clear what value we place on choice and what we are prepared to sacrifice in order to obtain it.

*Next month (March) the King's Fund will be publishing an extended discussion of patient choice title:

Choice in Health Care: A price worth paying?
For details call the King's Fund on 020 7307 2581

Commissioning mental health for black people

A project aimed at helping mental health services and voluntary sector groups provide better standards of mental health care for black people has been launched by the Sainsbury Centre for Mental Health (SCMH).

Launching the new *Breaking the Circles of Fear** project, SCMH Chief Executive Matt Muijen said: 'Research shows that black African and Caribbean people too often find mental health services oppressive and unhelpful. They are at least three times more likely than white people to be subject to forcible treatment yet less likely to be offered "talking" therapies. As a result, many do not come forward for treatment until their illnesses have become very serious. This is one of the biggest inequalities in UK health care today.'

The three-year project has two aims. First, it will give black users of mental health services a stronger voice in how services are run. Second, it will support mental health workers to offer a better standard of care to black people.

To achieve these goals, the project will:

- Support black user and community groups to establish 'gateway' agencies to foster better communication between mental health services and black communities;

- Provide leadership training for black workers in the NHS, social services and voluntary groups;
- Offer learning opportunities to help mental health workers respond better to diversity;
- Support the creation of a national voice for black mental health service users.

Project Manager Errol Francis said: '*Breaking the Circles of Fear* will help black communities and mental health services to work together locally, often for the first time, to deliver better care to patients. It is not about imposing a single blueprint on every service around the country, it is more about overcoming the mutual fear that so badly damages relations between staff and patients.'

'We hope that *the project* will inspire a whole range of public services to respond more positively to diversity. Housing services, the police, prisons and the benefits system all need to work more closely with black communities to promote better mental health. Our approach may help them to do that.'

(*The report *Breaking the Circles of Fear* was published in June 2002 by the Sainsbury Centre for Mental Health. Its 15 recommendations included the creation of 'gateway' agencies; better training for mental health workers; a review of the role of acute in-patient services; and the creation of a national black user movement.

The implementation project will be managed by the Sainsbury Centre for Mental Health with funding from the Gatsby Charitable Foundation. It is currently seeking further funding for its development activities.)

A briefing paper giving full details of the implementation project is available online at www.scmh.org.uk.

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Cancer BACUP directory of cancer services

The charity's new and improved 2003 directory contains a new section specifically aimed at addressing the needs of hard to reach communities.

See website details at:

www.cancerbacup.org.uk

The Psychological Care of Medical Patients: A Practical Guide

A new joint report from the Royal College of Physicians (RCP) and Royal College of Psychiatrists (RCPsych) addresses the question, how can doctors help patients with psychological problems? A new, free patient leaflet is also available.

Details at www.rcplondon.ac.uk

Value in Health in Practice Priorities, QALYs, and Choice

By Douglas McCulloch

This informative and authoritative book explains health service choice, focusing in particular on the QALY success story. The merits and drawbacks of this measure are thoroughly and accessibly explained. It is aimed at healthcare professionals, pharmaceutical industry managers and students of economics.

Ashgate Publishers £38.95

Details at www.ashgate.com

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Partnerships with Social Services

Break down the barriers to care and create new shared roles



Cathy Mitchell

PCTs need to review traditional roles and responsibilities to deliver integrated, seamless services says Cathy Mitchell, Head of Community Care Services, London Borough of Barking and Dagenham

Primary Care Trusts have to view their role as a provider of services in the context of the whole Health and Social Care economy in order to deliver seamless services which maximise resources, eg, financial and human.

Increasing demands are placed on the whole economy and therefore presenting services with needs that are significantly more complex.

In addition to the above older people's expectations have changed. They want their complex needs met within community settings.

People also want alternative models of care, such as housing with extra care. Outreach intermediate care services can only be delivered as a service if the workforce is equipped to undertake the new roles and responsibilities.

This requires the PCT to build capacity to deliver the service. This has to be done by reviewing traditional roles and responsibilities and mapping the range of competencies required for the future, thus complimenting nursery and social work roles with new roles that combine Health and Social Care skills/competence which provides a differentiated workforce that can deliver integrated seamless services as part of the care-pathway.

The challenges that will be faced are the professional, clinical and organisational boundaries that exist between partners. The cultural differences and language barriers that are pertinent to each organisation evidence these boundaries.

There is no immediate short-term solution to overcome these issues, it requires partners to work together to develop a new culture and language that underpins the new integrated working arrangements and care delivery models. This will require managers and staff

to review the documents such as policies and procedures that reinforce behaviour and cultural norms.

Therefore we need to use funding imaginatively to support the change and have a clear strategic direction which feeds into the training and development agenda for health and social care.

However throughout this process of change the user/patient experience must be harnessed to inform future development across all partner agencies.

The recognition that professional boundaries can be a limiting factor must be viewed as a challenge not a constraint. Service parties must be prepared to review the roles/responsibilities of the workforce to develop whole system working and develop relationships, trust and understanding in order to deliver service options that are tailored to the user/patient needs now and for the future.

The new integrated organisation has managers who are now managing across previous health and social care structures. This has been underpinned by the post holder retaining their substantive contract plus terms and conditions and receiving an additional honorary contract for the other organisation.

The initial difficulties of managing across a new integrated organisation become apparent in the need to maintain two systems during the integration phase. This has an impact on capacity and time.

It is critical to involve staff throughout the process and harness the potential across health and social care colleagues. Without their ownership of the vision, the organisation would become an umbrella management structure with two discrete components.

New guidelines for preventing and treating glucocorticoid-induced osteoporosis

In light of important new research since the Royal College of Physicians' 1999 Clinical Guidelines on Osteoporosis it has jointly published a supplement on glucocorticoids* with The Bone and Tooth Society of Great Britain and the National Osteoporosis Society.

Dr Juliet Compston, Chair of the Guidelines Development Group, said: 'Glucocorticoids are an important but still relatively neglected cause of osteoporosis. There are now effective prevention measures and these guidelines provide an evidence-based approach to the management of glucocorticoid-treated patients.'

Aimed at all health professionals in primary and secondary care who have a role in the management of patients treated with glucocorticoids, recommendations for patients include:

- Patients at high risk, such as those aged 65 and over, and those who have already had a bone fracture related to fragile bones should be advised to commence bone-protective therapy at the same time as starting glucocorticoids.
- Other patients taking glucocorticoids should have their bone mineral density measured with dual energy X-ray absorptiometry.
- General measures to reduce bone loss include reduction of the dose of glucocorticoids to a minimum, consideration of other formulations or ways of administering the drug and prescription of alternative immunosuppressive agents.

The report, *Glucocorticoid-Induced Osteoporosis: Guidelines for Prevention and treatment* includes an algorithm and a patient information leaflet. Price £15 from the RCP Publications Dept on 020 7935 1174 ext.254 or at www.rcplondon.ac.uk.

Putting CHD Policy Into Practice

Supported by educational grants from



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A PCP SUPPLEMENT ON PROGRESS OF THE NSF FOR CHD

Heart Disease in England Today

By Dr Roger Boyle, National Clinical Director for Heart Disease

Heart disease is England's biggest killer. Although deaths from heart disease have decreased considerably in the past twenty years, England still has one of the highest rates in the world. More than 1.4 million people suffer from angina. 300,000 have heart attacks every year. More than 111,000 people die of heart problems in England every year. The impact of heart disease is unequal being much more common in deprived areas, but treatment and care is often better in more prosperous areas. The National Service Framework for Coronary Heart disease set out to tackle this unacceptable postcode lottery of care.

The National Service Framework for Coronary Heart Disease

The National Service Framework for Coronary Heart disease was published in March 2000. It was drawn up by clinicians, patients, managers and government. It is a blueprint for how coronary heart disease (CHD) services will be modernised over the next ten years.

We have a way to go to catch up with health systems in some other countries. There is a great deal to be done. CHD services need more staff – doctors, nurses, scientists and a whole range of other essential members of the CHD team. Staff are too often hard pressed. Patients rightly expect a lot more from the NHS than they used to.

Early Progress

The CHD NSF is nearing the end of its third year of implementation. It is working - delivering many of its key targets and delivering some of them ahead of schedule:

- Death rates from all circulatory diseases have been reduced by some 15% from the 1995-7 baseline (and projections indicate that if the current trend continues the target of a 40% reduction in mortality by 2010 could be achieved by 2008)
- The National School Fruit Scheme now covers 425,000 children in 3,500 schools and 'Five-a-day' community projects are being set up in 66 PCTs.
- NHS smoking cessation services have helped more than 200,000 people to quit for at least 4 weeks and the ban on tobacco advertising and promotion comes into force shortly.
- The Primary Care and CHD Collaboratives are supporting GPs and their teams in making improvements to the care of patients with CHD across England. Already we are seeing marked improvements in the uptake of effective medications in patients with CHD and,

- increasingly, those at risk of developing it.
- Prescribing of cholesterol-lowering drugs – such as statins – has risen by about one third in just a year. The expected reductions in mortality are now being seen - one Primary Care Organisation has reported a validated reduction in CHD deaths of 45% in only one year.
- Clear evidence is emerging that prescribing rates for statins are beginning to match morbidity as judged by SMR, a trend that should have a major impact in reducing inequalities.
- Growing numbers of ambulance trusts are responding to top priority calls within eight minutes, helping to shave life saving minutes off the time it takes for patients with a heart attack to receive "clot-busting" drugs. Also information from the national audit, MINAP, in nearly all acute trusts in England shows that 74% of people with acute heart attacks are now receiving thrombolysis within 30 minutes of arrival in hospital compared with only 39% in 2000.
- There are 180 Rapid Access Chest Pain Clinics offering faster diagnosis for new patients with suspected heart disease, easily exceeding the target of 100 by March 2002.
- The target of 6,000 extra heart operations by April 2003 has already been achieved. Latest estimates show that by March 2002 we had already performed an extra 8,300 procedures. Waiting times are now falling in many areas as a result. For example, in December 1999 some 2,500 patients were waiting more than 9 months for heart surgery while the latest figures show that there are now under 200.
- New planning guidance issued to the NHS in October 2002 also sets out that instead of achieving a maximum three months wait for a heart operation by 2008, the target date to reach this maximum wait can now be achieved by March 2005.

Problems and Challenges

While the NHS has delivered well in achieving milestone successes, there are still substantial challenges ahead particularly in those areas of the NSF that were not early priorities.

- The growth in effective prescribing (and evidence of benefit) has put pressure on PCT budgets.
- The new targets for reducing admissions with heart failure will require primary

- and secondary care to work together to develop programmes that improve identification and treatment of this large group of largely older patients.
- There is still work to be done in identifying all patients suitable for statin therapy particularly older patients following the Heart Protection Study and those at risk of CHD. There is evidence too that about half of all patients receiving statins are not achieving target levels (total cholesterol < 5mmol/l).
- There will be important work to be done in marrying up the CHD activity with that needed for diabetes and stroke prevention. The new GP contract should help this approach.

All this requires, is that staff work together across organisational boundaries supporting the changes still needed for the future. Great progress has been made but there is more to be done than has yet been done. It is vital that lessons are learnt from the changes that have proved effective already and that the innovators (and there are many) help to disseminate the good ideas that really make a difference.

January 2003

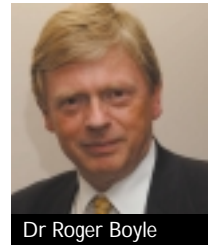
'The treatment of heart disease in general practice has vastly improved over the last few years especially in the field of secondary prevention.'

'There has been a tension between the desire to improve treatment using statins and other relatively expensive therapies and the need to prevent escalating drug budgets. Even where statins are being widely prescribed they could still be used more systematically as up to half of all patients are not achieving their target levels for cholesterol. However on the whole I believe the general practitioner has got it right and is not there for GPs to be punished either for exceeding drug budgets or failing to meet all standards.'

Dr Michael Dixon OBE, Chairman, NHS Alliance

'I welcome the increase in statin prescribing targeted to patients in most need. The use of statins and aspirins can drastically reduce mortality and demonstrates the expertise in primary care in improving the overall outcome for patients.'

Professor David Colin-Thomé, National Clinical Director of Primary Care, DoH



Dr Roger Boyle

Better primary care prevention has reduced CHD mortality

Dr Andrew Foulkes, Primary Care Adviser, Heart Team, DoH and PEC Chair, Western Sussex PCT says implementation has been impressive but more needs to be done on managing heart failure.

Since the launch of the National Service Framework for Coronary Heart Disease in March 2000, there have been sustained and impressive improvements in the management of CHD, particularly in primary care.

Most PCTs now have organised programmes supporting the implementation of the NSF. In some cases, these programmes were already in existence before March 2000. In others, Health Authorities and PCGs were instrumental in organising local networks of cardiac care and developing lead clinicians to support the changes required. In some areas the CHD Collaborative has played a lead role.

In primary care, local programmes have been supported by a number of organisations, including the Primary Care Collaborative, HIP for CHD and PRIMIS. Many PCTs have designed and supported their own programmes. Most can demonstrate both qualitative and quantitative improvements in the management of patients with established CHD. More patients are being prescribed aspirin and statins, and more patients are being reviewed on an annual basis. Statin prescribing nationally is increasing by more than 30% year on year. Evidence is emerging that from these measures alone, CHD mortality is falling. Most practices are using their practice

nurses to run CHD clinics and are using audit tools to assess progress against milestones.

Practices are beginning to identify those patients at significant risk of CHD and are taking active measures to reduce their risk. These include patients with hypertension and diabetes. There is also good evidence from prescribing data that the number of patients offered smoking cessation treatments is increasing. Many practices have access to smoking cessation advisers, exercise on prescription schemes and dietetic programmes. Improvements in GP computer systems software have helped with the recording of key data and further refinements will aid register maintenance and monitoring arrangements.

Although some practices have established programmes to identify and manage their patients at significant risk of CHD, others have yet to complete this task. CHD mortality is steadily falling by a combination of improvements in the management of the

acute coronary syndromes and improvements in secondary prevention. Preventing the disease will make further improvements in mortality, and this must be an important health improvement aim.

Some practices are beginning to turn their attention towards those patients with heart failure. The evidence suggests that this group of patients remain under diagnosed and under managed in primary care. Early detection and appropriate treatment can significantly improve the quality of life and prevent hospital admissions. For these reasons, PCTs are now developing programmes to support practices with the heart failure agenda.

The NSF has been well received in primary care and the implementation has been impressive considering the challenges that exist within general practice. The recently launched diabetes NSF should experience a much smoother passage since many of the organisational issues have already been identified and tackled.

Improving clinical outcomes through the CHD Collaborative programme

Jim Heys is Coronary Heart Disease (CHD) Collaborative Leader for South East zone.

The programme has produced many successes through its pioneering projects, but there are still 'black spots' he says in an interview with Primary Care Partnerships Editor Jenny Sims.

Part of the NHS Modernisation Agency, the Collaborative is a nationally funded programme designed to make improvements in the way CHD services are delivered to patients and is a key element in the delivery of standards laid out in the National Service Framework for CHD.

Since its launch in October 2000 with 10 local CHD programme teams it has brought together professionals involved in CHD from primary care, ambulance and hospital services to 'put patients first' in redesigning cardiac services. It has also involved patients themselves.

In particular it has pioneered the 'Discovery Interview' allowing clinical teams to understand the needs of patients and carers by getting them to talk about the impact of CHD on their lives.

Successes include shorter waiting times, better information and support and more convenient services. Many milestones are being met.

'But the really positive thing is that people are being given the tools and techniques, the opportunity and the time to do things differently,' Heys enthuses.

He comments: 'The number of sites in the collaborative have grown from 10 in 2000 to 30 today - at least one for every Strategic Health Authority, so all of England is now covered.'

Each month local clinicians and primary care leads meet to discuss progress on implementing change and improvement. However, key areas of concern remain says Heys. These include:

- Access to care
- Drug compliance
- Tertiary, secondary and primary care teams working together.

Though communications between the three sectors have improved, they could be better.

Heys says: 'The problems include getting everyone to understand what each other needs to meet requirements. This is quite difficult, for example, between tertiary and primary care as there are no natural links between tertiary consultants and more distant communities.'

'The Collaborative has succeeded in getting people from primary care teams liaising with tertiary centres so that within four days of discharging patients, GPs are informed of the discharge, told what drugs they are on, and given a management treatment plan.'

'In the past people could get admitted via A&E and might have been admitted to a hospital 20 or 30 miles away. Later, they might be recalled for aftercare check up, when quite often it could be done in the local hospital or the primary care setting. The first thing the GP would know would be when the patient walked into his surgery. That's changing.'

Asked about the concerns of cardiologists about CHD being treated in the community, and particularly how echo-cardiography services are being managed, Heys says processes are being improved in hospitals and the community.

Rapid Access Clinics were one example of success and GPs were gaining greater understanding of when to refer to clinicians in acute care.

'We have been successful in reducing waits from nine months to one or two weeks by improving processes, managing demand better and by GPs referring via agreed protocols,' he adds.

The 180 different projects have brought about many different improvements to services and patient outcomes, but there are still 'black spots,' diagnostically and geographically which need to be dealt with.

However, Heys is optimistic for future implementation of the NSF. He points out that successes are reported regularly on the Collaborative's on-line management system, which is heavily accessed by many health professionals. For more information visit www.modern.nhs.uk/chd