MEETING REPORT

# Making change happen

'Making change happen' was the theme of the 12th Annual Scientific Meeting of the Primary Care Cardiovascular Society (PCCS) in Nottingham on 1st – 3rd October 2009. The largest ever meeting of the society debated the challenges and advantages of change in a time of economic downturn in the NHS, with innovative projects and studies revealing best practice. Medical journalist Jacqui Thornton reports from the meeting where many delegates believed working together to enable change was possible and desired.

## Creative solutions

Andrew Kenworthy, the chief executive for NHS Nottingham City Primary Care Trust, and an adviser to the PCCS, set the scene for the meeting with his keynote speech on World Class Commissioning. He told delegates that although times were going to be hard in the next few years, he hoped that such financial adversity would lead to creative solutions.

Andrew Kenworthy asks delegates to be creative

In the session that followed, 'How can we make change happen', panelist Dr Adrian Brown, a consultant in public health medicine at NHS Westminster, told of two innovative programmes which, along with NHS Health Checks, were helping to transform his area. Westminster has major health inequalities – there is an 11% difference between the richest and poorest men's life expectancies, and 9% between the richest and poorest women.

To help address this imbalance, MyAction, a vascular prevention programme is being offered to 1,500 families every year in seven accessible community centres across the borough. In addition, community cardiac teams are being introduced, moving 90% of outpatient care into the community, co-located with diabetes services. Problems to be overcome included integrating NHS Health Checks with existing IT systems, and a lack of appropriate premises in the community.

Fellow panelist Dr Andrew Honeyman, a former cardiac physiologist, agreed that the next stage was cardiologists working directly for PCTs, referring patients to GPs for cardiology services in the community.

Dr Honeyman, who now works with Physiological Measurements Ltd, gave details of a study of GPs using the company's software which enables them to see their patients' echocardiograms online via a secure connection. After 12 months, 62% of users considered the service good and 23% excellent. He explained the system prevents PCTs having to pay for diagnostics twice. "Technology is an enabler…the success of this technology is a lever for more change."

Dr Jonathan Morrell, a Hastings GP and a long-standing member of the PCCS, asked in the subsequent debate for practical advice in carrying out new initiatives in this era of 'constricting resources'. Mr Kenworthy replied that it will not be possible to find new money to fund developments. "That mode of operating is gone," he said.

GP Dr Stewart Findlay and PCCS Treasurer, said PCTs were inefficient and ineffective and needed to be replaced, with GPs in the forefront as providers. Dr Mark Davis, a GP in Leeds and a founder member of PCCS, agreed and said PCTs are tinkering with a sick system. He added: "We need to do things completely differently; we need to bring in more providers, and involve general practice. Unless we change dramatically, we will go bankrupt".

## Behavioural change

Dr Alex Bobak, a GP partner in Wandsworth, London, with a special interest in smoking cessation, said altering behaviour in a positive, non-authoritarian way was a vital part of the change needed to prevent CVD.

He revealed some worrying statistics, such as the fact that 80% of pregnant women continue to smoke, based on urine tests, even though many claim to have given up.

He said nicotine receptors in the brain take two to three months to down-regulate, even though nicotine leaves the body in 24–48 hours, which is why smokers need support from trained cessation advisors for three months – not the four weeks they currently receive from the NHS.

Many patients have no idea on how to give up smoking and he described the most effective way to persuade patients to quit is to say: "I see you smoke. Did you know the best way to stop smoking is a combination of support from trained advisors and drug treatments, which

can increase your success by 10 times". He said that this intervention should be repeated every time doctors and nurses see the patient.

Dr Alison Oldam, a consultant clinical psychologist in South Tyneside, and physiotherapist Cath Robertson, a tutor in cardiovascular disease prevention in Leeds, echoed his argument in a fascinating joint talk on how motivational interviewing can help change behaviour in people reluctant to heed smoking or lifestyle advice.

They showed two videos using actors playing GP and patient – one using a negative approach, the other an open, positive, motivational approach. The second, more effective one was shorter – showing motivational interviewing can actually save clinicians' time.

## Beyond QOF

In the session 'How to make a difference', the leaders of two projects showed they have gone 'beyond the quality and outcomes framework (QOF)' with innovative schemes. In the North West, the BIG Bolton Health Check has been a great success, run by former GP Dr Stephen Liversedge, who now is chair of the Professional Executive Committee at NHS Bolton.

The scheme promoting health checks for the over 45s, through GPs, with an aim of 90% uptake through 'logarithmic incentivisation', was launched in the town square, where MPs and councillors were given health checks along with 500 residents. Community outreach in supermarkets, betting shops, mosques, and pubs led to uptake in hard-to-reach groups. Dr Liversedge warned to beware of duplication, though – one man came to be assessed in four different locations because he enjoyed it so.

Some GPs took to it extremely well, others not so well. "In some practices there was a grudging agreement this is something that should be done and rapid delegation to the youngest GP present to do it all," he added. Dr Liversedge audited peer group clusters, comparing like with like, so practices could not trot out familiar excuses for failure.

A key learning was that written invitations to patients from surgeries to come for checks didn't work. "What did work was a personal telephone call from a receptionist that the patient knew… they were instrumental in getting good uptake." A second key learning was that the male working population is the hardest to reach. As a result of the programme, primary prevention registers have swelled from 9,000 to 19,000.

Dr George Kassianos, a GP who runs a 14,100 patient practice in Bracknell, told how his practice holds frequent QOF audits with the whole team, including receptionists.

'Darzi' evenings are held where receptionists phone patients encouraging health checks, and GPs ring patients during evenings and weekends. QOF financial incentives are awarded to all staff, including salaried GPs, cleaners and receptionists, if achieved. He carries out opportunistic cardiovascular screening, encourages patients to check their own blood pressure, and offers firm lifestyle advice.

## Cardiac rehabilitation in QOF

Dr John Buckley, an exercise physiologist and the incoming president of the British Association of Cardiac Rehabilitation, talked about the importance of cardiac rehabilitation for secondary prevention in primary care and argued it should be in QOF. The target for cardiac rehabilitation is 85% but the actual uptake is, on average, only 38%, he said.

Improvements to this target appear unlikely without proactive measures, because the NHS appears to be moving towards treating myocardial infarction in one day. He said people were moving through hospitals so quickly there was a risk they were not being referred for life-saving rehabilitation.

He told delegates that he wanted to see cardiac rehabilitation in QOF. "It's just as good as beta blockers – if something is going in GPs pockets they will use it. If we could put cardiac rehab in plastic and bottle it, we would be millionaires."

Dr Kathryn Griffith, a GP in York and chair-elect of the PCCS, agreed with the speed at which patients are passing through acute trusts. She told the plenary session that some patients with primary percutaneous coronary intervention (PCI) think that they have not had a heart attack, so they are 'alright' – they frequently do not get cardiac rehabilitation because they are in and out so quickly, particularly at the weekend.

She said: "This is why primary care is so important in reinforcing 'yes, they are lucky their heart is not damaged, but there are lots of things to do now to prevent them having a future heart attack that could kill them".

Professor Mike Kirby urges enthusiasm

Delegates are optimistic trust will return to the NHS

## Trust and the future

Despite the bleak warnings at the beginning of the meeting about the lack of money available to the NHS in the next few years, the mood was cautiously optimistic.

What was important to keep hold of was trust. Professor Mike Kirby, Visiting Professor, Faculty of Health and Human Sciences, University of Hertfordshire, asked: "With so much change, every time there's a change, trust goes. How can we maintain enthusiasm when there's so much change?".

Past chairman and board member Professor Richard Hobbs, from the Department of General Practice and Primary Care, University of Birmingham, who chaired the debate on 'How can we make change happen' said: "That's an important word – trust. That's going to be a big issue for the NHS".

At the end of the debate there was a vote on whether the future is positive for the NHS. Only a third said it was. But on the question of whether trust and partnership working might return, half were affirmative, leading Professor Richard Hobbs to declare: "There's room for optimism.

"World Class Commissioning is only going to work if there's World Class clinical services available. We do have World Class Clinical Services in the UK, so, at least it's possible."