

Working with Guidelines

Last month, Ivor Eisenstadt used a specific guideline to show how the industry and the NHS may gain mutual benefit from supporting its implementation. Unfortunately, a Pf layout error caused confusion within the article. Pf apologises for its mistake and this month re-runs this valuable piece.

The recently published NICE guideline on the identification and management of familial hypercholesterolaemia (FH) is summarised below. The guideline recommends that: 'Healthcare professionals should consider prescribing a high-intensity statin to achieve a recommended reduction in LDL-C concentration of greater than 50% from baseline (that is, LDL-C concentration before treatment).'

Clearly this is an opportunity for those companies marketing statins to support the implementation of the guidance to their own

benefit as well as that of healthcare professionals and ultimately patients.

The NICE press release that introduced the guidance quoted Dr Rubin Minhas, General Practitioner and Guideline Development Group chair as saying: "By pulling together the best available evidence and advances in technology with professional and patient expertise, this guideline provides the NHS with a pragmatic and effective blueprint for reducing tens of thousands of deaths from premature heart disease. Only a fraction of people with FH in the

UK are identified and the majority of people will remain unaware of their condition and untreated, often with tragic consequences. At the moment, we know that without treatment 50% of men with untreated FH will suffer a heart attack by the age of 50, and 30% of women with untreated FH will suffer a heart attack by the age of 60. Once an individual is diagnosed with FH, the condition can be managed, usually with a statin, to help them reach normal life expectancy."

NICE provides on-line tools to help healthcare professionals

implement its guidelines. National cost reports and local cost templates have been developed to support the implementation of the FH guideline—these are available at www.nice.org.uk/CG071 and are summarised below:

- Costing reports – estimates of the national savings and costs associated with implementation. These are based on assumptions about current practice, and predictions of how it might change following implementation of the guideline.
- Costing templates – spreadsheets that allow individual organisations to estimate the local costs and savings involved. These quickly assess the impact that implementing the guideline may have on local budgets.

What can you do to help?

Support in implementing the guidance can range from straightforward sponsorship of support materials, conferences and workshops that educate and raise awareness of the guidance (as outlined in the previous article in this series) to genuine joint working arrangements.

Such joint working arrangements would need to follow:

- The ABPI Code of Practice
- Best Practice Guidance on joint working between the NHS and pharmaceutical industry and other relevant commercial organisations prepared by the Medicines, Pharmacy and Industry Group and

Familial hypercholesterolaemia – Identification and management of familial hypercholesterolaemia

Guidance type: NICE Clinical Guideline

Date issued: August 2008

Expected review date: TBC

Summary

The advice in the NICE guideline covers the care and treatment of adults and children/young people with familial hypercholesterolaemia (FH) (a specific type of inherited high cholesterol that runs in the family).

Diagnosis

A family history of premature coronary heart disease should always be assessed in a person being considered for a diagnosis of FH. In children at risk of FH because of one affected parent, the following diagnostic tests

should be carried out by the age of 10 years or at the earliest opportunity thereafter:

- a DNA test if the family mutation is known
- LDL-C concentration measurement if the family mutation is not known.

Identifying people with FH using cascade testing

Healthcare professionals should offer all people with FH a referral to a specialist with expertise in FH for confirmation of diagnosis and initiation of cascade testing. Cascade testing using a combination of DNA testing and LDL-C concentration measurement is recommended to identify affected relatives of those index individuals with a clinical diagnosis of FH. This should

include at least the first- and second- and, when possible, third-degree biological relatives.

Management

Adults

Healthcare professionals should consider prescribing a high-intensity statin to achieve a recommended reduction in LDL-C concentration of greater than 50% from baseline (that is, LDL-C concentration before treatment).

Children and young people

Healthcare professionals should offer all children and young people diagnosed with, or being investigated for, a diagnosis of FH a referral to a specialist with expertise in FH in children and young people.

published by the Department of Health (DH) in February 2008.

Joint working is defined by the Best Practice Guidance as: 'situations where, for the benefit of patients, organisations pool skills, experience and/or resources for the joint development and implementation of patient-centred projects and share a commitment to successful delivery'. Joint working differs from sponsorship, where pharmaceutical companies simply provide funds for a specific event or work programme. The DH is actively encouraging such joint working initiatives.

The guidance additionally states that: 'Joint working between the pharmaceutical industry and the NHS must be for the benefit of patients or the NHS and preserve patient care. Any joint working between the NHS and the pharmaceutical industry should be conducted in an open and transparent manner. All such activities, if properly managed, should be of mutual benefit, with the principal beneficiary being the patient. The length of the arrangement, the potential implications for patients and the NHS, together with the perceived benefits for all parties, should be clearly outlined before entering into any joint working'.

A toolkit on joint working between the NHS and pharmaceutical industry, entitled 'Moving beyond sponsorship' was issued to augment this guidance. It focuses on learning from useful examples with a view to recommending and spreading best practice.

Two 'Good Practice Examples' featured in the toolkit can be seen above. These are practical examples of the way in which support might

Ashton Leigh and Wigan PCT (ALWPCT) 'Find and Treat' Strategy

ALWPCT has a population with one of the lowest life expectancies in England and a high prevalence of coronary heart disease and diabetes. It saw valuable potential to work with industry to find a large cohort of people with these diseases and treat them. It also saw industry as a valuable contributor to its 'Learning Network', which aims to deliver high quality continuing professional development

to the PCT's clinical and managerial staff. The Find and Treat strategy involves the PCT working with pharmaceutical companies. A project manager, seconded from industry, has been appointed and is jointly funded by the PCT and ABPI to support the learning network. The pharmaceutical companies are sharing their expertise to support the PCT in the delivery of this innovative project, which aims to decrease

morbidity and mortality and increase life expectancy for the people of Wigan. A joint PCT/ABPI Project Board, which reports to both the PCT's Professional Executive Committee and ABPI's NHS Task Force, has been set up to oversee development of the Find and Treat Programme and Learning Network Curriculum and overall governance of the working relationship between the PCT and industry.

Nottingham City PCT and the ABPI NHS Outreach Programme: Happy Hearts Project

Nottingham City is the seventh most deprived local authority area in the country and as such its population suffers from associated high incidence of coronary vascular disease. Working in collaboration with six pharmaceutical companies and facilitated by the ABPI NHS Outreach Programme, the parties joined forces to develop and implement a primary care based CVD risk identification programme. Targeted at 13 practices situated in Nottingham City's most deprived areas, the 'Happy Hearts' project aims to reduce levels of CVD risk and associated premature mortality through primary care

identification and management of those people at more than a 20% risk of developing diseases such as diabetes, heart disease and stroke. Jointly (and equally) funded by the PCT and the pharmaceutical companies the project has funded the employment and training of 13 Clinical Healthcare Assistants (CHCAs) who will be employed by the practices and, using specially developed software, will identify patients who fit the criteria for potential risk. The patients will be invited to attend a consultation with the CHCA who will conduct relevant clinical tests (BP, blood glucose, cholesterol, etc) and

offer appropriate lifestyle advice and support. Patients will be signposted to relevant services such as smoking cessation clinics and, where necessary, appropriate medical intervention via the GP will be offered.

The NHS and the pharmaceutical industry stakeholders have worked together via a joint project board from start to finish, with equal input into all decisions regarding design, implementation and evaluation of the project, and have equal accountability for ensuring desired patient outcomes are achieved.

be given to implementing the FH guidelines and the principles are transferable across many disease areas. The challenge is to recognise the opportunity that a guideline may present and to work with your local NHS to develop genuine win/win arrangements that conform to the best practice guidance on joint working.

Ivor Eisenstadt is Managing Director of MGP, the publishers of Guidelines, Guidelines in Practice and Medendum. Its medical education division, Connectmedical, provides opportunities for companies to support healthcare professionals in their pursuit of best practice.

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Achieving win/win with the NHS through clinical guidance

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